# REVISOR'S REPORT

## A NONSUBSTANTIVE REVISION
## OF SUBTITLE I, TITLE 4, GOVERNMENT CODE

Submitted to the 88th Legislature
as part of the
Texas Legislative Council's
Statutory Revision Program

Austin, Texas
2023

# FOREWORD

The Texas Legislative Council is required by Section 323.007, Government Code, to carry out a complete nonsubstantive revision of the Texas statutes. The process involves reclassifying and rearranging the statutes in a more logical order, eliminating repealed, invalid, duplicative, and other ineffective provisions while employing a format and numbering system designed to accommodate future expansion of the law, and improving the draftsmanship of the statutes as practicable. The revision is intended to further the legislature's stated purpose of making the statutes "more accessible, understandable, and usable" without altering the sense, meaning, or effect of the law.

Under the classification scheme adopted by the Texas Legislative Council, the statutes will eventually consist of 27 codes, each governing a different subject matter. To date, the council has produced and the legislature has enacted the Agriculture Code, Alcoholic Beverage Code, Business & Commerce Code, Civil Practice and Remedies Code, Education Code, Election Code (a substantive revision), Estates Code, Finance Code, Government Code, Health and Safety Code, Human Resources Code, Insurance Code, Labor Code, Local Government Code, Natural Resources Code, Occupations Code, Parks and Wildlife Code, Property Code, Special District Local Laws Code, Tax Code (Title 1 of which was a substantive revision), Transportation Code, Utilities Code, and Water Code. The council's staff assisted the state bar in the Business Organizations Code, Penal Code, and Family Code projects, which were substantive revisions, and revised miscellaneous criminal procedure provisions as Title 2 of the Code of Criminal Procedure. The council's staff also assisted the Sunset Advisory Commission with a substantive revision of law related to the state's health and human services agencies. In addition, as part of its continuing statutory revision program, the council is revising other laws, including various portions of the Code of Criminal Procedure.

The revised provisions of Subtitle I, Title 4, Government Code, which govern the Health and Human Services Commission and the provision of health and human services by the commission and other health and human services agencies, included in this revision are placed in that subtitle. The subtitle is divided into chapters by subject matter and sections for distinct provisions of law. Sections are numbered decimally, with the number to the left of the decimal the same as the number of the chapter in which the section is contained. The revised provisions are added as new chapters to Subtitle I and include subchapters for organization. The chapter and section numbering system incorporates gaps to accommodate later expansions of the law.

This revisor's report reflects the enactment of Chapter 769 (H.B. 4611), Acts of the 88th Legislature, Regular Session, 2023, the Texas Legislative Council staff's revision of the statutes relating to the Health and Human Services Commission, Medicaid, and other social services. The revisor's report states the Revised Law, which is the text of the new law, and immediately following

that law provides the Source Law, which is the text of the former law from which the new law was derived. If the revised law or source law requires any explanation, a Revisor's Note is included after the source law. All substance of the source law is revised in the revised law or the reason for its omission is explained in a revisor's note.

Note that this revision does not take effect until April 1, 2025, to provide all affected persons a complete legislative cycle to review the revision more closely.

Because of the extensive reorganization of many provisions, a reader may find it helpful to read the entire source law for a given chapter of the revised law and to refer to the disposition table, which shows where the former provisions, as revised, are placed in Subtitle I, Title 4, Government Code. The disposition table is printed as Appendix C to the revisor's report.

The revision required conforming amendments to many statutes. These amendments, also enacted into law by Chapter 769 (H.B. 4611), Acts of the 88th Legislature, Regular Session, 2023, are printed in Appendix A to the revisor's report. Appendix A also includes a section listing the laws repealed effective April 1, 2025, and a section stating the legislature's intent that Subtitle I, Title 4, Government Code, be a nonsubstantive revision.

In reviewing this revisor's report, the reader should keep in mind that:

(1) Except as otherwise provided, Chapter 311, Government Code (Code Construction Act), applies to Subtitle I, Title 4, Government Code. Chapter 311 establishes certain principles of statutory construction applicable to the revised law and also provides some definitions. The chapter is printed as Appendix B to this report.

(2) The proposed provisions of the subtitle are written in modern American English. Where possible, the revised law uses the present tense, favors the use of the active voice over the passive voice, and prefers the singular over the plural.

(3) This enactment is a nonsubstantive revision. The Texas Legislative Council staff's authority does not include improving the substance of the source law. The sole purpose of the revision is to compile all the relevant law, arrange it in a logical fashion, and rewrite it without altering its sense, meaning, or legal effect. If a particular source law provision is ambiguous and the ambiguity cannot be resolved without a potential substantive effect, the ambiguity is preserved.

This revision project is under the direction of Kristine Rodriguez, Legislative Counsel, of the Texas Legislative Council's legal division staff. Questions may be directed to Ms. Rodriguez at P.O. Box 12128, Capitol Station, Austin, Texas 78711-2128, or by telephone at (512) 463-1151.

GOVERNMENT CODE

TITLE 4. EXECUTIVE BRANCH

SUBTITLE I. HEALTH AND HUMAN SERVICES


CHAPTER 521. GENERAL PROVISIONS

CHAPTER 522. PROVISIONS APPLICABLE TO ALL HEALTH AND HUMAN SERVICES AGENCIES AND CERTAIN OTHER STATE ENTITIES

CHAPTER 523. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 524. AUTHORITY OVER HEALTH AND HUMAN SERVICES SYSTEM

CHAPTER 525. GENERAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

CHAPTER 526. ADDITIONAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

CHAPTER 532. MEDICAID ADMINISTRATION AND OPERATION IN GENERAL

CHAPTER 540. MEDICAID MANAGED CARE PROGRAM

CHAPTER 540A. MEDICAID MANAGED TRANSPORTATION SERVICES

CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

CHAPTER 543. CLINICAL INITIATIVES TO IMPROVE MEDICAID QUALITY OF CARE AND COST-EFFECTIVENESS

CHAPTER 543A. QUALITY-BASED OUTCOMES AND PAYMENTS UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM

CHAPTER 544. FRAUD, WASTE, ABUSE, AND OVERCHARGES RELATING TO HEALTH AND HUMAN SERVICES

CHAPTER 545. CERTAIN PUBLIC ASSISTANCE BENEFITS

CHAPTER 546. LONG-TERM CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES AND ELDERLY INDIVIDUALS

CHAPTER 547. MENTAL HEALTH AND SUBSTANCE USE SERVICES

CHAPTER 547A. COMMUNITY COLLABORATIVES

CHAPTER 548. HEALTH CARE SERVICES PROVIDED THROUGH TELE-CONNECTIVE MEANS

CHAPTER 549. PROVISION OF DRUGS AND DRUG INFORMATION

# CHAPTER 550. HUMAN SERVICES AND OTHER SOCIAL SERVICES PROVIDED THROUGH FAITH- AND COMMUNITY-BASED ORGANIZATIONS

CHAPTER 521. GENERAL PROVISIONS
Sec. 521.0001. DEFINITIONS . . . . . 3
Sec. 521.0002. REFERENCES IN LAW MEANING COMMISSION OR COMMISSION DIVISION . . . . . 6
Sec. 521.0003. REFERENCES IN LAW MEANING EXECUTIVE COMMISSIONER, EXECUTIVE COMMISSIONER'S DESIGNEE, OR DIVISION DIRECTOR . . . . . 9
Sec. 521.0004. REFERENCES IN LAW TO PROVISIONS DERIVED FROM FORMER CHAPTER 531 . . . . . 12

CHAPTER 521. GENERAL PROVISIONS

Revised Law

Sec. 521.0001. DEFINITIONS. In this subtitle:

(1) "Child health plan program" means the programs established under Chapters 62 and 63, Health and Safety Code.

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

(3) "Executive commissioner" means the executive commissioner of the commission.

(4) "Executive council" means the council established under Subchapter C, Chapter 523.

(5) "Health and human services agencies" includes the Department of State Health Services.

(6) "Health and human services system" means the system for providing or otherwise administering health and human services in this state by the commission, including through:

(A) an office or division of the commission; or

(B) another entity under the administrative and operational control of the executive commissioner.

(7) "Home telemonitoring service" means a health service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home and community support services agency or hospital, as those terms are defined by Section 548.0251.

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

(9) "Medicaid managed care organization" means a managed care organization as defined by Section 540.0001 that contracts with the commission under Chapter 540 or 540A to provide health care services to Medicaid recipients.

(10) "Platform" means the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service, teledentistry dental service, or telehealth service.

(11) "Section 1915(c) waiver program" means a federally funded state Medicaid program authorized under Section 1915(c) of the Social Security Act (42 U.S.C. Section 1396n(c)).

(12) "Teledentistry dental service," "telehealth service," and "telemedicine medical service" have the meanings assigned by Section 111.001, Occupations Code. (Gov. Code, Secs. 531.001(1-a), (2), (3), (3-a), (4), (4-a), (4-b), (4-c), (4-d), (6), (6-a), (7), (8); New.)

Source Law

Sec. 531.001. DEFINITIONS. In this subtitle:

(1-a) "Child health plan program" means the child health plan program established under Chapters 62 and 63, Health and Safety Code.

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

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

(3-a) "Health and human services system" means the system for providing or otherwise administering health and human services in this state by the commission, including through an office or division of the commission or through another entity under the administrative and operational control of the executive commissioner.

(4) "Health and human services agencies" includes the:

(A) Department of Aging and Disability Services;

(B) Department of State Health Services; and

(C) Department of Assistive and Rehabilitative Services.

(4-a) "Home telemonitoring service" means a health service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home and community support services agency or a hospital, as those terms are defined by Section 531.02164(a).

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

(4-c) "Medicaid managed care organization" means a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients.

(4-d) "Platform" means the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service, teledentistry dental service, or telehealth service.

(6) "Section 1915(c) waiver program" means a federally funded program of the state under Medicaid that is authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)).

(6-a) "Teledentistry dental service" has the meaning assigned by Section 111.001, Occupations Code.

(7) "Telehealth service" has the meaning assigned by Section 111.001, Occupations Code.

(8) "Telemedicine medical service" has the meaning assigned by Section 111.001, Occupations Code.

Revisor's Note

(1) The definition of "executive council" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition throughout Subtitle I, Title 4, Government Code, which includes this chapter. The executive council was originally established under Section 531.0051, Government Code. The provisions of that section are revised in this subtitle as Subchapter C, Chapter 523, and the revised law is drafted accordingly.

(2) Section 531.001(4), Government Code, provides that "[h]ealth and human services agencies" includes the "Department of Aging and Disability Services" and the "Department of Assistive and Rehabilitative Services." The Department of Aging and Disability Services was abolished September 1, 2017,

in accordance with Section 531.0202(b), Government Code, which is executed law that expired September 1, 2023. The Department of Assistive and Rehabilitative Services was abolished September 1, 2016, in accordance with Section 531.0202(a), Government Code, which is also executed law that expired September 1, 2023. Because those agencies have been abolished, the revised law omits the quoted references as obsolete.

Revised Law

Sec. 521.0002. REFERENCES IN LAW MEANING COMMISSION OR COMMISSION DIVISION. (a) This section applies notwithstanding Section 521.0001(5).

(b) A reference in any law to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, means the commission or the division of the commission performing the function previously performed by the state agency or entity before the transfer, as appropriate:

(1) health and human services agency;

(2) the Department of State Health Services;

(3) the Department of Aging and Disability Services;

(4) subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, the Department of Family and Protective Services; or

(5) the Department of Assistive and Rehabilitative Services.

(c) Notwithstanding any other law, a reference in any law to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, from the state agency that assumed the relevant function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003,

means the commission or the division of the commission performing the function previously performed by the agency that assumed the function before the transfer, as appropriate:

(1) the Texas Department on Aging;

(2) the Texas Commission on Alcohol and Drug Abuse;

(3) the Texas Commission for the Blind;

(4) the Texas Commission for the Deaf and Hard of Hearing;

(5) the Texas Department of Health;

(6) the Texas Department of Human Services;

(7) the Texas Department of Mental Health and Mental Retardation;

(8) the Texas Rehabilitation Commission;

(9) the Texas Health Care Information Council; or

(10) the Interagency Council on Early Childhood Intervention.

(d) Notwithstanding any other law and subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, a reference in any law to the Department of Protective and Regulatory Services in relation to a function transferred under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, from the Department of Family and Protective Services means the commission or the division of the commission performing the function previously performed by the Department of Family and Protective Services before the transfer. (Gov. Code, Sec. 531.0011.)

Source Law

> Sec. 531.0011. REFERENCES IN LAW MEANING COMMISSION OR APPROPRIATE DIVISION. (a) In this code or in any other law, a reference to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, means the commission or the division of the commission performing the function previously performed by the state agency or entity before the transfer, as appropriate:
>
> (1) health and human services agency;
>
> (2) the Department of State Health Services;

(3) the Department of Aging and Disability Services;

(4) the Department of Family and Protective Services; or

(5) the Department of Assistive and Rehabilitative Services.

(b) In this code or in any other law and notwithstanding any other law, a reference to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, from the state agency that assumed the relevant function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, means the commission or the division of the commission performing the function previously performed by the agency that assumed the function before the transfer, as appropriate:

(1) the Texas Department on Aging;

(2) the Texas Commission on Alcohol and Drug Abuse;

(3) the Texas Commission for the Blind;

(4) the Texas Commission for the Deaf and Hard of Hearing;

(5) the Texas Department of Health;

(6) the Texas Department of Human Services;

(7) the Texas Department of Mental Health and Mental Retardation;

(8) the Texas Rehabilitation Commission;

(9) the Texas Health Care Information Council; or

(10) the Interagency Council on Early Childhood Intervention.

(c) In this code or in any other law and notwithstanding any other law, a reference to the Department of Protective and Regulatory Services in relation to a function transferred under Section 531.0201, 531.02011, or 531.02012, as applicable, from the Department of Family and Protective Services means the commission or the division of the commission performing the function previously performed by the Department of Family and Protective Services before the transfer.

(d) This section applies notwithstanding Section 531.001(4).

Revisor's Note

(1) Sections 531.0011(a), (b), and (c), Government Code, refer to a function transferred under Section 531.0201, 531.02011, or 531.02012 of that code, each of which provides for the transfer of certain functions from health and human services agencies to the Health and Human Services Commission. Because Sections 531.0201, 531.02011, and 531.02012 expired on September 1, 2023, the revised law adds "as those sections existed immediately before their expiration on September 1, 2023," following each

reference to those sections for clarity after September 1, 2023.

(2) Sections 531.0011(a) and (c), Government Code, provide that references to the Department of Family and Protective Services and the Department of Protective and Regulatory Services, respectively, as they relate to functions transferred from the Department of Family and Protective Services to the Health and Human Services Commission under Sections 531.0201, 531.02011, and 531.02012, Government Code, mean the commission or a division of the commission. Sections 531.0201, 531.02011, and 531.02012 were enacted in 2015 by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session. In 2017, Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, retransferred to the department certain powers and duties previously transferred to the commission by Chapter 837 in 2015. For accuracy, the revised law adds language to the department references to clarify that the transfer and performance of certain functions transferred by Chapter 837 in 2015 have been superseded by transfers of the functions made by Chapter 316 in 2017.

Revised Law

Sec. 521.0003. REFERENCES IN LAW MEANING EXECUTIVE COMMISSIONER, EXECUTIVE COMMISSIONER'S DESIGNEE, OR DIVISION DIRECTOR. (a) A reference in any law to any of the following persons in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, means the executive commissioner, the executive commissioner's designee, or the director of the commission division performing the function previously performed by the state agency from which the function was transferred and that the person represented, as

appropriate:

(1) the commissioner of aging and disability services;

(2) the commissioner of assistive and rehabilitative services;

(3) the commissioner of state health services; or

(4) subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, the commissioner of the Department of Family and Protective Services.

(b) Notwithstanding any other law and subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, a reference in any law to any of the following persons or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, from the state agency that assumed or continued to perform the function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, means the executive commissioner or the director of the commission division performing the function performed before the enactment of Chapter 198 (H.B. 2292) by the state agency that was abolished or renamed by Chapter 198 (H.B. 2292) and that the person or entity represented:

(1) an executive director or other chief administrative officer of a state agency listed in Section 521.0002(c) or of the Department of Protective and Regulatory Services; or

(2) the governing body of a state agency listed in Section 521.0002(c) or of the Department of Protective and Regulatory Services.

(c) A reference to any of the following councils means the executive commissioner or the executive commissioner's designee, as appropriate, and a function of any of the following councils is a function of that appropriate person:

(1) the Health and Human Services Council;

(2) the Aging and Disability Services Council;

(3) the Assistive and Rehabilitative Services Council;

(4) subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, the Family and Protective Services Council; or

(5) the State Health Services Council. (Gov. Code, Sec. 531.0012.)

Source Law

Sec. 531.0012. REFERENCES IN LAW MEANING EXECUTIVE COMMISSIONER OR DESIGNEE. (a) In this code or in any other law, a reference to any of the following persons in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, means the executive commissioner, the executive commissioner's designee, or the director of the division of the commission performing the function previously performed by the state agency from which it was transferred and that the person represented, as appropriate:

(1) the commissioner of aging and disability services;

(2) the commissioner of assistive and rehabilitative services;

(3) the commissioner of state health services; or

(4) the commissioner of the Department of Family and Protective Services.

(b) In this code or in any other law and notwithstanding any other law, a reference to any of the following persons or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, from the state agency that assumed or continued to perform the function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, means the executive commissioner or the director of the division of the commission performing the function performed before the enactment of Chapter 198 (H.B. 2292) by the state agency that was abolished or renamed by Chapter 198 (H.B. 2292) and that the person or entity represented:

(1) an executive director or other chief administrative officer of a state agency listed in Section 531.0011(b) or of the Department of Protective and Regulatory Services; or

(2) the governing body of a state agency listed in Section 531.0011(b) or of the Department of Protective and Regulatory Services.

(c) A reference to any of the following councils means the executive commissioner or the executive commissioner's designee, as appropriate, and a function of any of the following councils is a function of that appropriate person:

(1) the Health and Human Services Council;

(2) the Aging and Disability Services Council;

(3) the Assistive and Rehabilitative Services Council;

(4) the Family and Protective Services Council; or

(5) the State Health Services Council.

Revisor's Note

(1) Sections 531.0012(a) and (b), Government Code, refer to a function transferred under Section 531.0201, 531.02011, or 531.02012 of that code, each of which provides for the transfer of certain functions from health and human services agencies to the Health and Human Services Commission. The revised law adds "as those sections existed immediately before their expiration on September 1, 2023," following each reference to those sections for the reason stated in Revisor's Note (1) to Section 521.0002 of this chapter.

(2) Sections 531.0012(a), (b), and (c), Government Code, provide that references to certain persons, entities, and councils associated with the Department of Family and Protective Services as they relate to certain department functions mean the executive commissioner of the Health and Human Services Commission, the executive commissioner's designee, or a director of a commission division. The revised law adds language to those department references for the reason stated in Revisor's Note (2) to Section 521.0002 of this chapter.

Revised Law

Sec. 521.0004. REFERENCES IN LAW TO PROVISIONS DERIVED FROM FORMER CHAPTER 531. A reference in any law to "revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025," is a reference to the following:

(1) Sections 532.0051, 532.0052, 532.0053, 532.0054, 532.0055, 532.0057, 532.0058, 532.0059, 532.0060, 532.0061, and 540.0051;

(2) Subchapters B, C, D, E, F, G, H, I, and J, Chapter 532, Subchapters A, B, C, D, E, F, G, H, and I, Chapter 548, and

Subchapters D, D-1, and E, Chapter 550; and

(3) this chapter and Chapters 522, 523, 524, 525, 526, 544, 545, 546, 547, and 549. (New.)

Revisor's Note

Various provisions of Subtitle I, Title 4, Government Code, and other laws contain references to Chapter 531, Government Code, or to "this chapter," meaning Chapter 531. See, e.g., Sections 531.004 and 531.033, Government Code, referring to "this chapter," meaning Chapter 531, and Section 31.0127(b), Human Resources Code, referring to Chapter 531. Provisions of Chapter 531 are revised throughout Subtitle I, Title 4, along with other provisions that are not derived from Chapter 531. Because of this, in each occurrence of a source law reference to Chapter 531, the revised law would need to contain an exhaustive list of every provision derived from the chapter, making the law cumbersome and difficult to read. For clarity and the convenience of the reader, the revised law adds Section 521.0004, Government Code, listing each provision of the revised law that is derived from Chapter 531 and stating that a reference in law to the "revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025," means the provisions specified in that list.

CHAPTER 522. PROVISIONS APPLICABLE TO ALL HEALTH AND HUMAN SERVICES AGENCIES AND CERTAIN OTHER STATE ENTITIES

SUBCHAPTER A. FISCAL PROVISIONS

Sec. 522.0001. LEGISLATIVE APPROPRIATIONS REQUEST BY HEALTH AND HUMAN SERVICES AGENCY . . . . . 15

Sec. 522.0002. ACCEPTANCE OF CERTAIN GIFTS AND GRANTS BY HEALTH AND HUMAN SERVICES AGENCY . . . . 15

SUBCHAPTER B. CONTRACTS
Sec. 522.0051. NEGOTIATION AND REVIEW OF CERTAIN CONTRACTS FOR HEALTH CARE PURPOSES . . . . . 16
Sec. 522.0052. PERFORMANCE STANDARDS FOR CONTRACTED SERVICES PROVIDED TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY . . . . . 18
SUBCHAPTER C. DATA SHARING
Sec. 522.0101. SHARING OF DATA RELATED TO CERTAIN GENERAL REVENUE FUNDED PROGRAMS . . . . . 22
SUBCHAPTER D. COORDINATION OF MULTIAGENCY SERVICES
Sec. 522.0151. DEFINITION . . . . . 23
Sec. 522.0152. APPLICABILITY OF SUBCHAPTER TO CERTAIN STATE ENTITIES . . . . . 23
Sec. 522.0153. MEMORANDUM OF UNDERSTANDING REQUIRED . . . . 24
Sec. 522.0154. DEVELOPMENT AND IMPLEMENTATION OF MEMORANDUM OF UNDERSTANDING . . . . . 25
Sec. 522.0155. CONTENTS OF MEMORANDUM OF UNDERSTANDING . . . 25
Sec. 522.0156. ADOPTION OF MEMORANDUM OF UNDERSTANDING; REVISIONS . . . . . 29
Sec. 522.0157. STATE-LEVEL INTERAGENCY STAFFING GROUP DUTIES; BIENNIAL REPORT . . . . . 29
SUBCHAPTER E. PUBLIC ACCESS TO MEETINGS
Sec. 522.0201. DEFINITION . . . . . 30
Sec. 522.0202. ADDITIONAL APPLICABILITY TO CERTAIN ADVISORY BODIES . . . . . 30
Sec. 522.0203. INTERNET BROADCAST AND ARCHIVE OF OPEN MEETING . . . . . 31
Sec. 522.0204. INTERNET NOTICE OF OPEN MEETING . . . . . 32
Sec. 522.0205. EXEMPTION UNDER CERTAIN CIRCUMSTANCES . . . . 32
Sec. 522.0206. CONTRACTING AUTHORIZED . . . . . 33
SUBCHAPTER F. FACILITIES
Sec. 522.0251. LEASE OR SUBLEASE OF CERTAIN OFFICE SPACE . . . . . 33

Sec. 522.0252. ASSUMPTION OF LEASE FOR IMPLEMENTATION OF INTEGRATED ENROLLMENT SERVICES INITIATIVE . . . . . 35
Sec. 522.0253. PREREQUISITES FOR ESTABLISHING NEW HEALTH AND HUMAN SERVICES FACILITY IN CERTAIN COUNTIES . . . . . 35

CHAPTER 522. PROVISIONS APPLICABLE TO ALL HEALTH AND HUMAN SERVICES AGENCIES AND CERTAIN OTHER STATE ENTITIES

SUBCHAPTER A. FISCAL PROVISIONS

Revised Law

Sec. 522.0001. LEGISLATIVE APPROPRIATIONS REQUEST BY HEALTH AND HUMAN SERVICES AGENCY. (a) Each health and human services agency shall submit to the commission a biennial agency legislative appropriations request on a date determined by commission rule.

(b) A health and human services agency may not submit the agency's legislative appropriations request to the legislature or the governor until the commission reviews and comments on the request. (Gov. Code, Sec. 531.027.)

Source Law

> Sec. 531.027. APPROPRIATIONS REQUEST BY AGENCIES. (a) Each health and human services agency shall submit to the commission a biennial agency legislative appropriations request on a date to be determined by commission rule.
>
> (b) A health and human services agency may not submit to the legislature or the governor its legislative appropriations request until the commission reviews and comments on the legislative appropriations request.

Revised Law

Sec. 522.0002. ACCEPTANCE OF CERTAIN GIFTS AND GRANTS BY HEALTH AND HUMAN SERVICES AGENCY. (a) Subject to the executive commissioner's written approval, a health and human services agency may accept a gift or grant of money, drugs, equipment, or any other item of value from a pharmaceutical manufacturer, distributor, provider, or other entity engaged in a pharmaceutical-related business.

(b) Chapter 575 does not apply to a gift or grant under this section.

(c) The executive commissioner may adopt rules and procedures to implement this section. The rules must ensure that acceptance of a gift or grant under this section:

(1) is consistent with federal laws and regulations; and

(2) does not adversely affect federal financial participation in any state program, including Medicaid.

(d) This section does not affect the commission's or a health and human services agency's authority under other law to accept a gift or grant from a person other than a pharmaceutical manufacturer, distributor, provider, or other entity engaged in a pharmaceutical-related business. (Gov. Code, Sec. 531.0381.)

Source Law

> Sec. 531.0381. CERTAIN GIFTS AND GRANTS TO HEALTH AND HUMAN SERVICES AGENCIES. (a) Subject to this section, a health and human services agency may accept a gift or grant of money, drugs, equipment, or any other item of value from a pharmaceutical manufacturer, distributor, provider, or another entity engaged in a pharmaceutical-related business.
>
> (b) Acceptance of a gift or grant under this section is subject to the written approval of the executive commissioner. Chapter 575 does not apply to a gift or grant under this section.
>
> (c) The executive commissioner may adopt rules and procedures to implement this section. The rules must ensure that acceptance of a gift or grant under this section is consistent with any applicable federal law or regulation and does not adversely affect federal financial participation in any state program, including Medicaid.
>
> (d) This section does not affect the authority under other law of the commission or a health and human services agency to accept a gift or grant from a person other than a pharmaceutical manufacturer, distributor, provider, or another entity engaged in a pharmaceutical-related business.

SUBCHAPTER B. CONTRACTS

Revised Law

Sec. 522.0051. NEGOTIATION AND REVIEW OF CERTAIN CONTRACTS FOR HEALTH CARE PURPOSES. (a) This section applies to a contract with a contract amount of $250 million or more:

(1) under which a person will provide goods or

services in connection with the provision of medical or health care services, coverage, or benefits; and

(2) that will be entered into by the person and:

(A) the commission;

(B) a health and human services agency; or

(C) any other state agency under the commission's jurisdiction.

(b) An agency described by Subsection (a)(2) must notify the office of the attorney general at the time the agency initiates the planning phase of the contracting process for a contract described by Subsection (a). A representative of the office of the attorney general or another attorney advising the agency as provided by Subsection (d) may:

(1) participate in negotiations or discussions with proposed contractors; and

(2) be physically present during those negotiations or discussions.

(c) Notwithstanding any other law, before an agency described by Subsection (a)(2) may enter into a contract described by Subsection (a), a representative of the office of the attorney general shall review the form and terms of the contract and may make recommendations to the agency for changes to the contract if the attorney general determines that the office of the attorney general has sufficient subject matter expertise and resources available to provide this service.

(d) If the attorney general determines that the office of the attorney general does not have sufficient subject matter expertise or resources available to provide the services described by this section, the office of the attorney general may require the agency described by Subsection (a)(2) to enter into an interagency agreement or obtain outside legal services under Section 402.0212 for the provision of services described by this section.

(e) The agency described by Subsection (a)(2) shall provide to the office of the attorney general any information the office of

the attorney general determines is necessary to administer this section. (Gov. Code, Sec. 531.018.)

Source Law

Sec. 531.018. CERTAIN CONTRACTS FOR HEALTH CARE PURPOSES; REVIEW BY ATTORNEY GENERAL. (a) This section applies to any contract with a contract amount of $250 million or more:

(1) under which a person provides goods or services in connection with the provision of medical or health care services, coverage, or benefits; and

(2) entered into by the person and:

(A) the commission;

(B) a health and human services agency; or

(C) any other state agency under the jurisdiction of the commission.

(b) Notwithstanding any other law, before a contract described by Subsection (a) may be entered into by the agency, a representative of the office of the attorney general shall review the form and terms of the contract and may make recommendations to the agency for changes to the contract if the attorney general determines that the office of the attorney general has sufficient subject matter expertise and resources available to provide this service.

(c) An agency described by Subsection (a)(2) must notify the office of the attorney general at the time the agency initiates the planning phase of the contracting process. A representative of the office of the attorney general or another attorney advising the agency under Subsection (d) may participate in negotiations or discussions with proposed contractors and may be physically present during those negotiations or discussions.

(d) If the attorney general determines that the office of the attorney general does not have sufficient subject matter expertise or resources available to provide the services described by this section, the office of the attorney general may require the state agency to enter into an interagency agreement or to obtain outside legal services under Section 402.0212 for the provision of services described by this section.

(e) The state agency shall provide to the office of the attorney general any information the office of the attorney general determines is necessary to administer this section.

Revised Law

Sec. 522.0052. PERFORMANCE STANDARDS FOR CONTRACTED SERVICES PROVIDED TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY. (a) This section does not apply to 2-1-1 services provided by the Texas Information and Referral Network.

(b) Each contract with the commission or a health and human services agency that requires the provision of call center services or written communications related to call center services must

include performance standards that measure the effectiveness, promptness, and accuracy of the contractor's oral and written communications with individuals with limited English proficiency.

(c) A person who seeks to enter into a contract described by Subsection (b) must include in the bid or other applicable expression of interest for the contract a proposal for providing call center services or written communications related to call center services to individuals with limited English proficiency. The proposal must include a language access plan that describes how the contractor will:

(1) achieve any performance standards described in the request for bids or other applicable expressions of interest;

(2) identify individuals who need language assistance;

(3) provide language assistance measures, including the translation of forms into languages other than English and the provision of translators and interpreters;

(4) inform individuals with limited English proficiency of the language services available to them and how to obtain those services;

(5) develop and implement qualifications for bilingual staff; and

(6) monitor compliance with the plan.

(d) In determining which bid or other applicable expression of interest offers the best value, the commission or a health and human services agency, as applicable, shall evaluate the extent to which the proposal for providing call center services or written communications related to call center services in languages other than English will provide meaningful access to the services for individuals with limited English proficiency.

(e) In determining the extent to which a proposal will provide meaningful access under Subsection (d), the commission or health and human services agency, as applicable, shall consider:

(1) the language access plan described by Subsection

(c);

(2) the number or proportion of individuals with limited English proficiency in the commission's or agency's eligible service population;

(3) the frequency with which individuals with limited English proficiency seek information regarding the commission's or agency's programs;

(4) the importance of the services provided by the commission's or agency's programs; and

(5) the resources available to the commission or agency.

(f) The commission or health and human services agency, as applicable, shall avoid selecting a contractor that the commission or agency reasonably believes will:

(1) provide information in languages other than English that is limited in scope;

(2) unreasonably delay the provision of information in languages other than English; or

(3) provide program information, including forms, notices, and correspondence, in English only. (Gov. Code, Sec. 531.0191.)

Source Law

Sec. 531.0191. SERVICES PROVIDED BY CONTRACTOR TO PERSONS WITH LIMITED ENGLISH PROFICIENCY. (a) Each contract with the commission or a health and human services agency that requires the provision of call center services or written communications related to call center services must include performance standards that measure the effectiveness, promptness, and accuracy of the contractor's oral and written communications with persons with limited English proficiency. Each person who seeks to enter into a contract described by this subsection shall include in the bid or other applicable expression of interest for the contract a proposal for providing call center services or written communications related to call center services to persons with limited English proficiency.

(b) The proposal required under Subsection (a) must include a language access plan that describes how the contractor will achieve any performance standards described in the request for bids, proposals, or other applicable expressions of interest. The plan must also describe how the contractor will:

(1) identify persons who need language

assistance;

(2) provide language assistance measures, including the translation of forms into languages other than English and the provision of translators and interpreters;

(3) inform persons with limited English proficiency of the language services available to them and how to obtain them;

(4) develop and implement qualifications for bilingual staff; and

(5) monitor compliance with the language access plan.

(c) In determining which bid or other applicable expression of interest offers the best value, the commission or a health and human services agency, as applicable, shall evaluate the extent to which the proposal for providing call center services or written communications related to call center services in languages other than English will provide meaningful access to the services for persons with limited English proficiency.

(d) In determining the extent to which a proposal will provide meaningful access under Subsection (c), the agency shall consider:

(1) the language access plan developed under Subsection (b);

(2) the number or proportion of persons with limited English proficiency in the agency's eligible service population;

(3) the frequency with which persons with limited English proficiency seek information regarding the agency's programs;

(4) the importance of the services provided by the agency's programs; and

(5) the resources available to the agency.

(e) The agency must avoid selecting a contractor that the agency reasonably believes will:

(1) provide information in languages other than English that is limited in scope;

(2) unreasonably delay the provision of information in languages other than English; or

(3) provide program information, including forms, notices, and correspondence, in English only.

(f) This section does not apply to 2-1-1 services provided by the Texas Information and Referral Network.

Revisor's Note

(1) Sections 531.0191(a), (b), (c), (d), and (e), Government Code, refer to call center services or written communications related to those services provided to "persons with limited English proficiency" and "persons who need language assistance." Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the

definition of "person" provided by Section 311.005, Government Code (Code Construction Act), applicable to this code.

(2) Sections 531.0191(a) and (c), Government Code, refer to a "bid or other applicable expression of interest" for a contract, and Section 531.0191(b), Government Code, refers to "bids, proposals, or other applicable expressions of interest." The revised law omits "proposals" for consistency in the terminology used within the section and because the term "proposals" is included within the meaning of "other applicable expressions of interest."

(3) Section 531.0191(c), Government Code, requires the "commission or a health and human services agency, as applicable," to evaluate proposals for providing call center services or written communications related to those services, and Sections 531.0191(d) and (e), Government Code, respectively, require "the agency" to consider certain elements in that evaluation and prohibit "[t]he agency" from selecting certain contractors. The revised law substitutes references to the "commission or health and human services agency, as applicable," or to "commission or agency," as appropriate, for references to the "agency" throughout the section for clarity and consistency in the terminology used within the section.

SUBCHAPTER C. DATA SHARING

Revised Law

Sec. 522.0101. SHARING OF DATA RELATED TO CERTAIN GENERAL REVENUE FUNDED PROGRAMS. To the extent permitted under federal law and notwithstanding any provision of Chapter 191 or 192, Health and Safety Code, the commission and other health and human services agencies shall share data to facilitate patient care coordination,

quality improvement, and cost savings in Medicaid, the child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund. (Gov. Code, Sec. 531.024(a-1).)

Source Law

(a-1) To the extent permitted under applicable federal law and notwithstanding any provision of Chapter 191 or 192, Health and Safety Code, the commission and other health and human services agencies shall share data to facilitate patient care coordination, quality improvement, and cost savings in Medicaid, the child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund.

SUBCHAPTER D. COORDINATION OF MULTIAGENCY SERVICES

Revised Law

Sec. 522.0151. DEFINITION. In this subchapter, "least restrictive setting" means a service setting for an individual that, in comparison to other available service settings:

(1) is most able to meet the individual's identified needs;

(2) prioritizes a home and community-based care setting; and

(3) engages the strengths of the family. (Gov. Code, Sec. 531.055(f).)

Source Law

(f) In this section, "least restrictive setting" means a service setting for a person that, in comparison to other available service settings:
(1) is most able to meet the identified needs of the person;
(2) prioritizes a home and community-based care setting; and
(3) engages the strengths of the family.

Revised Law

Sec. 522.0152. APPLICABILITY OF SUBCHAPTER TO CERTAIN STATE ENTITIES. This subchapter applies to the following state entities:

(1) the commission;

(2) the Department of Family and Protective Services;

(3) the Department of State Health Services;

(4) the Texas Education Agency;

(5) the Texas Correctional Office on Offenders with Medical or Mental Impairments;

(6) the Texas Department of Criminal Justice;

(7) the Texas Department of Housing and Community Affairs;

(8) the Texas Workforce Commission; and

(9) the Texas Juvenile Justice Department. (Gov. Code, Sec. 531.055(a) (part).)

Source Law

> Sec. 531.055. MEMORANDUM OF UNDERSTANDING ON SERVICES FOR PERSONS NEEDING MULTIAGENCY SERVICES. (a) The Health and Human Services Commission, the Department of Family and Protective Services, the Department of State Health Services, the Texas Education Agency, the Texas Correctional Office on Offenders with Medical or Mental Impairments, the Texas Department of Criminal Justice, the Texas Department of Housing and Community Affairs, the Texas Workforce Commission, and the Texas Juvenile Justice Department . . . .

Revised Law

Sec. 522.0153. MEMORANDUM OF UNDERSTANDING REQUIRED. The state entities to which this subchapter applies shall enter into a joint memorandum of understanding to promote a system of local-level interagency staffing groups for the identification and coordination of services for individuals needing multiagency services that:

(1) are to be provided in the least restrictive setting appropriate; and

(2) use residential, institutional, or congregate care settings only as a last resort. (Gov. Code, Sec. 531.055(a) (part).)

Source Law

> Sec. 531.055. MEMORANDUM OF UNDERSTANDING ON SERVICES FOR PERSONS NEEDING MULTIAGENCY SERVICES. (a) [The Health and Human Services Commission, the Department of Family and Protective Services, the Department of State Health Services, the Texas Education Agency, the Texas Correctional Office on Offenders with Medical or Mental Impairments, the Texas Department of Criminal Justice, the Texas Department of Housing and Community Affairs, the Texas Workforce Commission, and the Texas Juvenile Justice Department] shall enter into a joint memorandum of

understanding to promote a system of local-level interagency staffing groups to identify and coordinate services for persons needing multiagency services to be provided in the least restrictive setting appropriate, using residential, institutional, or congregate care settings only as a last resort. . . .

Revised Law

Sec. 522.0154. DEVELOPMENT AND IMPLEMENTATION OF MEMORANDUM OF UNDERSTANDING. (a) The division within the commission that coordinates the policy for and delivery of mental health services shall oversee the development and implementation of the memorandum of understanding required by this subchapter.

(b) The state entities that participate in developing the memorandum of understanding shall consult with and solicit input from advocacy and consumer groups. (Gov. Code, Secs. 531.055(a) (part), (c).)

Source Law

(a) . . . The division within the Health and Human Services Commission that coordinates the policy and delivery of mental health services shall oversee the development and implementation of the joint memorandum of understanding.

(c) The agencies that participate in the formulation of the memorandum of understanding shall consult with and solicit input from advocacy and consumer groups.

Revised Law

Sec. 522.0155. CONTENTS OF MEMORANDUM OF UNDERSTANDING. The memorandum of understanding required by this subchapter must:

(1) clarify the statutory responsibilities of each state entity to which this subchapter applies in relation to individuals needing multiagency services, including subcategories for different services such as:

(A) family preservation and strengthening;

(B) physical and behavioral health care;

(C) prevention and early intervention services, including services designed to prevent:

(i) child abuse;

(ii) neglect; or

(iii) delinquency, truancy, or school

dropout;

(D) diversion from juvenile or criminal justice involvement;

(E) housing;

(F) aging in place;

(G) emergency shelter;

(H) residential care;

(I) after-care;

(J) information and referral; and

(K) investigation services;

(2) include a functional definition of "individuals needing multiagency services";

(3) outline membership, officers, and necessary standing committees of local-level interagency staffing groups;

(4) define procedures aimed at eliminating duplication of services relating to assessment and diagnosis, treatment, residential placement and care, and case management of individuals needing multiagency services;

(5) define procedures for addressing disputes between the state entities that relate to the entities' areas of service responsibilities;

(6) provide that each local-level interagency staffing group includes:

(A) a local representative of each state entity;

(B) representatives of local private sector agencies; and

(C) family members or caregivers of individuals needing multiagency services or other current or previous consumers of multiagency services acting as general consumer advocates;

(7) provide that the local representative of each state entity has authority to contribute entity resources to solving problems identified by the local-level interagency staffing group;

(8) provide that if an individual's needs exceed the

resources of a state entity, the entity may, with the consent of the individual's legal guardian, if applicable, submit a referral on behalf of the individual to the local-level interagency staffing group for consideration;

(9) provide that a local-level interagency staffing group may be called together by a representative of any member state entity;

(10) provide that a state entity representative may be excused from attending a meeting if the staffing group determines that the age or needs of the individual to be considered are clearly not within the entity's service responsibilities, provided that each entity representative is encouraged to attend all meetings to contribute to the collective ability of the staffing group to solve an individual's need for multiagency services;

(11) define the relationship between state-level interagency staffing groups and local-level interagency staffing groups in a manner that defines, supports, and maintains local autonomy;

(12) provide that records used or developed by a local-level interagency staffing group or the group's members that relate to a particular individual are confidential and may not be released to any other person or agency except as provided by this subchapter or other law; and

(13) provide a procedure that permits the state entities to share confidential information while preserving the confidential nature of the information. (Gov. Code, Sec. 531.055(b).)

Source Law

(b) The memorandum must:

(1) clarify the statutory responsibilities of each agency in relation to persons needing multiagency services, including subcategories for different services such as:

(A) family preservation and strengthening;

(B) physical and behavioral health care;

(C) prevention and early intervention services, including services designed to

prevent:

(i) child abuse;

(ii) neglect; or

(iii) delinquency, truancy, or school dropout;

(D) diversion from juvenile or criminal justice involvement;

(E) housing;

(F) aging in place;

(G) emergency shelter;

(H) residential care;

(I) after-care;

(J) information and referral; and

(K) investigation services;

(2) include a functional definition of "persons needing multiagency services";

(3) outline membership, officers, and necessary standing committees of local-level interagency staffing groups;

(4) define procedures aimed at eliminating duplication of services relating to assessment and diagnosis, treatment, residential placement and care, and case management of persons needing multiagency services;

(5) define procedures for addressing disputes between the agencies that relate to the agencies' areas of service responsibilities;

(6) provide that each local-level interagency staffing group includes:

(A) a local representative of each agency;

(B) representatives of local private sector agencies; and

(C) family members or caregivers of persons needing multiagency services or other current or previous consumers of multiagency services acting as general consumer advocates;

(7) provide that the local representative of each agency has authority to contribute agency resources to solving problems identified by the local-level interagency staffing group;

(8) provide that if a person's needs exceed the resources of an agency, the agency may, with the consent of the person's legal guardian, if applicable, submit a referral on behalf of the person to the local-level interagency staffing group for consideration;

(9) provide that a local-level interagency staffing group may be called together by a representative of any member agency;

(10) provide that an agency representative may be excused from attending a meeting if the staffing group determines that the age or needs of the person to be considered are clearly not within the agency's service responsibilities, provided that each agency representative is encouraged to attend all meetings to contribute to the collective ability of the staffing group to solve a person's need for multiagency services;

(11) define the relationship between state-level interagency staffing groups and local-level interagency staffing groups in a manner that defines, supports, and maintains local autonomy;

(12) provide that records that are used or developed by a local-level interagency staffing group or its members that relate to a particular person are confidential and may not be released to any other person or agency except as provided by this section or

by other law; and

(13) provide a procedure that permits the agencies to share confidential information while preserving the confidential nature of the information.

Revised Law

Sec. 522.0156. ADOPTION OF MEMORANDUM OF UNDERSTANDING; REVISIONS. Each state entity to which this subchapter applies shall adopt the memorandum of understanding required by this subchapter and all revisions to the memorandum. The entities shall develop revisions as necessary to reflect major reorganizations or statutory changes affecting the entities. (Gov. Code, Sec. 531.055(d).)

Source Law

(d) Each agency shall adopt the memorandum of understanding and all revisions to the memorandum. The agencies shall develop revisions as necessary to reflect major agency reorganizations or statutory changes affecting the agencies.

Revised Law

Sec. 522.0157. STATE-LEVEL INTERAGENCY STAFFING GROUP DUTIES; BIENNIAL REPORT. The state entities to which this subchapter applies shall ensure that a state-level interagency staffing group provides:

(1) information and guidance to local-level interagency staffing groups regarding:

(A) the availability of programs and resources in the community; and

(B) best practices for addressing the needs of individuals with complex needs in the least restrictive setting appropriate; and

(2) a biennial report to the administrative head of each entity, the legislature, and the governor that includes:

(A) the number of individuals served through the local-level interagency staffing groups and the outcomes of the services provided;

(B) a description of any identified barriers to the state's ability to provide effective services to individuals needing multiagency services; and

(C) any other information relevant to improving the delivery of services to individuals needing multiagency services. (Gov. Code, Sec. 531.055(e).)

Source Law

(e) The agencies shall ensure that a state-level interagency staffing group provides:

(1) information and guidance to local-level interagency staffing groups regarding:

(A) the availability of programs and resources in the community; and

(B) best practices for addressing the needs of persons with complex needs in the least restrictive setting appropriate; and

(2) a biennial report to the administrative head of each agency, the legislature, and the governor that includes:

(A) the number of persons served through the local-level interagency staffing groups and the outcomes of the services provided;

(B) a description of any barriers identified to the state's ability to provide effective services to persons needing multiagency services; and

(C) any other information relevant to improving the delivery of services to persons needing multiagency services.

SUBCHAPTER E. PUBLIC ACCESS TO MEETINGS

Revised Law

Sec. 522.0201. DEFINITION. In this subchapter, "agency" means the commission or a health and human services agency. (Gov. Code, Sec. 531.0165(a).)

Source Law

Sec. 531.0165. INTERNET BROADCAST AND ARCHIVE OF OPEN MEETINGS. (a) In this section, "agency" means the commission or a health and human services agency.

Revised Law

Sec. 522.0202. ADDITIONAL APPLICABILITY TO CERTAIN ADVISORY BODIES. (a) The requirements of this subchapter also apply to the meetings of any advisory body that advises the executive commissioner or an agency.

(b) The archived video and audio recording of an advisory body's meeting must be made available through the Internet website of the agency to which the advisory body provides advice. (Gov. Code, Sec. 531.0165(h).)

Source Law

(h) The requirements of this section also apply

to the meetings of any advisory body that advises the executive commissioner or an agency. The archived video and audio of an advisory body's meeting must be made available through the Internet website of the agency to which the advisory body provides advice.

Revisor's Note

Section 531.0165(h), Government Code, refers to "archived video and audio" of certain meetings. Section 531.0165(b), Government Code, revised as Section 522.0203(a) of this chapter, requires that a "video and audio recording" be made of a live video and audio broadcast of a meeting, and that the recording be archived and made available on the Internet. It is clear from the context that the reference to "archived video and audio" in Section 531.0165(h) is to the recorded and not the contemporaneous video and audio. For consistency in terminology throughout this chapter, the revised law substitutes "archived video and audio recording" for "archived video and audio" or similar terminology.

Revised Law

Sec. 522.0203. INTERNET BROADCAST AND ARCHIVE OF OPEN MEETING. (a) An agency shall:

(1) broadcast over the Internet live video and audio of each open meeting of the agency;

(2) make a video and audio recording of reasonable quality of the broadcast; and

(3) provide access to the archived video and audio recording on the agency's Internet website in accordance with Subsection (c).

(b) An agency may use for an Internet broadcast of an open meeting of the agency a room made available to the agency on request in any state building, as that term is defined by Section 2165.301.

(c) Not later than the seventh day after the date an open meeting is broadcast under this section, the agency shall make available through the agency's Internet website the archived video

and audio recording of the open meeting. The agency shall maintain the archived video and audio recording on the agency's Internet website until at least the second anniversary of the date the recording was first made available on the website. (Gov. Code, Secs. 531.0165(b), (c), (e).)

Source Law

(b) Each agency shall:

(1) broadcast over the Internet live video and audio of each open meeting of the agency;

(2) make a video and audio recording of reasonable quality of the broadcast; and

(3) provide access to the archived video and audio on the agency's Internet website.

(c) Not later than the seventh day after the date an open meeting is broadcast under this section, the agency shall make available through the agency's Internet website archived video and audio of the open meeting. The agency shall maintain the archived video and audio of the open meeting on the agency's Internet website for not less than two years after the date the archived video and audio was first made available on the website.

(e) Each agency may use for an Internet broadcast of an open meeting of the agency a room made available to the agency on request in any state building, as that term is defined by Section 2165.301.

Revised Law

Sec. 522.0204. INTERNET NOTICE OF OPEN MEETING. An agency shall provide on the agency's Internet website the same notice of an open meeting that the agency is required to post under Subchapter C, Chapter 551. The notice must be posted within the time required for posting notice under Subchapter C, Chapter 551. (Gov. Code, Sec. 531.0165(d).)

Source Law

(d) Each agency shall provide on the agency's Internet website the same notice of the open meeting that the agency is required to post under Subchapter C, Chapter 551. The notice must be posted on the agency's Internet website within the time required for posting notice under Subchapter C, Chapter 551.

Revised Law

Sec. 522.0205. EXEMPTION UNDER CERTAIN CIRCUMSTANCES. An agency is exempt from the requirements of this subchapter to the extent a catastrophe, as defined by Section 551.0411, or a technical breakdown prevents the agency from complying with this

subchapter. Following the catastrophe or technical breakdown, the agency shall make all reasonable efforts to make available in a timely manner the required video and audio recording of the open meeting. (Gov. Code, Sec. 531.0165(f).)

Source Law

> (f) Each agency is exempt from the requirements of this section to the extent a catastrophe, as defined by Section 551.0411, or a technical breakdown prevents the agency from complying with this section. Following the catastrophe or technical breakdown, the agency shall make all reasonable efforts to make the required video and audio of the open meeting available in a timely manner.

Revised Law

Sec. 522.0206. CONTRACTING AUTHORIZED. The commission shall consider contracting through competitive bidding with a private individual or entity to broadcast and archive an open meeting subject to this subchapter to minimize the cost of complying with this subchapter. (Gov. Code, Sec. 531.0165(g).)

Source Law

> (g) The commission shall consider contracting through competitive bidding with a private individual or entity to broadcast and archive an open meeting subject to this section to minimize the cost of complying with this section.

SUBCHAPTER F. FACILITIES

Revised Law

Sec. 522.0251. LEASE OR SUBLEASE OF CERTAIN OFFICE SPACE. (a) A health and human services agency, with the commission's approval, or the Texas Workforce Commission or any other state agency that administers employment services programs may lease or sublease office space to a private service entity or lease or sublease office space from a private service entity that provides publicly funded health, human, or workforce services to enable agency eligibility and enrollment personnel to work with the entity if:

(1) client access to services would be enhanced; and

(2) the colocation of offices would improve the efficiency of the administration and delivery of services.

(b) Subchapters D and E, Chapter 2165, do not apply to a state agency that leases or subleases office space to a private service entity under this section.

(c) Subchapter B, Chapter 2167, does not apply to a state agency that leases or subleases office space from a private service entity under this section.

(d) A state agency is delegated the authority to enter into a lease or sublease under this section and may negotiate the terms of the lease or sublease.

(e) To the extent authorized by federal law, a state agency may share business resources with a private service entity that enters into a lease or sublease agreement with the agency under this section. (Gov. Code, Sec. 531.053.)

Source Law

Sec. 531.053. LEASES AND SUBLEASES OF CERTAIN OFFICE SPACE. (a) A health and human services agency, with the approval of the commission, or the Texas Workforce Commission or any other state agency that administers employment services programs may sublease office space to a private service entity or lease office space from a private service entity that provides publicly funded health, human, or workforce services to enable agency eligibility and enrollment personnel to work with the entity if:

(1) client access to services would be enhanced; and

(2) the colocation of offices would improve the efficiency of the administration and delivery of services.

(b) Subchapters D and E, Chapter 2165, do not apply to a state agency that leases office space to a private service entity or subleases office space to a private service entity under this section.

(c) Subchapter B, Chapter 2167, does not apply to a state agency that leases office space from a private service entity or subleases office space from a private service entity under this section.

(d) A state agency is delegated the authority to enter into a lease or sublease under this section and may negotiate the terms of the lease or sublease.

(e) To the extent authorized by federal law, a state agency may share business resources with a private service entity that enters into a lease or sublease agreement with the agency under this section.

Revisor's Note

Section 531.053(a), Government Code, authorizes a health and human services agency and certain other state agencies to "sublease office space to a private

service entity or lease office space from a private service entity." Sections 531.053(b) and (c), Government Code, make clear, however, that an agency may lease or sublease office space to or from a private service entity. Therefore, for clarity and consistency of terminology, the revised law is drafted to expressly include the authority to both lease and sublease to and from a private service entity.

Revised Law

Sec. 522.0252. ASSUMPTION OF LEASE FOR IMPLEMENTATION OF INTEGRATED ENROLLMENT SERVICES INITIATIVE. (a) A health and human services agency, with the commission's approval, or the Texas Workforce Commission or any other state agency that administers employment services programs may assume a lease from an integrated enrollment services initiative contractor or subcontractor to implement the initiative at one development center, one mail center, or 10 or more call or change centers.

(b) Subchapter B, Chapter 2167, does not apply to a state agency that assumes a lease from a contractor or subcontractor under this section. (Gov. Code, Sec. 531.054.)

Source Law

> Sec. 531.054. ASSUMPTION OF LEASES FOR IMPLEMENTATIONS OF INTEGRATED ENROLLMENT SERVICES INITIATIVE. (a) A health and human services agency, with the approval of the commission, or the Texas Workforce Commission or any other state agency that administers employment services programs may assume a lease from an integrated enrollment services initiative contractor or subcontractor for the purpose of implementing the initiative at one development center, one mail center, or 10 or more call or change centers.
>
> (b) Subchapter B, Chapter 2167, does not apply to a state agency that assumes a lease from a contractor or subcontractor under this section.

Revised Law

Sec. 522.0253. PREREQUISITES FOR ESTABLISHING NEW HEALTH AND HUMAN SERVICES FACILITY IN CERTAIN COUNTIES. A health and human services agency may not establish a new facility in a county with a population of less than 200,000 until the agency provides notice

about the facility and the facility's location and purpose to:

(1) each state representative and state senator who represents all or part of the county;

(2) the county judge who represents the county; and

(3) the mayor of any municipality in which the facility would be located. (Gov. Code, Sec. 531.015.)

Source Law

> Sec. 531.015. NEW FACILITIES IN CERTAIN COUNTIES. A health and human services agency is prohibited from establishing a new facility in a county with a population of less than 200,000 until the agency provides notification about the facility, its location, and its purpose to each state representative and state senator that represents all or part of the county, the county judge that represents the county, and the mayor of any municipality in which the facility would be located.

CHAPTER 523. HEALTH AND HUMAN SERVICES COMMISSION

SUBCHAPTER A. GENERAL PROVISIONS


Sec. 523.0001. HEALTH AND HUMAN SERVICES COMMISSION; RESPONSIBILITY FOR DELIVERY OF HEALTH AND HUMAN SERVICES . . . . . 38

Sec. 523.0002. GOALS . . . . . 39

Sec. 523.0003. SUNSET PROVISION . . . . . 43

Sec. 523.0004. APPLICABILITY OF OTHER LAW . . . . . 43


SUBCHAPTER B. EXECUTIVE COMMISSIONER; PERSONNEL


Sec. 523.0051. EXECUTIVE COMMISSIONER . . . . . 43

Sec. 523.0052. ELIGIBILITY FOR APPOINTMENT AS EXECUTIVE COMMISSIONER OR TO SERVE IN CERTAIN EMPLOYMENT POSITIONS . . . . . 43

Sec. 523.0053. TERM . . . . . 45

Sec. 523.0054. MEDICAL DIRECTOR; OTHER PERSONNEL . . . . . 45

Sec. 523.0055. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS . . . . . 46

Sec. 523.0056. MERIT SYSTEM . . . . . 46

Sec. 523.0057. QUALIFICATIONS AND STANDARDS OF CONDUCT INFORMATION . . . . . 46

Sec. 523.0058. EQUAL EMPLOYMENT OPPORTUNITY POLICY . . . . . 47

Sec. 523.0059. USE OF AGENCY STAFF . . . . . 48
Sec. 523.0060. CRIMINAL HISTORY BACKGROUND CHECKS . . . . . 48
SUBCHAPTER C. EXECUTIVE COUNCIL
Sec. 523.0101. HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL . . . . . 50
Sec. 523.0102. POWERS AND DUTIES . . . . . 50
Sec. 523.0103. COMPOSITION . . . . . 51
Sec. 523.0104. ELIGIBILITY TO SERVE ON EXECUTIVE COUNCIL . . . . . 53
Sec. 523.0105. PRESIDING OFFICER; RULES FOR OPERATION . . . 54
Sec. 523.0106. MEETINGS; QUORUM . . . . . 54
Sec. 523.0107. COMPENSATION; REIMBURSEMENT FOR EXPENSES . . . . . 55
Sec. 523.0108. PUBLIC COMMENT . . . . . 56
Sec. 523.0109. CONSTRUCTION OF SUBCHAPTER . . . . . 56
Sec. 523.0110. INAPPLICABILITY OF CERTAIN OTHER LAW . . . . . 56
SUBCHAPTER D. COMMISSION ORGANIZATION
Sec. 523.0151. COMMISSION DIVISIONS . . . . . 57
Sec. 523.0152. DIVISION DIRECTOR APPOINTMENT AND QUALIFICATIONS . . . . . 57
Sec. 523.0153. DIVISION DIRECTOR DUTIES . . . . . 58
Sec. 523.0154. DATA ANALYSIS UNIT; QUARTERLY UPDATE . . . . . 58
Sec. 523.0155. OFFICE OF POLICY AND PERFORMANCE . . . . . 60
Sec. 523.0156. PURCHASING UNIT . . . . . 62
SUBCHAPTER E. ADVISORY COMMITTEES
Sec. 523.0201. ESTABLISHMENT OF ADVISORY COMMITTEES . . . . 63
Sec. 523.0202. APPLICABILITY OF OTHER LAW . . . . . 64
Sec. 523.0203. RULES FOR ADVISORY COMMITTEES . . . . . 64
Sec. 523.0204. PUBLIC ACCESS TO ADVISORY COMMITTEE MEETINGS . . . . . 65
Sec. 523.0205. ADVISORY COMMITTEE REPORTING . . . . . 67
SUBCHAPTER F. PUBLIC INTEREST INFORMATION, INPUT, AND COMPLAINTS
Sec. 523.0251. PUBLIC INTEREST INFORMATION AND INPUT GENERALLY . . . . . 68

Sec. 523.0252. PUBLIC HEARINGS . . . . . 69
Sec. 523.0253. NOTICE OF PUBLIC HEARING . . . . . 70
Sec. 523.0254. COMPLAINTS . . . . . 71
Sec. 523.0255. OFFICE OF OMBUDSMAN . . . . . 73
SUBCHAPTER G. OFFICE OF HEALTH COORDINATION AND CONSUMER SERVICES
Sec. 523.0301. DEFINITION . . . . . 74
Sec. 523.0302. OFFICE; STAFF . . . . . 75
Sec. 523.0303. GOALS . . . . . 75
Sec. 523.0304. STRATEGIC PLAN . . . . . 75
Sec. 523.0305. POWERS AND DUTIES . . . . . 77
Sec. 523.0306. TEXAS HOME VISITING PROGRAM TRUST FUND . . . . 78

## CHAPTER 523. HEALTH AND HUMAN SERVICES COMMISSION

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 523.0001. HEALTH AND HUMAN SERVICES COMMISSION; RESPONSIBILITY FOR DELIVERY OF HEALTH AND HUMAN SERVICES. (a) The Health and Human Services Commission is an agency of this state.

(b) The commission is the state agency with primary responsibility for ensuring the delivery of state health and human services in a manner that:

(1) uses an integrated system to determine client eligibility;

(2) maximizes the use of federal, state, and local funds; and

(3) emphasizes coordination, flexibility, and decision-making at the local level. (Gov. Code, Sec. 531.002.)

Source Law

Sec. 531.002. HEALTH AND HUMAN SERVICES COMMISSION; RESPONSIBILITY. (a) The Health and Human Services Commission is an agency of the state.

(b) The commission is the state agency with primary responsibility for ensuring the delivery of state health and human services in a manner that:

(1) uses an integrated system to determine client eligibility;

(2) maximizes the use of federal, state, and local funds; and

(3) emphasizes coordination, flexibility, and decision-making at the local level.

Revised Law

Sec. 523.0002. GOALS. The commission's goals are to:

(1) maximize federal funds through the efficient use of available state and local resources;

(2) provide a system that delivers prompt, comprehensive, effective services to individuals of this state by:

(A) improving access to health and human services at the local level; and

(B) eliminating architectural, communication, programmatic, and transportation barriers;

(3) promote the health of individuals of this state by:

(A) reducing the incidence of disease and disabling conditions;

(B) increasing the availability and improving the quality of health care services;

(C) addressing the high incidence of certain illnesses and conditions in minority populations;

(D) increasing the availability of trained health care professionals;

(E) improving knowledge of health care needs;

(F) reducing infant death and disease;

(G) reducing the impacts of mental disorders in adults and emotional disturbances in children;

(H) increasing nutritional education and participation in nutrition programs; and

(I) reducing substance abuse;

(4) foster the development of responsible, productive, and self-sufficient citizens by:

(A) improving workforce skills;

(B) increasing employment, earnings, and benefits;

(C) increasing housing opportunities;

(D) increasing child-care and other

dependent-care services;

(E) improving education and vocational training to meet specific career goals;

(F) reducing school dropouts and teen pregnancy;

(G) improving parental effectiveness;

(H) increasing support services for individuals with disabilities and services to help those individuals maintain or increase their independence;

(I) improving access to work sites, accommodations, transportation, and other public places and activities covered by the Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.); and

(J) improving services for juvenile offenders;

(5) provide needed resources and services to individuals of this state when they cannot provide or care for themselves by:

(A) increasing support services for adults and their families during periods of unemployment, financial need, or homelessness;

(B) reducing extended dependency on basic support services; and

(C) increasing the availability and diversity of long-term care provided to support individuals with chronic conditions in settings that focus on community-based services, with options ranging from their own homes to total-care facilities;

(6) protect the physical and emotional safety of all individuals of this state by:

(A) reducing abuse, neglect, and exploitation of elderly individuals and adults with disabilities;

(B) reducing child abuse and neglect;

(C) reducing family violence;

(D) increasing services to children who are truant or who run away, or who are at risk of truancy or running away, and their families;

(E) reducing crime and juvenile delinquency;

(F) reducing community health risks; and

(G) improving regulation of human services providers; and

(7) improve the coordination and delivery of children's services. (Gov. Code, Sec. 531.003.)

Source Law

Sec. 531.003. GOALS. The commission's goals are to:

(1) maximize federal funds through the efficient use of available state and local resources;

(2) provide a system that delivers prompt, comprehensive, effective services to the people of this state by:

(A) improving access to health and human services at the local level; and

(B) eliminating architectural, communications, programmatic, and transportation barriers;

(3) promote the health of the people of this state by:

(A) reducing the incidence of disease and disabling conditions;

(B) increasing the availability of health care services;

(C) improving the quality of health care services;

(D) addressing the high incidence of certain illnesses and conditions of minority populations;

(E) increasing the availability of trained health care professionals;

(F) improving knowledge of health care needs;

(G) reducing infant death and disease;

(H) reducing the impact of mental disorders in adults;

(I) reducing the impact of emotional disturbances in children;

(J) increasing participation in nutrition programs;

(K) increasing nutritional education; and

(L) reducing substance abuse;

(4) foster the development of responsible, productive, and self-sufficient citizens by:

(A) improving workforce skills;

(B) increasing employment, earnings, and benefits;

(C) increasing housing opportunities;

(D) increasing child-care and other dependent-care services;

(E) improving education and vocational training to meet specific career goals;

(F) reducing school dropouts;

(G) reducing teen pregnancy;

(H) improving parental effectiveness;

(I) increasing support services for people with disabilities;

(J) increasing services to help people with disabilities maintain or increase their independence;

(K) improving access to work sites, accommodations, transportation, and other public places and activities covered by the federal Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.); and

(L) improving services to juvenile offenders;

(5) provide needed resources and services to the people of this state when they cannot provide or care for themselves by:

(A) increasing support services for adults and their families during periods of unemployment, financial need, or homelessness;

(B) reducing extended dependency on basic support services; and

(C) increasing the availability and diversity of long-term care provided to support people with chronic conditions in settings that focus on community-based services with options ranging from their own homes to total-care facilities;

(6) protect the physical and emotional safety of all the people of this state by:

(A) reducing abuse, neglect, and exploitation of elderly people and adults with disabilities;

(B) reducing child abuse and neglect;

(C) reducing family violence;

(D) increasing services to truants and runaways, children at risk of truancy or running away, and their families;

(E) reducing crime and juvenile delinquency;

(F) reducing community health risks; and

(G) improving regulation of human services providers; and

(7) improve the coordination and delivery of children's services.

Revisor's Note

Section 531.003(2), Government Code, refers to delivering services to the "people" of this state. Throughout this chapter, the revised law substitutes "individuals" or "individual" for "people" or "person," respectively, for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), applicable to this code.

Revised Law

Sec. 523.0003. SUNSET PROVISION. The Health and Human Services Commission is subject to Chapter 325 (Texas Sunset Act). Unless continued in existence as provided by that chapter, the commission is abolished September 1, 2027, and Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025, expire on that date. (Gov. Code, Sec. 531.004.)

Source Law

> Sec. 531.004. SUNSET PROVISION. The Health and Human Services Commission is subject to Chapter 325 (Texas Sunset Act). Unless continued in existence as provided by that chapter, the commission is abolished and this chapter expires September 1, 2027.

Revised Law

Sec. 523.0004. APPLICABILITY OF OTHER LAW. The commission is subject to Chapters 2001 and 2002. (Gov. Code, Sec. 531.032.)

Source Law

> Sec. 531.032. APPLICATION OF OTHER LAWS. The commission is subject to Chapters 2001 and 2002.

SUBCHAPTER B. EXECUTIVE COMMISSIONER; PERSONNEL

Revised Law

Sec. 523.0051. EXECUTIVE COMMISSIONER. (a) The commission is governed by an executive commissioner.

(b) The governor appoints the executive commissioner with the advice and consent of the senate, and shall make the appointment without regard to race, color, disability, sex, religion, age, or national origin. (Gov. Code, Sec. 531.005.)

Source Law

> Sec. 531.005. EXECUTIVE COMMISSIONER. (a) The commission is governed by an executive commissioner appointed by the governor with the advice and consent of the senate.
>
> (b) The executive commissioner shall be appointed without regard to race, color, disability, sex, religion, age, or national origin.

Revised Law

Sec. 523.0052. ELIGIBILITY FOR APPOINTMENT AS EXECUTIVE COMMISSIONER OR TO SERVE IN CERTAIN EMPLOYMENT POSITIONS. (a) In

this section, "Texas trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) An individual may not be appointed as executive commissioner or be a commission employee employed in a "bona fide executive, administrative, or professional capacity," as that phrase is used for purposes of establishing an exemption to the overtime provisions of the Fair Labor Standards Act of 1938 (29 U.S.C. Section 201 et seq.), if:

(1) the individual is an officer, employee, or paid consultant of a Texas trade association in the field of health and human services; or

(2) the individual's spouse is an officer, manager, or paid consultant of a Texas trade association in the field of health and human services.

(c) An individual may not be appointed as executive commissioner or act as the commission's general counsel if the individual is required to register as a lobbyist under Chapter 305 because of the individual's activities for compensation on behalf of a profession related to the commission's operation.

(d) An individual may not be appointed as executive commissioner if the individual has a financial interest in a corporation, organization, or association under contract with:

(1) the commission or a health and human services agency;

(2) a local mental health or intellectual and developmental disability authority; or

(3) a community center. (Gov. Code, Secs. 531.006(a), (a-1) (part), (b), (c).)

Source Law

Sec. 531.006. ELIGIBILITY FOR APPOINTMENT AS

EXECUTIVE COMMISSIONER; EMPLOYEE RESTRICTIONS. (a) In this section, "Texas trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(a-1) A person may not be appointed as executive commissioner, . . . may not be a commission employee employed in a "bona fide executive, administrative, or professional capacity," as that phrase is used for purposes of establishing an exemption to the overtime provisions of the federal Fair Labor Standards Act of 1938 (29 U.S.C. Section 201 et seq.) if:

(1) the person is an officer, employee, or paid consultant of a Texas trade association in the field of health and human services; or

(2) the person's spouse is an officer, manager, or paid consultant of a Texas trade association in the field of health and human services.

(b) A person may not be appointed as executive commissioner or act as general counsel of the commission if the person is required to register as a lobbyist under Chapter 305 because of the person's activities for compensation on behalf of a profession related to the operation of the commission.

(c) A person may not be appointed as executive commissioner if the person has a financial interest in a corporation, organization, or association under contract with:

(1) the commission or a health and human services agency;

(2) a local mental health or intellectual and developmental disability authority; or

(3) a community center.

Revised Law

Sec. 523.0053. TERM. The executive commissioner serves a two-year term expiring February 1 of each odd-numbered year. (Gov. Code, Sec. 531.007.)

Source Law

Sec. 531.007. TERM. The executive commissioner serves a two-year term expiring February 1 of each odd-numbered year.

Revised Law

Sec. 523.0054. MEDICAL DIRECTOR; OTHER PERSONNEL. The executive commissioner:

(1) shall employ a medical director to provide medical expertise to the executive commissioner and the commission; and

(2) may employ other personnel necessary to administer the commission's duties. (Gov. Code, Sec. 531.009(a).)

Source Law

Sec. 531.009. PERSONNEL. (a) The executive

commissioner shall employ a medical director to provide medical expertise to the executive commissioner and the commission and may employ other personnel necessary to administer the commission's duties.

Revised Law

Sec. 523.0055. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS. (a) The executive commissioner shall develop an intra-agency career ladder program. The program must require the intra-agency posting of all non-entry-level positions concurrently with any public posting.

(b) The executive commissioner shall develop a system of annual performance evaluations based on measurable job tasks. All merit pay for commission employees must be based on the system established under this subsection. (Gov. Code, Secs. 531.009(b), (c).)

Source Law

(b) The executive commissioner shall develop an intra-agency career ladder program, one part of which must require the intra-agency posting of all non-entry-level positions concurrently with any public posting.

(c) The executive commissioner shall develop a system of annual performance evaluations based on measurable job tasks. All merit pay for commission employees must be based on the system established under this subsection.

Revised Law

Sec. 523.0056. MERIT SYSTEM. (a) The commission may establish a merit system for commission employees.

(b) The merit system may be maintained in conjunction with other state agencies that are required by federal law to operate under a merit system. (Gov. Code, Sec. 531.010.)

Source Law

Sec. 531.010. MERIT SYSTEM. (a) The commission may establish a merit system for its employees.

(b) The merit system may be maintained in conjunction with other state agencies that are required by federal law to operate under a merit system.

Revised Law

Sec. 523.0057. QUALIFICATIONS AND STANDARDS OF CONDUCT INFORMATION. The executive commissioner shall provide to

commission employees as often as necessary information regarding their qualifications under this chapter and their responsibilities under applicable laws relating to standards of conduct for state employees. (Gov. Code, Sec. 531.009(d).)

Source Law

> (d) The executive commissioner shall provide to commission employees as often as is necessary information regarding their qualifications under this chapter and their responsibilities under applicable laws relating to standards of conduct for state employees.

Revisor's Note

Section 531.009(d), Government Code, refers to qualifications for Health and Human Services Commission employees under "this chapter," meaning Chapter 531, Government Code. Chapter 531 is revised throughout Subtitle I, Title 4, Government Code. However, the relevant portions of Chapter 531 concerning qualifications for commission employees are revised in this chapter, and the revised law is drafted accordingly.

Revised Law

Sec. 523.0058. EQUAL EMPLOYMENT OPPORTUNITY POLICY. (a) The executive commissioner shall prepare and maintain a written policy statement that implements a program of equal employment opportunity to ensure that all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin.

(b) The policy statement must include:

(1) personnel policies, including policies relating to recruitment, evaluation, selection, training, and promotion of personnel, that show the commission's intent to avoid the unlawful employment practices described by Chapter 21, Labor Code; and

(2) an analysis of the extent to which the composition of the commission's personnel is in accordance with state and federal law and a description of reasonable methods to achieve

compliance with state and federal law.

(c) The policy statement must be:

(1) updated annually;

(2) reviewed by the Texas Workforce Commission civil rights division for compliance with Subsection (b)(1); and

(3) filed with the governor's office. (Gov. Code, Secs. 531.009(e), (f), (g).)

Source Law

> (e) The executive commissioner shall prepare and maintain a written policy statement that implements a program of equal employment opportunity to ensure that all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin.
>
> (f) The policy statement described by Subsection (e) must include:
>
> (1) personnel policies, including policies relating to recruitment, evaluation, selection, training, and promotion of personnel, that show the intent of the commission to avoid the unlawful employment practices described by Chapter 21, Labor Code; and
>
> (2) an analysis of the extent to which the composition of the commission's personnel is in accordance with state and federal law and a description of reasonable methods to achieve compliance with state and federal law.
>
> (g) The policy statement described by Subsection (e) must:
>
> (1) be updated annually;
>
> (2) be reviewed by the Texas Workforce Commission civil rights division for compliance with Subsection (f)(1); and
>
> (3) be filed with the governor's office.

Revised Law

Sec. 523.0059. USE OF AGENCY STAFF. To the extent the commission requests, a health and human services agency shall assign existing staff to perform a function imposed under Chapter 531 or revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025. (Gov. Code, Sec. 531.0242.)

Source Law

> Sec. 531.0242. USE OF AGENCY STAFF. To the extent requested by the commission, a health and human services agency shall assign existing staff to perform a function imposed under this chapter.

Revised Law

Sec. 523.0060. CRIMINAL HISTORY BACKGROUND CHECKS. (a) In this section, "eligible individual" means an individual whose

criminal history record information the executive commissioner or the executive commissioner's designee is entitled to obtain from the Department of Public Safety under Section 411.1106.

(b) The executive commissioner may require an eligible individual to submit fingerprints in a form and of a quality acceptable to the Department of Public Safety and the Federal Bureau of Investigation for use in conducting a criminal history background check by obtaining criminal history record information under Sections 411.087 and 411.1106.

(c) Criminal history record information the executive commissioner obtains under Sections 411.087 and 411.1106 may be used only to evaluate the qualification or suitability for employment, including continued employment, of an eligible individual.

(d) Notwithstanding Subsection (c), the executive commissioner or the executive commissioner's designee may release or disclose criminal history record information obtained under Section 411.087 only to a governmental entity or as otherwise authorized by federal law, including federal regulations and executive orders. (Gov. Code, Sec. 531.00554.)

Source Law

Sec. 531.00554. CRIMINAL BACKGROUND CHECKS. (a) In this section, "eligible person" means a person whose criminal history record information the executive commissioner, or the executive commissioner's designee, is entitled to obtain from the Department of Public Safety under Section 411.1106.

(b) The executive commissioner may require an eligible person to submit fingerprints in a form and of a quality acceptable to the Department of Public Safety and the Federal Bureau of Investigation for use in conducting a criminal history background check by obtaining criminal history record information under Sections 411.1106 and 411.087.

(c) Criminal history record information obtained by the executive commissioner under Sections 411.1106 and 411.087 may be used only to evaluate the qualification or suitability for employment, including continued employment, of an eligible person.

(d) Notwithstanding Subsection (c), the executive commissioner or the executive commissioner's designee may release or disclose criminal history record information obtained under Section 411.087 only to a governmental entity or as otherwise authorized by federal law, including federal regulations and

executive orders.

SUBCHAPTER C. EXECUTIVE COUNCIL

Revised Law

Sec. 523.0101. HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL. The Health and Human Services Commission Executive Council is established to receive public comment and advise the executive commissioner regarding the commission's operation. (Gov. Code, Sec. 531.0051(a) (part).)

Source Law

> Sec. 531.0051. HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL. (a) The Health and Human Services Commission Executive Council is established to receive public input and advise the executive commissioner regarding the operation of the commission. . . .

Revised Law

Sec. 523.0102. POWERS AND DUTIES. (a) The executive council shall seek and receive public comment on:

(1) proposed rules;

(2) advisory committee recommendations;

(3) legislative appropriations requests or other documents related to the appropriations process;

(4) the operation of health and human services programs; and

(5) other items the executive commissioner determines appropriate.

(b) The executive council does not have authority to make administrative or policy decisions. (Gov. Code, Secs. 531.0051(a) (part), (b).)

Source Law

> (a) . . . The council shall seek and receive public comment on:
> (1) proposed rules;
> (2) recommendations of advisory committees;
> (3) legislative appropriations requests or other documents related to the appropriations process;
> (4) the operation of health and human services programs; and
> (5) other items the executive commissioner determines appropriate.
> (b) The council does not have authority to make

administrative or policy decisions.

Revised Law

Sec. 523.0103. COMPOSITION. (a) The executive council is composed of:

(1) the executive commissioner;

(2) the director of each division the executive commissioner established under former Section 531.008(c) before the expiration of that subsection on September 1, 2023;

(3) the commissioner of a health and human services agency;

(4) the commissioner of the Department of Family and Protective Services, regardless of whether that agency continues as a state agency separate from the commission; and

(5) other individuals the executive commissioner appoints as the executive commissioner determines necessary.

(b) To the extent the executive commissioner appoints members to the executive council under Subsection (a)(5), the executive commissioner shall make every effort to ensure that those appointments result in the executive council including:

(1) a balanced representation of a broad range of health and human services industry and consumer interests; and

(2) representation from broad geographic regions of this state.

(c) An executive council member appointed under Subsection (a)(5) serves at the executive commissioner's pleasure. (Gov. Code, Secs. 531.0051(c), (c-1), (e) (part).)

Source Law

(c) The council is composed of:

(1) the executive commissioner;

(2) the director of each division established by the executive commissioner under Section 531.008(c);

(3) the commissioner of a health and human services agency;

(4) the commissioner of the Department of Family and Protective Services, regardless of whether that agency continues as a state agency separate from the commission; and

(5) other individuals appointed by the executive commissioner as the executive commissioner determines necessary.

(c-1) To the extent the executive commissioner appoints members to the council under Subsection (c)(4), the executive commissioner shall make every effort to ensure that those appointments result in a council membership that includes:

(1) a balanced representation of a broad range of health and human services industry and consumer interests; and

(2) representation from broad geographic regions of this state.

(e) Members of the council appointed under Subsection (c)(4):

. . .

(2) serve at the pleasure of the executive commissioner.

Revisor's Note

(1) Section 531.0051(c)(2), Government Code, refers to "each division established by the executive commissioner under Section 531.008(c)" of that code. Section 531.008(c), Government Code, requires the executive commissioner to establish certain divisions and offices within the Health and Human Services Commission. That subsection expires September 1, 2023, in accordance with Section 531.008(d), Government Code. The revised law will take effect on a date later than the expiration date for the requirement in Section 531.008(c) to establish specified divisions and offices. However, some or all divisions and offices established under that subsection may continue to exist after the requirement to establish them expires. For that reason, the revised law substitutes for the quoted language a reference to "each division the executive commissioner established under former Section 531.008(c) before the expiration of that subsection on September 1, 2023."

(2) Sections 531.0051(c-1) and (e), Government Code, refer to members of the Health and Human Services Commission Executive Council appointed under Subsection (c)(4) of Section 531.0051. Chapter 312 (S.B. 1021), Acts of the 85th Legislature, Regular Session, 2017, renumbered Subsection (c)(4) as

Subsection (c)(5) without amending the cross-references to the subsection in Subsections (c-1) and (e) to correctly refer to Subsection (c)(5). Because it is clear from the context that the references should be to the substance contained in Subsection (c)(5) of the source law, the revised law substitutes references to the correct provision.

Revised Law

Sec. 523.0104. ELIGIBILITY TO SERVE ON EXECUTIVE COUNCIL. (a) In this section, "Texas trade association" has the meaning assigned by Section 523.0052.

(b) An individual may not serve on the executive council if:

(1) the individual is an officer, employee, or paid consultant of a Texas trade association in the field of health and human services; or

(2) the individual's spouse is an officer, manager, or paid consultant of a Texas trade association in the field of health and human services. (Gov. Code, Secs. 531.0051(e) (part), 531.006(a), (a-1) (part).)

Source Law

[Sec. 531.0051]

(e) Members of the council appointed under Subsection (c)(4):

(1) are subject to the restrictions applicable to service on the council provided by Section 531.006(a-1); and

. . .

Sec. 531.006. ELIGIBILITY FOR APPOINTMENT AS EXECUTIVE COMMISSIONER; EMPLOYEE RESTRICTIONS. (a) In this section, "Texas trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(a-1) A person . . . may not serve on the commission's executive council, and . . . if:

(1) the person is an officer, employee, or paid consultant of a Texas trade association in the field of health and human services; or

(2) the person's spouse is an officer, manager, or paid consultant of a Texas trade association in the field of health and human services.

Revised Law

Sec. 523.0105. PRESIDING OFFICER; RULES FOR OPERATION. The executive commissioner serves as the chair of the executive council and shall adopt rules for the council's operation. (Gov. Code, Sec. 531.0051(d).)

Source Law

(d) The executive commissioner serves as the chair of the council and shall adopt rules for the operation of the council.

Revised Law

Sec. 523.0106. MEETINGS; QUORUM. (a) The executive council shall meet at the executive commissioner's call at least quarterly. The executive commissioner may call additional meetings as the executive commissioner determines necessary.

(b) A majority of the executive council members constitutes a quorum for the transaction of business.

(c) The executive council shall comply with the requirements of Subchapter E, Chapter 522. The archived video and audio recording of a council meeting must be made available through the commission's Internet website.

(d) A meeting of individual executive council members that occurs in the ordinary course of commission operation is not a council meeting, and the requirements of Subsection (c) do not apply to the meeting. (Gov. Code, Secs. 531.0051(f), (g), (h), (k).)

Source Law

(f) The council shall meet at the call of the executive commissioner at least quarterly. The executive commissioner may call additional meetings as the executive commissioner determines necessary.

(g) The council shall comply with the requirements of Section 531.0165. The archived video and audio of a council meeting must be made available through the commission's Internet website.

(h) A majority of the members of the council constitute a quorum for the transaction of business.

(k) A meeting of individual members of the council that occurs in the ordinary course of commission operation is not a meeting of the council, and the requirements of Subsection (g) do not apply.

Revisor's Note

Section 531.0051(g), Government Code, requires the Health and Human Services Commission Executive Council to comply with the requirements of Section 531.0165, Government Code, which is revised in this subtitle as Subchapter E, Chapter 522, and requires that an "archived video and audio" of an executive council meeting be made available through the Health and Human Services Commission's Internet website. Section 531.0165(b), Government Code, revised in this subtitle as Section 522.0203(a), requires that a "video and audio recording" be made of a live video and audio broadcast of a meeting, and that the recording be archived and made available on the Internet. It is clear from the context that the reference to "archived video and audio" in Section 531.0051(g) is to the recorded and not the contemporaneous video and audio. For clarity and consistency in terminology throughout this subtitle, the revised law substitutes "archived video and audio recording" for "archived video and audio."

Revised Law

Sec. 523.0107. COMPENSATION; REIMBURSEMENT FOR EXPENSES. An executive council member appointed under Section 523.0103(a)(5) may not receive compensation for service as a council member but is entitled to reimbursement for travel expenses the member incurs while conducting council business as provided by the General Appropriations Act. (Gov. Code, Sec. 531.0051(i).)

Source Law

(i) A council member appointed under Subsection (c)(4) may not receive compensation for service as a member of the council but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the council as provided by the General Appropriations Act.

Revisor's Note

Section 531.0051(i), Government Code, refers to a member of the Health and Human Services Commission Executive Council appointed under Subdivision (4) of Section 531.0051(c), which is revised in this chapter as Section 523.0103(a). The revised law substitutes a reference to Subdivision (5) of that subsection for the reason stated in Revisor's Note (2) to Section 523.0103 of this chapter.

Revised Law

Sec. 523.0108. PUBLIC COMMENT. The executive commissioner shall develop and implement policies that provide the public with a reasonable opportunity to appear before the executive council which may include holding meetings in various geographic areas across this state or allowing public comment at teleconferencing centers in various geographic areas across this state and to speak on any issue under the commission's jurisdiction. (Gov. Code, Sec. 531.0051(j).)

Source Law

(j) The executive commissioner shall develop and implement policies that provide the public with a reasonable opportunity to appear before the council which may include holding meetings in various geographic areas across this state, or through allowing public comment at teleconferencing centers in various geographic areas across this state and to speak on any issue under the jurisdiction of the commission.

Revised Law

Sec. 523.0109. CONSTRUCTION OF SUBCHAPTER. This subchapter does not limit the executive commissioner's authority to establish additional advisory committees or councils. (Gov. Code, Sec. 531.0051(l).)

Source Law

(l) This section does not limit the authority of the executive commissioner to establish additional advisory committees or councils.

Revised Law

Sec. 523.0110. INAPPLICABILITY OF CERTAIN OTHER LAW.

Except as provided by Section 522.0204, Chapters 551 and 2110 do not apply to the executive council. (Gov. Code, Sec. 531.0051(m).)

Source Law

(m) Except as provided by Section 531.0165(d), Chapters 551 and 2110 do not apply to the council.

SUBCHAPTER D. COMMISSION ORGANIZATION

Revised Law

Sec. 523.0151. COMMISSION DIVISIONS. (a) The executive commissioner shall establish divisions within the commission along functional lines as necessary for effective administration and the discharge of the commission's functions.

(b) The executive commissioner may allocate and reallocate functions among the commission's divisions. (Gov. Code, Secs. 531.008(a), (b).)

Source Law

Sec. 531.008. DIVISIONS OF COMMISSION. (a) The executive commissioner shall establish divisions within the commission along functional lines as necessary for effective administration and for the discharge of the commission's functions.

(b) The executive commissioner may allocate and reallocate functions among the commission's divisions.

Revised Law

Sec. 523.0152. DIVISION DIRECTOR APPOINTMENT AND QUALIFICATIONS. (a) The executive commissioner shall appoint a director for each division established within the commission under Section 523.0151, except that the director of the office of inspector general is appointed in accordance with Section 544.0101.

(b) The executive commissioner shall:

(1) develop clear qualifications for each director appointed under this section to ensure the director has:

(A) demonstrated experience in fields relevant to the director position; and

(B) executive-level administrative and leadership experience; and

(2) ensure the qualifications developed under Subdivision (1) are publicly available. (Gov. Code, Sec.

531.00561.)

Source Law

> Sec. 531.00561. APPOINTMENT AND QUALIFICATIONS OF DIVISION DIRECTORS. (a) The executive commissioner shall appoint a director for each division established within the commission under Section 531.008, except that the director of the office of inspector general is appointed in accordance with Section 531.102(a-1).
>
> (b) The executive commissioner shall:
>
> (1) develop clear qualifications for the director of each division appointed under this section that ensure that an individual appointed director has:
>
> (A) demonstrated experience in fields relevant to the director position; and
>
> (B) executive-level administrative and leadership experience; and
>
> (2) ensure the qualifications developed under Subdivision (1) are publicly available.

Revised Law

Sec. 523.0153. DIVISION DIRECTOR DUTIES. (a) The executive commissioner shall clearly define the duties and responsibilities of a division director.

(b) The executive commissioner shall develop clear policies for the delegation to division directors of specific decision-making authority, including budget authority. The delegation should be significant enough to ensure the efficient administration of the commission's programs and services. (Gov. Code, Sec. 531.00562.)

Source Law

> Sec. 531.00562. DIVISION DIRECTOR DUTIES. (a) The executive commissioner shall clearly define the duties and responsibilities of a division director and develop clear policies for the delegation of specific decision-making authority, including budget authority, to division directors.
>
> (b) The delegation of decision-making authority should be significant enough to ensure the efficient administration of the commission's programs and services.

Revised Law

Sec. 523.0154. DATA ANALYSIS UNIT; QUARTERLY UPDATE. (a) The executive commissioner shall establish a data analysis unit within the commission to establish, employ, and oversee data analysis processes designed to:

(1) improve contract management;

(2) detect data trends; and

(3) identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts.

(b) The commission shall assign to the data analysis unit staff who perform duties only in relation to the unit.

(c) The data analysis unit shall use all available data and tools for data analysis when establishing, employing, and overseeing data analysis processes under this section.

(d) Not later than the 30th day following the end of each calendar quarter, the data analysis unit shall provide an update on the unit's activities and findings to the governor, the lieutenant governor, the speaker of the house of representatives, the chair of the Senate Finance Committee, the chair of the House Appropriations Committee, and the chairs of the standing committees of the senate and house of representatives having jurisdiction over Medicaid. (Gov. Code, Sec. 531.0082.)

Source Law

Sec. 531.0082. DATA ANALYSIS UNIT. (a) The executive commissioner shall establish a data analysis unit within the commission to establish, employ, and oversee data analysis processes designed to:

(1) improve contract management;

(2) detect data trends; and

(3) identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts.

(b) The commission shall assign staff to the data analysis unit who perform duties only in relation to the unit.

(c) The data analysis unit shall use all available data and tools for data analysis when establishing, employing, and overseeing data analysis processes under this section.

(d) Not later than the 30th day following the end of each calendar quarter, the data analysis unit shall provide an update on the unit's activities and findings to the governor, the lieutenant governor, the speaker of the house of representatives, the chair of the Senate Finance Committee, the chair of the House Appropriations Committee, and the chairs of the standing committees of the senate and house of representatives having jurisdiction over Medicaid.

Revised Law

Sec. 523.0155. OFFICE OF POLICY AND PERFORMANCE. (a) In this section, "office" means the office of policy and performance established under this section.

(b) The executive commissioner shall establish the office of policy and performance as an executive-level office designed to coordinate policy and performance efforts across the health and human services system. To coordinate those efforts, the office shall:

(1) develop a performance management system;

(2) take the lead in providing support and oversight for the implementation of major policy changes and in managing organizational changes; and

(3) act as a centralized body of experts within the commission that offers program evaluation and process improvement expertise.

(c) In developing a performance management system under Subsection (b)(1), the office shall:

(1) gather, measure, and evaluate performance measures and accountability systems the health and human services system uses;

(2) develop new and refined performance measures as appropriate; and

(3) establish targeted, high-level system metrics capable of measuring overall performance and achievement of goals by the health and human services system and of communicating that performance and achievement to both internal and public audiences through various mechanisms, including the Internet.

(d) In providing support and oversight for the implementation of policy or organizational changes within the health and human services system under Subsection (b)(2), the office shall:

(1) ensure individuals receiving services from or participating in programs administered through the health and human

services system do not lose visibility or attention during the implementation of any new policy or organizational change by:

(A) establishing timelines and milestones for any transition;

(B) supporting health and human services system staff in any change between service delivery methods; and

(C) providing feedback to executive management on technical assistance and other support needed to achieve a successful transition;

(2) address cultural differences among health and human services system staff; and

(3) track and oversee changes in policy or organization mandated by legislation or administrative rule.

(e) In acting as a centralized body of experts under Subsection (b)(3), the office shall:

(1) for the health and human services system, provide program evaluation and process improvement guidance both generally and for specific projects identified with executive or stakeholder input or through risk analysis; and

(2) identify and monitor cross-functional efforts involving different administrative components within the health and human services system and the establishment of cross-functional teams when necessary to improve the coordination of services provided through the system.

(f) Except as otherwise provided by this section, the executive commissioner may develop the office's structure and duties as the executive commissioner determines appropriate. (Gov. Code, Sec. 531.0083.)

Source Law

Sec. 531.0083. OFFICE OF POLICY AND PERFORMANCE. (a) In this section, "office" means the office of policy and performance established by this section.

(b) The executive commissioner shall establish the office of policy and performance as an executive-level office designed to coordinate policy and performance efforts across the health and human services system. To coordinate those efforts, the

office shall:

(1) develop a performance management system;

(2) take the lead in supporting and providing oversight for the implementation of major policy changes and in managing organizational changes; and

(3) act as a centralized body of experts within the commission that offers program evaluation and process improvement expertise.

(c) In developing a performance management system under Subsection (b)(1), the office shall:

(1) gather, measure, and evaluate performance measures and accountability systems used by the health and human services system;

(2) develop new and refined performance measures as appropriate; and

(3) establish targeted, high-level system metrics that are capable of measuring and communicating overall performance and achievement of goals by the health and human services system to both internal and public audiences through various mechanisms, including the Internet.

(d) In providing support and oversight for the implementation of policy or organizational changes within the health and human services system under Subsection (b)(2), the office shall:

(1) ensure individuals receiving services from or participating in programs administered through the health and human services system do not lose visibility or attention during the implementation of any new policy or organizational change by:

(A) establishing timelines and milestones for any transition;

(B) supporting staff of the health and human services system in any change between service delivery methods; and

(C) providing feedback to executive management on technical assistance and other support needed to achieve a successful transition;

(2) address cultural differences among staff of the health and human services system; and

(3) track and oversee changes in policy or organization mandated by legislation or administrative rule.

(e) In acting as a centralized body of experts under Subsection (b)(3), the office shall:

(1) for the health and human services system, provide program evaluation and process improvement guidance both generally and for specific projects identified with executive or stakeholder input or through risk analysis; and

(2) identify and monitor cross-functional efforts involving different administrative components within the health and human services system and the establishment of cross-functional teams when necessary to improve the coordination of services provided through the system.

(f) The executive commissioner may otherwise develop the office's structure and duties as the executive commissioner determines appropriate.

Revised Law

Sec. 523.0156. PURCHASING UNIT. (a) The commission shall establish a purchasing unit to manage administrative activities

related to the purchasing functions within the health and human services system.

(b) The purchasing unit shall:

(1) seek to achieve targeted cost reductions, increase process efficiencies, improve technological support and customer services, and enhance purchasing support within the health and human services system; and

(2) if cost-effective, contract with private entities to perform purchasing functions for the health and human services system. (Gov. Code, Sec. 531.017.)

Source Law

> Sec. 531.017. PURCHASING UNIT. (a) The commission shall establish a purchasing unit for the management of administrative activities related to the purchasing functions within the health and human services system.
>
> (b) The purchasing unit shall:
>
> (1) seek to achieve targeted cost reductions, increase process efficiencies, improve technological support and customer services, and enhance purchasing support within the health and human services system; and
>
> (2) if cost-effective, contract with private entities to perform purchasing functions for the health and human services system.

SUBCHAPTER E. ADVISORY COMMITTEES

Revised Law

Sec. 523.0201. ESTABLISHMENT OF ADVISORY COMMITTEES. The executive commissioner shall establish and maintain advisory committees to consider issues and solicit public input across all major areas of the health and human services system which may be from various geographic areas across this state, which may be done either in person or through teleconferencing centers, including relating to the following issues:

(1) Medicaid and other social services programs;

(2) managed care under Medicaid and the child health plan program;

(3) health care quality initiatives;

(4) aging;

(5) individuals with disabilities, including

individuals with autism;

(6) rehabilitation, including for individuals with brain injuries;

(7) children;

(8) public health;

(9) behavioral health;

(10) regulatory matters;

(11) protective services; and

(12) prevention efforts. (Gov. Code, Sec. 531.012(a).)

Source Law

Sec. 531.012. ADVISORY COMMITTEES. (a) The executive commissioner shall establish and maintain advisory committees to consider issues and solicit public input across all major areas of the health and human services system which may be from various geographic areas across the state, which may be done either in person or through teleconferencing centers, including relating to the following issues:

(1) Medicaid and other social services programs;

(2) managed care under Medicaid and the child health plan program;

(3) health care quality initiatives;

(4) aging;

(5) persons with disabilities, including persons with autism;

(6) rehabilitation, including for persons with brain injuries;

(7) children;

(8) public health;

(9) behavioral health;

(10) regulatory matters;

(11) protective services; and

(12) prevention efforts.

Revised Law

Sec. 523.0202. APPLICABILITY OF OTHER LAW. Chapter 2110 applies to an advisory committee established under this subchapter. (Gov. Code, Sec. 531.012(b).)

Source Law

(b) Chapter 2110 applies to an advisory committee established under this section.

Revised Law

Sec. 523.0203. RULES FOR ADVISORY COMMITTEES. The executive commissioner shall adopt rules:

(1) in compliance with Chapter 2110 to govern the

purpose, tasks, reporting requirements, and date of abolition of an advisory committee established under this subchapter; and

(2) related to an advisory committee's:

(A) size and quorum requirements;

(B) membership, including:

(i) member qualifications and any experience requirements;

(ii) required geographic representation;

(iii) appointment procedures; and

(iv) members' terms; and

(C) duty to comply with the requirements for open meetings under Chapter 551. (Gov. Code, Sec. 531.012(c).)

Source Law

(c) The executive commissioner shall adopt rules:

(1) in compliance with Chapter 2110 to govern an advisory committee's purpose, tasks, reporting requirements, and date of abolition; and

(2) related to an advisory committee's:

(A) size and quorum requirements;

(B) membership, including:

(i) qualifications to be a member, including any experience requirements;

(ii) required geographic representation;

(iii) appointment procedures; and

(iv) terms of members; and

(C) duty to comply with the requirements for open meetings under Chapter 551.

Revised Law

Sec. 523.0204. PUBLIC ACCESS TO ADVISORY COMMITTEE MEETINGS. (a) This section applies to an advisory committee established under this subchapter.

(b) The commission shall create a master calendar that includes all advisory committee meetings across the health and human services system.

(c) The commission shall make available on the commission's Internet website:

(1) the master calendar;

(2) all meeting materials for an advisory committee meeting; and

(3) streaming live video and audio of each advisory committee meeting.

(d) The commission shall provide Internet access in each room used for a meeting that appears on the master calendar.

(e) The commission shall ensure that, to the same extent and in the same manner as the broadcast, archiving, and notice of agency meetings are required under Subchapter E, Chapter 522, advisory committee meetings are:

(1) broadcast;

(2) archived on the Internet website of the agency to which the advisory committee provides advice; and

(3) subject to public notice requirements. (Gov. Code, Sec. 531.0121.)

Source Law

Sec. 531.0121. PUBLIC ACCESS TO ADVISORY COMMITTEE MEETINGS. (a) This section applies to an advisory committee established under Section 531.012.

(b) The commission shall create a master calendar that includes all advisory committee meetings across the health and human services system.

(c) The commission shall make available on the commission's Internet website:

(1) the master calendar;

(2) all meeting materials for an advisory committee meeting; and

(3) streaming live video and audio of each advisory committee meeting.

(d) The commission shall provide Internet access in each room used for a meeting that appears on the master calendar.

(e) The commission shall ensure that advisory committee meetings are broadcast, are archived on the Internet website of the agency to which the advisory committee provides advice, and are subject to public notice requirements to the same extent and in the same manner that the broadcast, archiving, and notice of agency meetings are required under Section 531.0165.

Revisor's Note

Section 531.0121(e), Government Code, requires the Health and Human Services Commission to ensure an advisory committee complies with the requirements of Section 531.0165, Government Code, which is revised in this subtitle as Subchapter E, Chapter 522. The revised law is drafted accordingly.

Revised Law

Sec. 523.0205. ADVISORY COMMITTEE REPORTING. An advisory committee established under this subchapter shall:

(1) report any recommendations to the executive commissioner; and

(2) submit a written report to the legislature of any policy recommendations the advisory committee made to the executive commissioner under Subdivision (1). (Gov. Code, Sec. 531.012(d), as added Acts 84th Leg., R.S., Ch. 946.)

Source Law

(d) An advisory committee established under this section shall:

(1) report any recommendations to the executive commissioner; and

(2) submit a written report to the legislature of any policy recommendations made to the executive commissioner under Subdivision (1).

Revisor's Note

Section 531.012(d), Government Code, as added by Section 2.02, Chapter 946 (S.B. 277), Acts of the 84th Legislature, Regular Session, 2015, requires an advisory committee established under Section 531.012, Government Code, to report the committee's recommendations to the executive commissioner of the Health and Human Services Commission and submit to the legislature any policy recommendations made to the executive commissioner. Section 531.012(d), Government Code, as added by Section 3.02, Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015, imposes the same duties on an advisory committee established under Section 531.012, except that the section specifically requires that the advisory committee report the committee's recommendations to the executive commissioner at a meeting of the Health and Human Services Commission Executive Council. Because Section 531.012(d) as added by Chapter 837 is more specific in its requirements

than Section 531.012(d) as added by Chapter 946, the statutes are irreconcilable. Under Section 311.025(a), Government Code (Code Construction Act), if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails. Under Section 311.025(d), Government Code (Code Construction Act), the date of enactment is the date on which the last legislative vote is taken on the bill enacting the statute. The last legislative vote on Chapter 837 was taken on May 28, 2015. The last legislative vote on Chapter 946 was taken on May 29, 2015. Accordingly, the revised law omits Section 531.012(d) as added by Chapter 837 as superseded by Section 531.012(d) as added by Chapter 946. The omitted law reads:

> (d) An advisory committee established under this section shall:
>
> (1) report any recommendations to the executive commissioner at a meeting of the Health and Human Services Commission Executive Council established under Section 531.0051; and
>
> (2) submit a written report to the legislature of any policy recommendations made to the executive commissioner under Subdivision (1).

SUBCHAPTER F. PUBLIC INTEREST INFORMATION, INPUT, AND COMPLAINTS

Revised Law

Sec. 523.0251. PUBLIC INTEREST INFORMATION AND INPUT GENERALLY. (a) The commission shall develop and implement policies that provide the public a reasonable opportunity to appear before the commission and speak on any issue under the commission's jurisdiction.

(b) The commission shall develop and implement routine and ongoing mechanisms, in accessible formats, to:

(1) receive consumer input;

(2) involve consumers in the planning, delivery, and evaluation of programs and services under the commission's jurisdiction; and

(3) communicate to the public regarding the input the commission receives under this section and actions taken in response to that input.

(c) The commission shall prepare information of public interest describing the commission's functions. The commission shall make the information available to the public and appropriate state agencies. (Gov. Code, Secs. 531.011(a), (b), (c) (part).)

Source Law

> Sec. 531.011. PUBLIC INPUT INFORMATION AND COMPLAINTS. (a) The commission shall develop and implement policies that provide the public a reasonable opportunity to appear before the commission and to speak on any issue under the commission's jurisdiction.
>
> (b) The commission shall develop and implement routine and ongoing mechanisms, in accessible formats, to:
>
> (1) receive consumer input;
>
> (2) involve consumers in planning, delivery, and evaluation of programs and services under the jurisdiction of the commission; and
>
> (3) communicate to the public regarding the input received by the commission under this section and actions taken in response to that input.
>
> (c) The commission shall prepare information of public interest describing the functions of the commission and . . . . The commission shall make the information available to the public and appropriate state agencies.

Revised Law

Sec. 523.0252. PUBLIC HEARINGS. (a) The commission biennially shall conduct a series of public hearings in diverse locations throughout this state to give citizens of this state an opportunity to comment on health and human services issues. The commission shall conduct a sufficient number of hearings to allow reasonable access by citizens in both rural and urban areas, with an emphasis on geographic diversity.

(b) In conducting a public hearing under this section, the commission shall, to the greatest extent possible, encourage participation in the hearings process by diverse groups of citizens in this state.

(c) A public hearing held under this section is subject to Chapter 551. (Gov. Code, Sec. 531.036.)

Source Law

Sec. 531.036. PUBLIC HEARINGS. (a) The commission biennially shall conduct a series of public hearings in diverse locations throughout the state to give citizens of the state an opportunity to comment on health and human services issues.

(b) A hearing held under this section is subject to Chapter 551.

(c) In conducting a public hearing under this section, the commission shall, to the greatest extent possible, encourage participation in the hearings process by diverse groups of citizens in this state. Hearings shall be of a sufficient number to allow reasonable access to citizens in both rural and urban areas, with an emphasis on geographic diversity.

Revised Law

Sec. 523.0253. NOTICE OF PUBLIC HEARING. (a) In addition to the notice required by Chapter 551, the commission shall:

(1) publish notice of a public hearing under Section 523.0252 in a newspaper of general circulation in the county in which the hearing is to be held; and

(2) provide written notice of the hearing to public officials in the affected area.

(b) If the county in which the public hearing is to be held does not have a newspaper of general circulation, the commission shall publish notice in a newspaper of general circulation in an adjacent county or in the nearest county in which a newspaper of general circulation is published.

(c) Notice must be published once a week for two consecutive weeks before the public hearing, with the first publication appearing not later than the 15th day before the date set for the hearing. (Gov. Code, Sec. 531.037.)

Source Law

Sec. 531.037. NOTICE OF PUBLIC HEARINGS. (a) In addition to the notice required by Chapter 551, the commission shall:

(1) provide written notification to public officials in the affected area; and

(2) publish notice of a public hearing under Section 531.036 in a newspaper of general circulation in the county in which the hearing is to be held.

(b) If the county in which the hearing is to be held does not have a newspaper of general circulation, the commission shall publish notice in a newspaper of general circulation in an adjacent county or in the nearest county in which a newspaper of general

circulation is published.

(c) Notice shall be published once a week for two consecutive weeks before the hearing, with the first publication appearing not later than the 15th day before the date set for the hearing.

Revisor's Note

Section 531.037(a)(1), Government Code, requires the Health and Human Services Commission to provide written "notification" to certain public officials, and Section 531.037(a)(2), Government Code, requires the commission to publish notice of a public hearing. For clarity and the convenience of the reader, the revised law substitutes "notice of the hearing" for "notification" because it is clear from the context that the notification to which Section 531.037(a)(1) refers means notice of the hearing.

Revised Law

Sec. 523.0254. COMPLAINTS. (a) The commission shall prepare information of public interest describing the commission's procedures by which complaints are filed with and resolved by the commission. The commission shall make the information available to the public and appropriate state agencies.

(b) The executive commissioner by rule shall establish methods by which the public, consumers, and service recipients can be notified of the mailing addresses and telephone numbers of appropriate agency personnel for the purpose of directing complaints to the commission. The commission may provide for that notice:

(1) on each registration form, application, or written contract for services of a person the commission regulates;

(2) on a sign prominently displayed in the place of business of each person the commission regulates; or

(3) in a bill for service provided by a person the commission regulates.

(c) The commission shall:

(1) keep an information file about each complaint

filed with the commission relating to:

(A) a license holder or entity the commission regulates; or

(B) a service the commission delivers; and

(2) maintain an information file about each complaint the commission receives relating to any other matter or agency under the commission's jurisdiction.

(d) If a written complaint is filed with the commission relating to a license holder or entity the commission regulates or a service the commission delivers, the commission, at least quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless notice would jeopardize an undercover investigation. (Gov. Code, Secs. 531.011(c) (part), (d), (e), (f), (g).)

Source Law

> (c) The commission shall prepare information of public interest describing . . . the commission's procedures by which complaints are filed with and resolved by the commission. The commission shall make the information available to the public and appropriate state agencies.
>
> (d) The executive commissioner by rule shall establish methods by which the public, consumers, and service recipients can be notified of the mailing addresses and telephone numbers of appropriate agency personnel for the purpose of directing complaints to the commission. The commission may provide for that notification:
>
> (1) on each registration form, application, or written contract for services of a person regulated by the commission;
>
> (2) on a sign prominently displayed in the place of business of each person regulated by the commission; or
>
> (3) in a bill for service provided by a person regulated by the commission.
>
> (e) The commission shall keep an information file about each complaint filed with the commission relating to:
>
> (1) a license holder or entity regulated by the commission; or
>
> (2) a service delivered by the commission.
>
> (f) If a written complaint is filed with the commission relating to a license holder or entity regulated by the commission or a service delivered by the commission, the commission, at least quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless notice would jeopardize an undercover investigation.
>
> (g) In addition to the information file maintained under Subsection (e), the commission shall

maintain an information file on a complaint received by the commission relating to any matter or agency under the jurisdiction of the commission.

Revised Law

Sec. 523.0255. OFFICE OF OMBUDSMAN. (a) The executive commissioner shall establish the commission's office of the ombudsman with authority and responsibility over the health and human services system in performing the following functions:

(1) providing dispute resolution services for the health and human services system;

(2) performing consumer protection and advocacy functions related to health and human services, including assisting a consumer or other interested person with:

(A) raising a matter within the health and human services system that the person feels is being ignored; and

(B) obtaining information regarding a filed complaint; and

(3) collecting inquiry and complaint data related to the health and human services system.

(b) The office of the ombudsman does not have the authority to provide a separate process for resolving complaints or appeals.

(c) The executive commissioner shall develop a standard process for tracking and reporting received inquiries and complaints within the health and human services system. The process must provide for the centralized tracking of inquiries and complaints submitted to field, regional, or other local health and human services system offices.

(d) Using the process developed under Subsection (c), the office of the ombudsman shall collect inquiry and complaint data from all agencies, divisions, offices, and other entities within the health and human services system. To assist with the collection of data under this subsection, the office may access any system or process for recording inquiries and complaints the health and human services system uses or maintains. (Gov. Code, Sec. 531.0171.)

Source Law

Sec. 531.0171. OFFICE OF OMBUDSMAN. (a) The executive commissioner shall establish the commission's office of the ombudsman with authority and responsibility over the health and human services system in performing the following functions:

(1) providing dispute resolution services for the health and human services system;

(2) performing consumer protection and advocacy functions related to health and human services, including assisting a consumer or other interested person with:

(A) raising a matter within the health and human services system that the person feels is being ignored; and

(B) obtaining information regarding a filed complaint; and

(3) collecting inquiry and complaint data related to the health and human services system.

(b) The office of the ombudsman does not have the authority to provide a separate process for resolving complaints or appeals.

(c) The executive commissioner shall develop a standard process for tracking and reporting received inquiries and complaints within the health and human services system. The process must provide for the centralized tracking of inquiries and complaints submitted to field, regional, or other local health and human services system offices.

(d) Using the process developed under Subsection (c), the office of the ombudsman shall collect inquiry and complaint data from all offices, agencies, divisions, and other entities within the health and human services system. To assist with the collection of data under this subsection, the office may access any system or process for recording inquiries and complaints used or maintained within the health and human services system.

SUBCHAPTER G. OFFICE OF HEALTH COORDINATION AND CONSUMER SERVICES

Revised Law

Sec. 523.0301. DEFINITION. In this subchapter, "office" means the Office of Health Coordination and Consumer Services. (Gov. Code, Sec. 531.281.)

Source Law

Sec. 531.281. DEFINITION. In this chapter, "office" means the Office of Health Coordination and Consumer Services.

Revisor's Note

Section 531.281, Government Code, defines the term "office" for "this chapter," meaning Chapter 531, Government Code. The office to which the term refers is the Office of Health Coordination and Consumer Services. The provisions concerning that office are

contained in Subchapter H, Chapter 531, which is revised in this chapter as Subchapter G. The revised law substitutes "subchapter" for "chapter" because it is clear from the context that the defined term is intended to apply only to Subchapter G of this chapter.

Revised Law

Sec. 523.0302. OFFICE; STAFF. (a) The Office of Health Coordination and Consumer Services is an office within the commission.

(b) The executive commissioner shall employ staff as needed to carry out the duties of the office. (Gov. Code, Sec. 531.282.)

Source Law

> Sec. 531.282. OFFICE; STAFF. (a) The Office of Health Coordination and Consumer Services is an office within the commission.
>
> (b) The executive commissioner shall employ staff as needed to carry out the duties of the office.

Revised Law

Sec. 523.0303. GOALS. The goals of the office are to:

(1) promote community support for parents of children younger than six years of age through an integrated state and local-level decision-making process; and

(2) provide for the seamless delivery of health and human services to children younger than six years of age to ensure that children are prepared to succeed in school. (Gov. Code, Sec. 531.283.)

Source Law

> Sec. 531.283. GOALS. The goals of the office are to:
>
> (1) promote community support for parents of all children younger than six years of age through an integrated state and local-level decision-making process; and
>
> (2) provide for the seamless delivery of health and human services to all children younger than six years of age to ensure that all children are prepared to succeed in school.

Revised Law

Sec. 523.0304. STRATEGIC PLAN. (a) The office shall create and implement a statewide strategic plan for the delivery of health

and human services to children younger than six years of age.

(b) In developing the statewide strategic plan, the office shall:

(1) consider existing programs and models to serve children younger than six years of age, including:

(A) community resource coordination groups;

(B) the Texas System of Care; and

(C) the Texas Information and Referral Network and the 2-1-1 telephone number for access to human services;

(2) attempt to maximize federal funds and local existing infrastructure and funds; and

(3) provide for local participation to the greatest extent possible.

(c) The statewide strategic plan must address the needs of children with disabilities who are younger than six years of age. (Gov. Code, Sec. 531.284.)

Source Law

Sec. 531.284. STRATEGIC PLAN. (a) The office shall create and implement a statewide strategic plan for the delivery of health and human services to children younger than six years of age.

(b) In developing the statewide strategic plan, the office shall:

(1) consider existing programs and models to serve children younger than six years of age, including:

(A) community resource coordination groups;

(B) the Texas System of Care;

(C) the Texas Information and Referral Network; and

(D) efforts to create a 2-1-1 telephone number for access to human services;

(2) attempt to maximize federal funds and local existing infrastructure and funds; and

(3) provide for local participation to the greatest extent possible.

(c) The statewide strategic plan must address the needs of children younger than six years of age with disabilities.

Revisor's Note

Section 531.284(b)(1)(D), Government Code, refers to "efforts to create" a 2-1-1 telephone number for access to human services. The revised law omits the quoted phrase as executed because the telephone

number has been created.

Revised Law

Sec. 523.0305. POWERS AND DUTIES. (a) The office shall identify:

(1) gaps in early childhood services by functional area and geographical area;

(2) state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing available services;

(3) sources of funds for early childhood services, including federal, state, and private-public venture sources;

(4) opportunities for collaboration between the Texas Education Agency and health and human services agencies to better serve the needs of children younger than six years of age;

(5) methods for coordinating early childhood services provided by the Texas Head Start State Collaboration Office, the Texas Education Agency, and the Texas Workforce Commission;

(6) quantifiable benchmarks for success within early childhood service delivery; and

(7) national best practices in early care and educational delivery models.

(b) The office shall establish community outreach efforts and ensure adequate communication lines that provide:

(1) the office with information about community-level efforts; and

(2) communities with information about funds and programs available to communities.

(c) The office shall make recommendations to the commission on strategies to:

(1) ensure optimum collaboration and coordination between state agencies serving the needs of children younger than six years of age and other community stakeholders;

(2) fill functional and geographical gaps in early childhood services; and

(3) amend state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing services. (Gov. Code, Sec. 531.285.)

Source Law

Sec. 531.285. POWERS AND DUTIES. (a) The office shall identify:

(1) gaps in early childhood services by functional area and geographical area;

(2) state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing available services;

(3) sources of funds for early childhood services, including federal, state, and private-public ventures;

(4) opportunities for collaboration between the Texas Education Agency and health and human services agencies to better serve the needs of children younger than six years of age;

(5) methods for coordinating the provision of early childhood services provided by the Texas Head Start State Collaboration Office, the Texas Education Agency, and the Texas Workforce Commission;

(6) quantifiable benchmarks for success within early childhood service delivery; and

(7) national best practices in early care and educational delivery models.

(b) The office shall establish outreach efforts to communities and ensure adequate communication lines that provide the office with information about community-level efforts and communities with information about funds and programs available to communities.

(c) The office shall make recommendations to the commission on strategies to:

(1) ensure optimum collaboration and coordination between state agencies serving the needs of children younger than six years of age and other community stakeholders;

(2) fill geographical and functional gaps in early childhood services; and

(3) amend state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing services.

Revised Law

Sec. 523.0306. TEXAS HOME VISITING PROGRAM TRUST FUND. (a) The Texas Home Visiting Program trust fund is a trust fund outside the treasury with the comptroller. The fund is administered by the office under this section and rules the executive commissioner adopts. Money in the fund is not state money and is not subject to legislative appropriation.

(b) The fund consists of money from voluntary contributions under Section 191.0048, Health and Safety Code, and Section

118.018, Local Government Code.

(c) The office may spend money in the fund without appropriation and only for the purpose of the Texas Home Visiting Program the commission administers.

(d) Interest and income from fund assets shall be credited to and deposited in the fund. (Gov. Code, Sec. 531.287.)

Source Law

Sec. 531.287. TEXAS HOME VISITING PROGRAM TRUST FUND. (a) The Texas Home Visiting Program trust fund is created as a trust fund outside the treasury with the comptroller and shall be administered by the office under this section and rules adopted by the executive commissioner. Credits of money in the fund are not state funds or subject to legislative appropriation.

(b) The trust fund consists of money from voluntary contributions under Section 191.0048, Health and Safety Code, and Section 118.018, Local Government Code.

(c) Money in the fund may be spent without appropriation by the office only for the purpose of the Texas Home Visiting Program administered by the commission.

(d) Interest and income from the assets of the trust fund shall be credited to and deposited in the trust fund.

Revisor's Note

(1) Section 531.287(a), Government Code, states that the Texas Home Visiting Program trust fund "is created as" a trust fund. The revised law omits the quoted phrase as executed because the trust fund has already been created.

(2) Section 531.287(a), Government Code, refers to federal, state, and local "funds." The revised law substitutes "money" for "funds" because, in context, the meaning is the same and Section 531.287(b), Government Code, states that the trust fund consists of "money" from certain contributions.

CHAPTER 524. AUTHORITY OVER HEALTH AND HUMAN SERVICES SYSTEM

SUBCHAPTER A. SYSTEM OVERSIGHT AUTHORITY OF COMMISSION

Sec. 524.0001. GENERAL RESPONSIBILITY OF COMMISSION FOR HEALTH AND HUMAN SERVICES SYSTEM; PRIORITIZATION OF CERTAIN DUTIES . . . . . 81

Sec. 524.0002. GENERAL RESPONSIBILITY OF EXECUTIVE COMMISSIONER FOR HEALTH AND HUMAN SERVICES SYSTEM . . . . . 85
Sec. 524.0003. ADOPTION OR APPROVAL OF PAYMENT RATES . . . . 87
Sec. 524.0004. PROGRAM TO EVALUATE AND SUPERVISE DAILY OPERATIONS . . . . . 87
Sec. 524.0005. RULES . . . . . 88
SUBCHAPTER B. COMMISSIONERS OF HEALTH AND HUMAN SERVICES AGENCIES
Sec. 524.0051. APPOINTMENT OF AGENCY COMMISSIONER BY EXECUTIVE COMMISSIONER . . . . . 89
Sec. 524.0052. EVALUATION OF AGENCY COMMISSIONER . . . . . 90
SUBCHAPTER C. MEMORANDUM OF UNDERSTANDING FOR OPERATION OF SYSTEM
Sec. 524.0101. MEMORANDUM OF UNDERSTANDING BETWEEN EXECUTIVE COMMISSIONER AND HEALTH AND HUMAN SERVICES AGENCY COMMISSIONER . . . . 91
Sec. 524.0102. ADOPTION AND AMENDMENT OF MEMORANDUM OF UNDERSTANDING . . . . . 92
SUBCHAPTER D. RULES AND POLICIES FOR HEALTH AND HUMAN SERVICES
Sec. 524.0151. AUTHORITY TO ADOPT RULES AND POLICIES . . . . 93
Sec. 524.0152. PROCEDURES FOR ADOPTING RULES AND POLICIES . . . . . 94
Sec. 524.0153. POLICY FOR NEGOTIATED RULEMAKING AND ALTERNATIVE DISPUTE RESOLUTION PROCEDURES . . . . . 95
Sec. 524.0154. PERSON FIRST RESPECTFUL LANGUAGE PROMOTION . . . . . 96
SUBCHAPTER E. ADMINISTRATIVE SUPPORT SERVICES
Sec. 524.0201. DEFINITION . . . . . 96
Sec. 524.0202. CENTRALIZED SYSTEM OF ADMINISTRATIVE SUPPORT SERVICES . . . . . 97
Sec. 524.0203. PRINCIPLES FOR AND REQUIREMENTS OF CENTRALIZED SYSTEM; MEMORANDUM OF UNDERSTANDING . . . . . 97

SUBCHAPTER F. LEGISLATIVE OVERSIGHT
Sec. 524.0251. OVERSIGHT BY LEGISLATIVE COMMITTEES . . . . . 99
Sec. 524.0252. INFORMATION PROVIDED TO LEGISLATIVE COMMITTEES . . . . . 100

CHAPTER 524. AUTHORITY OVER HEALTH AND HUMAN SERVICES SYSTEM

SUBCHAPTER A. SYSTEM OVERSIGHT AUTHORITY OF COMMISSION

Revised Law

Sec. 524.0001. GENERAL RESPONSIBILITY OF COMMISSION FOR HEALTH AND HUMAN SERVICES SYSTEM; PRIORITIZATION OF CERTAIN DUTIES. (a) The commission shall:

(1) supervise the administration and operation of Medicaid, including the administration and operation of the Medicaid managed care system in accordance with Sections 532.0051 and 532.0057;

(2) perform information resources planning and management for the health and human services system under Section 525.0251, with:

(A) the provision of information technology services for the health and human services system as a centralized administrative support service performed either by commission personnel or under a contract with the commission; and

(B) an emphasis on research and implementation on a demonstration or pilot basis of appropriate and efficient uses of new and existing technology to improve the operation of the health and human services system and delivery of health and human services;

(3) monitor and ensure the effective use of all federal funds received for the health and human services system in accordance with Section 525.0052 and the General Appropriations Act;

(4) implement Texas Integrated Enrollment Services as required by Subchapter A, Chapter 545, except that notwithstanding that subchapter, the commission is responsible for determining and must centralize benefits eligibility under the following programs:

(A) the child health plan program;

(B) the financial assistance program under Chapter 31, Human Resources Code;

(C) Medicaid;

(D) the supplemental nutrition assistance program under Chapter 33, Human Resources Code;

(E) long-term care services as defined by Section 22.0011, Human Resources Code;

(F) community-based support services identified or provided in accordance with Subchapter D, Chapter 546; and

(G) other health and human services programs, as appropriate; and

(5) implement programs intended to prevent family violence and provide services to victims of family violence.

(b) The commission shall implement the powers and duties given to the commission under Sections 525.0002, 525.0153, 2155.144, and 2167.004.

(c) After implementing the commission's duties under Subsections (a) and (b), the commission shall implement the powers and duties given to the commission under Section 525.0160.

(d) Nothing in the priorities established by this section is intended to limit the commission's authority to work simultaneously to achieve the multiple tasks assigned to the commission in this section and Section 524.0202(a)(1) when that approach is beneficial in the commission's judgment. (Gov. Code, Secs. 531.0055(b), (c), (d) (part).)

Source Law

(b) The commission shall:

(1) supervise the administration and operation of Medicaid, including the administration and operation of the Medicaid managed care system in accordance with Section 531.021;

(2) perform information systems planning and management for the health and human services system under Section 531.0273, with:

(A) the provision of information technology services for the health and human services system considered to be a centralized administrative support service either performed by commission personnel or performed under a contract with the

commission; and

(B) an emphasis on research and implementation on a demonstration or pilot basis of appropriate and efficient uses of new and existing technology to improve the operation of the health and human services system and delivery of health and human services;

(3) monitor and ensure the effective use of all federal funds received for the health and human services system in accordance with Section 531.028 and the General Appropriations Act;

(4) implement Texas Integrated Enrollment Services as required by Subchapter F, except that notwithstanding Subchapter F, determining eligibility for benefits under the following programs is the responsibility of and must be centralized by the commission:

(A) the child health plan program;

(B) the financial assistance program under Chapter 31, Human Resources Code;

(C) Medicaid;

(D) the supplemental nutrition assistance program under Chapter 33, Human Resources Code;

(E) long-term care services, as defined by Section 22.0011, Human Resources Code;

(F) community-based support services identified or provided in accordance with Section 531.02481; and

(G) other health and human services programs, as appropriate; and

(5) implement programs intended to prevent family violence and provide services to victims of family violence.

(c) The commission shall implement the powers and duties given to the commission under Sections 531.0246, 531.0247, 2155.144, and 2167.004.

(d) After implementation of the commission's duties under Subsections (b) and (c), the commission shall implement the powers and duties given to the commission under Section 531.0248. Nothing in the priorities established by this section is intended to limit the authority of the commission to work simultaneously to achieve the multiple tasks assigned to the commission in this section, when such an approach is beneficial in the judgment of the commission. . . .

Revisor's Note

(1) Section 531.0055(b)(1), Government Code, refers to the administration and operation of Medicaid in accordance with Section 531.021, Government Code. The provisions of Section 531.021 are revised in this subtitle as Sections 532.0051 and 532.0057, and the revised law is drafted accordingly.

(2) Section 531.0055(b)(2), Government Code, requires the Health and Human Services Commission to perform "information systems planning and management"

under Section 531.0273, Government Code, which is revised in this title as Section 525.0251. Section 531.0273 refers to strategic planning for and the management of information "resources." The revised law substitutes "information resources planning and management" for "information systems planning and management" for consistency of terminology.

(3) Section 531.0055(b)(4), Government Code, refers to the implementation of Texas Integrated Enrollment Services as required by Subchapter F, Chapter 531, Government Code. The provisions of Subchapter F, Chapter 531, are revised in this subtitle as Subchapter A, Chapter 545, and the revised law is drafted accordingly.

(4) Section 531.0055(b)(4)(F), Government Code, refers to community-based support services identified or provided in accordance with Section 531.02481, Government Code. The provisions of Section 531.02481 are revised in this subtitle as Subchapter D, Chapter 546, and the revised law is drafted accordingly.

(5) Section 531.0055(d), Government Code, refers to the priorities established by "this section" and the tasks assigned to the Health and Human Services Commission in "this section," both meaning Section 531.0055. Although the provisions of Section 531.0055 are revised in various sections of this chapter and in Section 525.0254 of this subtitle, the provisions revised as Section 524.0001 of this chapter retain the reference to "this section" in the context of the prioritization of the commission's duties because all the relevant provisions of Section 531.0055 relating to that prioritization are revised in Section 524.0001. With respect to the tasks assigned to the commission, the revised law substitutes "this section

and Section 524.0202(a)(1)" of the revised law because those are the only provisions derived from Section 531.0055 that assign tasks to the commission, rather than the executive commissioner of the commission.

Revised Law

Sec. 524.0002. GENERAL RESPONSIBILITY OF EXECUTIVE COMMISSIONER FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) The executive commissioner, as necessary to perform the functions described by Section 524.0001 and Subchapter E in implementing applicable policies the executive commissioner establishes for a health and human services agency or division, shall:

(1) manage and direct the operations of each agency or division, as applicable;

(2) supervise and direct the activities of each agency commissioner or division director, as applicable; and

(3) be responsible for the administrative supervision of the internal audit program for the agencies, including:

(A) selecting the director of internal audit;

(B) ensuring the director of internal audit reports directly to the executive commissioner; and

(C) ensuring the independence of the internal audit function.

(b) The executive commissioner's operational authority and responsibility for purposes of Subsection (a) and Section 524.0151(a)(2) for each health and human services agency or division, as applicable, includes authority over and responsibility for:

(1) daily operations management of the agency or division, including the organization, management, and operating procedures of the agency or division;

(2) resource allocation within the agency or division, including the use of federal funds the agency or division receives;

(3) personnel and employment policies;

(4) contracting, purchasing, and related policies,

subject to this chapter and other laws relating to contracting and purchasing by a state agency;

(5) information resources systems the agency or division uses;

(6) facility location; and

(7) the coordination of agency or division activities with activities of other components of the health and human services system and state agencies. (Gov. Code, Secs. 531.0055(a) (part), (e) (part), (f).)

Source Law

Sec. 531.0055. EXECUTIVE COMMISSIONER: GENERAL RESPONSIBILITY FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) In this section and . . . "agency director" means the commissioner of a health and human services agency.

(e) . . . In addition, the executive commissioner, as necessary to perform the functions described by Subsections (b), (c), and (d) and Section 531.00553 in implementation of applicable policies established for a health and human services system agency or division, as applicable, by the executive commissioner, shall:

(1) manage and direct the operations of each agency or division, as applicable;

(2) supervise and direct the activities of each agency or division director, as applicable; and

(3) be responsible for the administrative supervision of the internal audit program for the health and human services system agencies, including:

(A) selecting the director of internal audit;

(B) ensuring that the director of internal audit reports directly to the executive commissioner; and

(C) ensuring the independence of the internal audit function.

(f) The operational authority and responsibility of the executive commissioner for purposes of Subsection (e) for each health and human services system agency or division, as applicable, includes authority over and responsibility for the:

(1) management of the daily operations of the agency or division, including the organization and management of the agency or division and its operating procedures;

(2) allocation of resources within the agency or division, including use of federal funds received by the agency or division;

(3) personnel and employment policies;

(4) contracting, purchasing, and related policies, subject to this chapter and other laws relating to contracting and purchasing by a state agency;

(5) information resources systems used by the agency or division;

(6) location of facilities; and

(7) coordination of agency or division activities with activities of other components of the health and human services system and state agencies.

Revisor's Note

Section 531.0055(f)(4), Government Code, refers to contracting, purchasing, and related policies, subject to "this chapter," meaning Chapter 531, Government Code, and "other laws" related to contracting and purchasing by a state agency. Chapter 531 is revised throughout Subtitle I, Title 4, Government Code, including in this chapter. The revised law retains the reference to "this chapter and other laws" because the provisions of Chapter 531 that are not revised in this chapter are included within the meaning of "other laws."

Revised Law

Sec. 524.0003. ADOPTION OR APPROVAL OF PAYMENT RATES. Notwithstanding any other law, the executive commissioner's operational authority and responsibility for purposes of Sections 524.0002(a) and 524.0151(a)(2) for each health and human services agency or division, as applicable, include the authority and responsibility to adopt or approve, subject to applicable limitations, any payment rate or similar provision a health and human services agency is required by law to adopt or approve. (Gov. Code, Sec. 531.0055(g).)

Source Law

(g) Notwithstanding any other law, the operational authority and responsibility of the executive commissioner for purposes of Subsection (e) for each health and human services system agency or division, as applicable, includes the authority and responsibility to adopt or approve, subject to applicable limitations, any rate of payment or similar provision required by law to be adopted or approved by a health and human services system agency.

Revised Law

Sec. 524.0004. PROGRAM TO EVALUATE AND SUPERVISE DAILY OPERATIONS. (a) For each health and human services agency and division, as applicable, the executive commissioner shall

implement a program to evaluate and supervise daily operations.

(b) The program must include:

(1) measurable performance objectives for each agency commissioner or division director; and

(2) adequate reporting requirements to permit the executive commissioner to perform the duties assigned to the executive commissioner under:

(A) this subchapter;

(B) Sections 524.0101(a), 524.0151(a)(2) and (b), and 525.0254(b); and

(C) Section 524.0202 with respect to the health and human services system. (Gov. Code, Secs. 531.0055(a) (part), (h).)

Source Law

> Sec. 531.0055. EXECUTIVE COMMISSIONER: GENERAL RESPONSIBILITY FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) In this section and . . . "agency director" means the commissioner of a health and human services agency.
>
> (h) For each health and human services system agency and division, as applicable, the executive commissioner shall implement a program to evaluate and supervise daily operations. The program must include measurable performance objectives for each agency or division director and adequate reporting requirements to permit the executive commissioner to perform the duties assigned to the executive commissioner under this section.

Revised Law

Sec. 524.0005. RULES. The executive commissioner shall adopt rules to implement the executive commissioner's authority under this subchapter with respect to the health and human services system. (Gov. Code, Sec. 531.0055(j).)

Source Law

> (j) The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section.

Revisor's Note

Section 531.0055(j), Government Code, requires the executive commissioner of the Health and Human Services Commission to adopt rules to implement the

executive commissioner's authority under "this section," meaning Section 531.0055, Government Code. The substantive provisions of Section 531.0055 are revised as Subchapter A and Sections 524.0101(a), 524.0151(a)(2) and (b), and 524.0202 of this chapter, and Section 525.0254(b) of this subtitle. The revised law, however, substitutes a reference to only "this subchapter," meaning Subchapter A of this chapter, for the reference to "this section" for the reasons that follow.

With respect to Section 524.0101(a) of this chapter, Section 531.0163, Government Code, revised as Section 524.0102 of this chapter, expressly requires the executive commissioner to adopt by rule the memorandum of understanding at issue in Section 524.0101(a), making the duty to adopt rules contained in Section 531.0055(j), Government Code, redundant and unnecessary as to Section 524.0101(a). Referencing the law revised as Sections 524.0151(a)(2) and (b) of this chapter is also unnecessary in this section's requirement to adopt rules because those sections provide for the adoption of rules.

The revision of Section 531.0055(j), Government Code, in this section does not include a reference to Section 524.0202 of this chapter or Section 525.0254(b) of this subtitle because the substance of Section 531.0055(j) is also revised with those provisions.

SUBCHAPTER B. COMMISSIONERS OF HEALTH AND HUMAN SERVICES AGENCIES

Revised Law

Sec. 524.0051. APPOINTMENT OF AGENCY COMMISSIONER BY EXECUTIVE COMMISSIONER. (a) The executive commissioner, with the governor's approval, shall appoint a commissioner for each health and human services agency.

(b) A health and human services agency commissioner serves at the executive commissioner's pleasure. (Gov. Code, Secs. 531.0055(a) (part), 531.0056(a), (b).)

Source Law

> Sec. 531.0055. EXECUTIVE COMMISSIONER: GENERAL RESPONSIBILITY FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) . . . in Section 531.0056, "agency director" means the commissioner of a health and human services agency.
>
> Sec. 531.0056. APPOINTMENT OF AGENCY DIRECTOR BY EXECUTIVE COMMISSIONER. (a) The executive commissioner shall appoint an agency director for each health and human services agency with the approval of the governor.
>
> (b) An agency director appointed by the executive commissioner serves at the pleasure of the executive commissioner.

Revised Law

Sec. 524.0052. EVALUATION OF AGENCY COMMISSIONER. Based on the performance objectives outlined in the memorandum of understanding entered into under Section 524.0101(a), the executive commissioner shall perform an employment evaluation of each health and human services agency commissioner. The executive commissioner shall submit the evaluation to the governor not later than January 1 of each even-numbered year. (Gov. Code, Secs. 531.0055(a) (part), 531.0056(c) (part), (e), (f).)

Source Law

> Sec. 531.0055. EXECUTIVE COMMISSIONER: GENERAL RESPONSIBILITY FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) . . . in Section 531.0056, "agency director" means the commissioner of a health and human services agency.
>
> [Sec. 531.0056]
>
> (c) In addition to the requirements of Section 531.0055(k)(1), the memorandum of understanding required by that section . . . .
>
> (e) Based upon the performance objectives outlined in the memorandum of understanding, the executive commissioner shall perform an employment evaluation of the agency director.
>
> (f) The executive commissioner shall submit the evaluation to the governor not later than January 1 of each even-numbered year.

Revisor's Note
(End of Subchapter)

Section 531.0056(g), Government Code, provides

that Section 531.0056, Government Code, applies to a state agency listed in Section 531.001(4), Government Code, only until the agency is abolished under Section 531.0202, Government Code. As of September 1, 2017, each agency identified for abolishment had been abolished. Therefore, the revised law omits this provision as executed. The omitted law reads:

> (g) The requirements of this section apply with respect to a state agency listed in Section 531.001(4) only until the agency is abolished under Section 531.0202.

SUBCHAPTER C. MEMORANDUM OF UNDERSTANDING FOR OPERATION OF SYSTEM

Revised Law

Sec. 524.0101. MEMORANDUM OF UNDERSTANDING BETWEEN EXECUTIVE COMMISSIONER AND HEALTH AND HUMAN SERVICES AGENCY COMMISSIONER. (a) The executive commissioner and each health and human services agency commissioner shall enter into a memorandum of understanding in the manner prescribed by Section 524.0102 that:

(1) clearly defines the responsibilities of the executive commissioner and the commissioner, including:

(A) the responsibility of the commissioner to:

(i) report to the governor; and

(ii) report to and implement policies of the executive commissioner; and

(B) the extent to which the commissioner acts as a liaison between the health and human services agency the commissioner serves and the commission;

(2) establishes the program to evaluate and supervise daily operations required by Section 524.0004;

(3) describes each power or duty delegated to a commissioner; and

(4) ensures the commission and each health and human services agency has access to databases or other information each other agency maintains or keeps that is necessary for the operation of a function the commission or the health and human services agency

performs, to the extent not prohibited by other law.

(b) The memorandum of understanding must also outline specific performance objectives, as the executive commissioner defines, to be fulfilled by the health and human services agency commissioner with whom the executive commissioner enters into the memorandum of understanding, including the performance objectives required by Section 524.0004. (Gov. Code, Secs. 531.0055(a) (part), (k), 531.0056(c), (d).)

Source Law

> Sec. 531.0055. EXECUTIVE COMMISSIONER: GENERAL RESPONSIBILITY FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) In this section and . . . "agency director" means the commissioner of a health and human services agency.
>
> (k) The executive commissioner and each agency director shall enter into a memorandum of understanding in the manner prescribed by Section 531.0163 that:
>
> (1) clearly defines the responsibilities of the agency director and the executive commissioner, including:
>
> (A) the responsibility of the agency director to report to the governor and to report to and implement policies of the executive commissioner; and
>
> (B) the extent to which the agency director acts as a liaison between the agency and the commission;
>
> (2) establishes the program of evaluation and supervision of daily operations required by Subsection (h);
>
> (3) describes each delegation of a power or duty made to an agency director; and
>
> (4) ensures that the commission and each health and human services agency has access to databases or other information maintained or kept by each other agency that is necessary for the operation of a function performed by the commission or the health and human services agency, to the extent not prohibited by other law.
>
> [Sec. 531.0056]
>
> (c) In addition to the requirements of Section 531.0055(k)(1), the memorandum of understanding required by that section must clearly define the responsibilities of the agency director.
>
> (d) The terms of the memorandum of understanding shall outline specific performance objectives, as defined by the executive commissioner, to be fulfilled by the agency director, including the performance objectives outlined in Section 531.0055(h).

Revised Law

Sec. 524.0102. ADOPTION AND AMENDMENT OF MEMORANDUM OF UNDERSTANDING. (a) The executive commissioner by rule shall adopt

the memorandum of understanding under Section 524.0101 in accordance with the procedures prescribed by Subchapter B, Chapter 2001, for adopting rules, except that the requirements of Sections 2001.033(a)(1)(A) and (C) do not apply with respect to any part of the memorandum of understanding that:

(1) concerns only internal management or organization within or among health and human services agencies and does not affect private rights or procedures; or

(2) relates solely to the internal personnel practices of health and human services agencies.

(b) The memorandum of understanding may be amended only by following the procedures prescribed by Subsection (a). (Gov. Code, Sec. 531.0163.)

Source Law

> Sec. 531.0163. MEMORANDUM OF UNDERSTANDING. (a) The memorandum of understanding under Section 531.0055(k) must be adopted by the executive commissioner by rule in accordance with the procedures prescribed by Subchapter B, Chapter 2001, for adopting rules, except that the requirements of Section 2001.033(a)(1)(A) or (C) do not apply with respect to any part of the memorandum of understanding that:
>
> (1) concerns only internal management or organization within or among health and human services agencies and does not affect private rights or procedures; or
>
> (2) relates solely to the internal personnel practices of health and human services agencies.
>
> (b) The memorandum of understanding may be amended only by following the procedures prescribed under Subsection (a).

SUBCHAPTER D. RULES AND POLICIES FOR HEALTH AND HUMAN SERVICES

Revised Law

Sec. 524.0151. AUTHORITY TO ADOPT RULES AND POLICIES. (a) The executive commissioner shall:

(1) adopt rules necessary to carry out the commission's duties under Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025; and

(2) notwithstanding any other law, adopt rules and policies for the operation of the health and human services system

and the provision of health and human services by that system.

(b) Notwithstanding any other law, the executive commissioner has the authority to adopt rules and policies governing:

(1) the delivery of services to persons the health and human services system serves; and

(2) the rights and duties of persons the system serves or regulates. (Gov. Code, Secs. 531.0055(e) (part), (l), 531.033.)

Source Law

[Sec. 531.0055]

(e) Notwithstanding any other law, the executive commissioner shall adopt rules and policies for the operation of and provision of health and human services by the health and human services system. . . .

(l) Notwithstanding any other law, the executive commissioner has the authority to adopt policies and rules governing the delivery of services to persons who are served by the health and human services system and the rights and duties of persons who are served or regulated by the system.

Sec. 531.033. RULES. The executive commissioner shall adopt rules necessary to carry out the commission's duties under this chapter.

Revised Law

Sec. 524.0152. PROCEDURES FOR ADOPTING RULES AND POLICIES. (a) The executive commissioner shall develop procedures for adopting rules for the health and human services agencies. The procedures must specify the manner in which the agencies may participate in the rulemaking process.

(b) A health and human services agency shall assist the executive commissioner in developing policies and guidelines needed for the administration of the agency's functions and shall submit any proposed policies and guidelines to the executive commissioner. The agency may implement a proposed policy or guideline only if the executive commissioner approves the policy or guideline. (Gov. Code, Sec. 531.00551.)

Source Law

Sec. 531.00551. PROCEDURES FOR ADOPTING RULES AND POLICIES. (a) The executive commissioner shall develop procedures for adopting rules for the health

and human services agencies. The procedures must specify the manner in which the health and human services agencies may participate in the rulemaking process.

(b) A health and human services agency shall assist the executive commissioner in the development of policies and guidelines needed for the administration of the agency's functions and shall submit any proposed policies and guidelines to the executive commissioner. The agency may implement a proposed policy or guideline only if the executive commissioner approves the policy or guideline.

Revised Law

Sec. 524.0153. POLICY FOR NEGOTIATED RULEMAKING AND ALTERNATIVE DISPUTE RESOLUTION PROCEDURES. (a) The commission shall develop and implement a policy for the commission and each health and human services agency to encourage the use of:

(1) negotiated rulemaking procedures under Chapter 2008 for the adoption of rules for the commission and each agency; and

(2) appropriate alternative dispute resolution procedures under Chapter 2009 to assist in the resolution of internal and external disputes under the commission's or agency's jurisdiction.

(b) The procedures relating to alternative dispute resolution must conform, to the extent possible, to any model guidelines the State Office of Administrative Hearings issues for the use of alternative dispute resolution by state agencies.

(c) The commission shall:

(1) coordinate the implementation of the policy developed under Subsection (a);

(2) provide training as needed to implement the procedures for negotiated rulemaking or alternative dispute resolution; and

(3) collect data concerning the effectiveness of those procedures. (Gov. Code, Sec. 531.0161.)

Source Law

Sec. 531.0161. NEGOTIATED RULEMAKING AND ALTERNATIVE DISPUTE PROCEDURES. (a) The commission shall develop and implement a policy, for the commission and each health and human services agency, to encourage the use of:

(1) negotiated rulemaking procedures under Chapter 2008 for the adoption of rules for the commission and each agency; and

(2) appropriate alternative dispute resolution procedures under Chapter 2009 to assist in the resolution of internal and external disputes under the commission's or agency's jurisdiction.

(b) The procedures relating to alternative dispute resolution must conform, to the extent possible, to any model guidelines issued by the State Office of Administrative Hearings for the use of alternative dispute resolution by state agencies.

(c) The commission shall:

(1) coordinate the implementation of the policy developed under Subsection (a);

(2) provide training as needed to implement the procedures for negotiated rulemaking or alternative dispute resolution; and

(3) collect data concerning the effectiveness of those procedures.

Revised Law

Sec. 524.0154. PERSON FIRST RESPECTFUL LANGUAGE PROMOTION. The executive commissioner shall ensure that the commission and each health and human services agency use the terms and phrases listed as preferred under the person first respectful language initiative in Chapter 392 when proposing, adopting, or amending the commission's or agency's rules, reference materials, publications, or electronic media. (Gov. Code, Sec. 531.0227.)

Source Law

Sec. 531.0227. PERSON FIRST RESPECTFUL LANGUAGE PROMOTION. The executive commissioner shall ensure that the commission and each health and human services agency use the terms and phrases listed as preferred under the person first respectful language initiative in Chapter 392 when proposing, adopting, or amending the commission's or agency's rules, reference materials, publications, and electronic media.

SUBCHAPTER E. ADMINISTRATIVE SUPPORT SERVICES

Revised Law

Sec. 524.0201. DEFINITION. In this subchapter, "administrative support services" includes strategic planning and evaluation, audit, legal, human resources, information resources, purchasing, contracting, financial management, and accounting services. (Gov. Code, Sec. 531.00553(a).)

Source Law

Sec. 531.00553. ADMINISTRATIVE SUPPORT SERVICES. (a) In this section, the term "administrative support services" includes strategic planning and evaluation, audit, legal, human

resources, information resources, purchasing, contracting, financial management, and accounting services.

Revised Law

Sec. 524.0202. CENTRALIZED SYSTEM OF ADMINISTRATIVE SUPPORT SERVICES. (a) Subject to Section 524.0203(a), the executive commissioner shall plan and implement an efficient and effective centralized system of administrative support services for:

(1) the health and human services system; and

(2) the Department of Family and Protective Services.

(b) The commission is responsible for the performance of administrative support services for the health and human services system. The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section with respect to that system. (Gov. Code, Secs. 531.0055(d) (part), (j), 531.00553(b).)

Source Law

[Sec. 531.0055]

(d) . . . The commission shall plan and implement an efficient and effective centralized system of administrative support services for the health and human services system in accordance with Section 531.00553.

(j) The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section.

[Sec. 531.00553]

(b) Subject to Subsection (c), the executive commissioner shall plan and implement an efficient and effective centralized system of administrative support services for the health and human services system and the Department of Family and Protective Services, as applicable. The performance of administrative support services for the health and human services system is the responsibility of the commission.

Revised Law

Sec. 524.0203. PRINCIPLES FOR AND REQUIREMENTS OF CENTRALIZED SYSTEM; MEMORANDUM OF UNDERSTANDING. (a) The executive commissioner shall plan and implement the centralized system of administrative support services in accordance with the following principles and requirements:

(1) the executive commissioner shall consult with the commissioner of each agency and the director of each division within the health and human services system to ensure the commission is responsive to and addresses agency or division needs;

(2) consolidation of staff providing the support services must be done in a manner that ensures each agency or division within the health and human services system that loses staff as a result of the centralization of support services has adequate resources to carry out functions of the agency or division, as appropriate; and

(3) the commission and each agency or division within the health and human services system shall, as appropriate, enter into a memorandum of understanding or other written agreement to ensure accountability for the provision of support services by clearly detailing:

(A) the responsibilities of each agency or division and the commission;

(B) the points of contact for each agency or division and the commission;

(C) the transfer of personnel among each agency or division and the commission;

(D) the agreement's budgetary effect on each agency or division and the commission; and

(E) any other item the executive commissioner determines is critical for maintaining accountability.

(b) A memorandum of understanding or other written agreement entered into under Subsection (a)(3) may be combined with the memorandum of understanding required under Section 524.0101(a), if appropriate. (Gov. Code, Secs. 531.00553(c), (d).)

Source Law

(c) The executive commissioner shall plan and implement the centralized system of administrative support services in accordance with the following principles and requirements:

(1) the executive commissioner shall

consult with the commissioner of each agency and with the director of each division within the health and human services system to ensure the commission is responsive to and addresses agency or division needs;

(2) consolidation of staff providing the support services must be done in a manner that ensures each agency or division within the health and human services system that loses staff as a result of the centralization of support services has adequate resources to carry out functions of the agency or division, as appropriate; and

(3) the commission and each agency or division within the health and human services system shall, as appropriate, enter into a memorandum of understanding or other written agreement for the purpose of ensuring accountability for the provision of administrative services by clearly detailing:

(A) the responsibilities of each agency or division and the commission;

(B) the points of contact for each agency or division and the commission;

(C) the transfer of personnel among each agency or division and the commission;

(D) the budgetary effect the agreement has on each agency or division and the commission; and

(E) any other item determined by the executive commissioner to be critical for maintaining accountability.

(d) The memorandum of understanding or other agreement required under Subsection (c), if appropriate, may be combined with the memorandum of understanding required under Section 531.0055(k).

SUBCHAPTER F. LEGISLATIVE OVERSIGHT

Revised Law

Sec. 524.0251. OVERSIGHT BY LEGISLATIVE COMMITTEES. The standing or other committees of the house of representatives and the senate that have jurisdiction over the commission and other agencies relating to implementation of Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025, as identified by the speaker of the house of representatives and the lieutenant governor, shall:

(1) to ensure implementation consistent with law, monitor the commission's:

(A) implementation of Subchapter A, Sections 524.0101(a), 524.0151(a)(2) and (b), and 525.0254(b), and Section 524.0202 with respect to the health and human services system; and

(B) other duties in consolidating and integrating health and human services;

(2) recommend any needed adjustments to the

implementation of the provisions listed in Subdivision (1)(A) and the commission's other duties in consolidating and integrating health and human services; and

(3) review the commission's rulemaking process, including the commission's plan for obtaining public input. (Gov. Code, Sec. 531.171(a).)

Source Law

> Sec. 531.171. COMMITTEE DUTIES. (a) The standing or other committees of the house of representatives and the senate that have jurisdiction over the commission and other agencies relating to implementation of this chapter, as identified by the speaker of the house of representatives and the lieutenant governor, shall:
>
> (1) monitor the commission's implementation of Section 531.0055 and the commission's other duties in consolidating and integrating health and human services to ensure implementation consistent with law;
>
> (2) recommend, as needed, adjustments to the implementation of Section 531.0055 and the commission's other duties in consolidating and integrating health and human services; and
>
> (3) review the rulemaking process used by the commission, including the commission's plan for obtaining public input.

Revised Law

Sec. 524.0252. INFORMATION PROVIDED TO LEGISLATIVE COMMITTEES. The commission shall provide the committees described by Section 524.0251 with copies of all required reports and proposed rules. Copies of the proposed rules must be provided to the committees before the rules are published in the Texas Register. At the request of a committee or the executive commissioner, a health and human services agency shall:

(1) provide other information to the committee, including information relating to the health and human services system; and

(2) report on agency progress in implementing statutory directives the committee identifies and the commission's directives. (Gov. Code, Sec. 531.171(b).)

Source Law

> (b) The commission shall provide copies of all required reports to the committees and shall provide the committees with copies of proposed rules before

the rules are published in the Texas Register. At the request of a committee or the executive commissioner, a health and human services agency shall provide other information to the committee, including information relating to the health and human services system, and shall report on agency progress in implementing statutory directives identified by the committee and the directives of the commission.

CHAPTER 525. GENERAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

SUBCHAPTER A. HEALTH AND HUMAN SERVICES ADMINISTRATION GENERALLY


Sec. 525.0001. POWERS AND DUTIES RELATING TO HEALTH AND HUMAN SERVICES ADMINISTRATION . . . . . 103

Sec. 525.0002. LOCATION OF AND CONSOLIDATION OF CERTAIN SERVICES AMONG HEALTH AND HUMAN SERVICES AGENCIES . . . . . 103

Sec. 525.0003. CONSOLIDATED INTERNAL AUDIT PROGRAM . . . . . 104

Sec. 525.0004. INTERAGENCY DISPUTE ARBITRATION . . . . . 105


SUBCHAPTER B. ACCOUNTING AND FISCAL PROVISIONS


Sec. 525.0051. MANAGEMENT INFORMATION AND COST ACCOUNTING SYSTEMS . . . . . 105

Sec. 525.0052. FEDERAL FUNDS: PLANNING AND MANAGEMENT; ANNUAL REPORT . . . . . 105

Sec. 525.0053. AUTHORITY TO TRANSFER CERTAIN APPROPRIATED AMOUNTS AMONG HEALTH AND HUMAN SERVICES AGENCIES . . . . . 108

Sec. 525.0054. EFFICIENCY AUDIT OF CERTAIN ASSISTANCE PROGRAMS . . . . . 109

Sec. 525.0055. GIFTS AND GRANTS . . . . . 112


SUBCHAPTER C. CONTRACTS


Sec. 525.0101. GENERAL CONTRACT AUTHORITY . . . . . 112

Sec. 525.0102. SUBROGATION AND THIRD-PARTY REIMBURSEMENT CONTRACTS . . . . . 112


SUBCHAPTER D. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES


Sec. 525.0151. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES GENERALLY . . . . . 114

Sec. 525.0152. PLANNING AND POLICY DIRECTION OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM . . . . . 116
Sec. 525.0153. ANNUAL BUSINESS SERVICES PLANS . . . . . 116
Sec. 525.0154. COORDINATED STRATEGIC PLAN AND BIENNIAL PLAN UPDATES FOR HEALTH AND HUMAN SERVICES . . . . . 117
Sec. 525.0155. COORDINATION WITH LOCAL GOVERNMENTAL ENTITIES . . . . . 119
Sec. 525.0156. SUBMISSION AND REVIEW OF AGENCY STRATEGIC PLANS AND BIENNIAL PLAN UPDATES . . . . . 120
Sec. 525.0157. STATEWIDE NEEDS APPRAISAL PROJECT . . . . . 120
Sec. 525.0158. STREAMLINING SERVICE DELIVERY . . . . . 121
Sec. 525.0159. HOTLINE AND CALL CENTER COORDINATION . . . . . 122
Sec. 525.0160. COMMUNITY-BASED SUPPORT SYSTEMS . . . . . 123
SUBCHAPTER E. HEALTH INFORMATION EXCHANGE SYSTEM
Sec. 525.0201. DEFINITIONS . . . . . 125
Sec. 525.0202. HEALTH INFORMATION EXCHANGE SYSTEM DEVELOPMENT . . . . . 127
Sec. 525.0203. HEALTH INFORMATION EXCHANGE SYSTEM IMPLEMENTATION IN STAGES . . . . . 130
Sec. 525.0204. HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ENCOUNTER DATA . . . . . 131
Sec. 525.0205. HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ELECTRONIC PRESCRIBING . . . . . 132
Sec. 525.0206. HEALTH INFORMATION EXCHANGE SYSTEM STAGE TWO: EXPANSION . . . . . 134
Sec. 525.0207. HEALTH INFORMATION EXCHANGE SYSTEM STAGE THREE: EXPANSION . . . . . 135
Sec. 525.0208. STRATEGIES TO ENCOURAGE HEALTH INFORMATION EXCHANGE SYSTEM USE . . . . . 136
Sec. 525.0209. RULES . . . . . 136

SUBCHAPTER F. INFORMATION RESOURCES AND TECHNOLOGY
Sec. 525.0251. INFORMATION RESOURCES STRATEGIC PLANNING AND MANAGEMENT . . . . . 136
Sec. 525.0252. TECHNOLOGICAL SOLUTIONS POLICIES . . . . . 138
Sec. 525.0253. TECHNOLOGY USE FOR ADULT PROTECTIVE SERVICES PROGRAM . . . . . 139
Sec. 525.0254. ELECTRONIC SIGNATURES . . . . . 140
Sec. 525.0255. HEALTH AND HUMAN SERVICES SYSTEM INTERNET WEBSITES . . . . . 141
Sec. 525.0256. AUTOMATION STANDARDS FOR DATA SHARING . . . . 142
Sec. 525.0257. ELECTRONIC EXCHANGE OF HEALTH INFORMATION; BIENNIAL REPORT . . . . . 143
SUBCHAPTER G. STUDIES, REPORTS, AND PUBLICATIONS
Sec. 525.0301. BIENNIAL REFERENCE GUIDE . . . . . 144
Sec. 525.0302. CONSOLIDATION OF REPORTS . . . . . 145
Sec. 525.0303. ANNUAL REPORT ON SAFEGUARDING PROTECTED HEALTH INFORMATION . . . . . 145

## CHAPTER 525. GENERAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

### SUBCHAPTER A. HEALTH AND HUMAN SERVICES ADMINISTRATION GENERALLY

Revised Law

Sec. 525.0001. POWERS AND DUTIES RELATING TO HEALTH AND HUMAN SERVICES ADMINISTRATION. The commission and the executive commissioner have all the powers and duties necessary to administer Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed March 31, 2025. (Gov. Code, Sec. 531.041.)

Source Law

> Sec. 531.041. GENERAL POWERS AND DUTIES. The executive commissioner and the commission have all the powers and duties necessary to administer this chapter.

Revised Law

Sec. 525.0002. LOCATION OF AND CONSOLIDATION OF CERTAIN SERVICES AMONG HEALTH AND HUMAN SERVICES AGENCIES. (a) The commission may require a health and human services agency, under

the commission's direction, to:

(1) ensure that the agency's location is accessible to:

(A) employees with disabilities; and

(B) agency clients with disabilities; and

(2) consolidate agency support services, including clerical, administrative, and information resources support services, with support services provided to or by another health and human services agency.

(b) The executive commissioner may require a health and human services agency, under the executive commissioner's direction, to locate all or a portion of the agency's employees and programs:

(1) in the same building as another health and human services agency; or

(2) at a location near or adjacent to another health and human services agency's location. (Gov. Code, Sec. 531.0246.)

Source Law

> Sec. 531.0246. REGIONAL MANAGEMENT OF HEALTH AND HUMAN SERVICES AGENCIES. (a) The commission may require a health and human services agency, under the direction of the commission, to:
>
> (1) ensure that the agency's location is accessible to employees with disabilities and agency clients with disabilities; and
>
> (2) consolidate agency support services, including clerical and administrative support services and information resources support services, with support services provided to or by another health and human services agency.
>
> (b) The executive commissioner may require a health and human services agency, under the direction of the executive commissioner, to locate all or a portion of the agency's employees and programs in the same building as another health and human services agency or at a location near or adjacent to the location of another health and human services agency.

Revised Law

Sec. 525.0003. CONSOLIDATED INTERNAL AUDIT PROGRAM. (a) Notwithstanding Section 2102.005, the commission shall operate the internal audit program required under Chapter 2102 for the commission and each health and human services agency as a consolidated internal audit program.

(b) For purposes of this section, a reference in Chapter 2102 to the administrator of a state agency with respect to a health and human services agency means the executive commissioner. (Gov. Code, Sec. 531.00552.)

Source Law

> Sec. 531.00552. CONSOLIDATED INTERNAL AUDIT PROGRAM. (a) Notwithstanding Section 2102.005, the commission shall operate the internal audit program required under Chapter 2102 for the commission and each health and human services agency as a consolidated internal audit program.
>
> (b) For purposes of this section, a reference in Chapter 2102 to the administrator of a state agency with respect to a health and human services agency means the executive commissioner.

Revised Law

Sec. 525.0004. INTERAGENCY DISPUTE ARBITRATION. The executive commissioner shall arbitrate and render the final decision on interagency disputes. (Gov. Code, Sec. 531.035.)

Source Law

> Sec. 531.035. DISPUTE ARBITRATION. The executive commissioner shall arbitrate and render the final decision on interagency disputes.

SUBCHAPTER B. ACCOUNTING AND FISCAL PROVISIONS

Revised Law

Sec. 525.0051. MANAGEMENT INFORMATION AND COST ACCOUNTING SYSTEMS. The executive commissioner shall establish a management information system and a cost accounting system for all health and human services that is compatible with and meets the requirements of the uniform statewide accounting project. (Gov. Code, Sec. 531.031.)

Source Law

> Sec. 531.031. MANAGEMENT INFORMATION AND COST ACCOUNTING SYSTEM. The executive commissioner shall establish a management information system and a cost accounting system for all health and human services that is compatible with and meets the requirements of the uniform statewide accounting project.

Revised Law

Sec. 525.0052. FEDERAL FUNDS: PLANNING AND MANAGEMENT; ANNUAL REPORT. (a) The commission, subject to the General Appropriations Act, is responsible for planning for and managing

the use of federal funds in a manner that maximizes the federal funding available to this state while promoting the delivery of services.

(b) The executive commissioner shall:

(1) establish a federal money management system to coordinate and monitor the use of federal money health and human services agencies receive to ensure that the money is spent in the most efficient manner;

(2) establish priorities for health and human services agencies' use of federal money in coordination with the coordinated strategic plan the executive commissioner develops under Section 525.0154;

(3) coordinate and monitor the use of federal money for health and human services to ensure that the money is spent in the most cost-effective manner throughout the health and human services system;

(4) review and approve all federal funding plans for health and human services in this state;

(5) estimate available federal money, including earned federal money, and monitor unspent money;

(6) ensure that the state meets federal requirements relating to receipt of federal money for health and human services, including requirements relating to state matching money and maintenance of effort;

(7) transfer appropriated amounts as described by Section 525.0053; and

(8) ensure that each governmental entity the executive commissioner identifies under Section 525.0155 has access to complete and timely information about all sources of federal money for health and human services programs and that technical assistance is available to governmental entities seeking grants of federal money to provide health and human services.

(c) The commission shall prepare an annual report regarding the results of implementing this section. The report must identify

strategies to:

(1) maximize the receipt and use of federal funds; and

(2) improve federal funds management.

(d) Not later than December 15 of each year, the commission shall file the report the commission prepares under Subsection (c) with the governor, the lieutenant governor, and the speaker of the house of representatives. (Gov. Code, Sec. 531.028.)

Source Law

Sec. 531.028. MONITORING AND EFFECTIVE MANAGEMENT OF FUNDS. (a) The commission, within the limits established by and subject to the General Appropriations Act, shall be responsible for planning for, and managing the use of, all federal funds in a manner that maximizes the federal funding available to the state while promoting the delivery of services.

(b) The executive commissioner shall establish a federal money management system to coordinate and monitor the use of federal money that is received by health and human services agencies to ensure that the money is spent in the most efficient manner and shall:

(1) establish priorities for use of federal money by all health and human services agencies, in coordination with the coordinated strategic plan established under Section 531.022;

(2) coordinate and monitor the use of federal money for health and human services to ensure that the money is spent in the most cost-effective manner throughout the health and human services system;

(3) review and approve all federal funding plans for health and human services in this state;

(4) estimate available federal money, including earned federal money, and monitor unspent money;

(5) ensure that the state meets federal requirements relating to receipt of federal money for health and human services, including requirements relating to state matching money and maintenance of effort;

(6) transfer appropriated amounts as described by Section 531.0271; and

(7) ensure that each governmental entity identified under Section 531.022(e) has access to complete and timely information about all sources of federal money for health and human services programs and that technical assistance is available to governmental entities seeking grants of federal money to provide health and human services.

(c) The commission shall prepare an annual report with respect to the results of the implementation of this section. The report must identify strategies to maximize the receipt and use of federal funds and to improve federal funds management. The commission shall file the report with the governor, the lieutenant governor, and the speaker of the house of representatives not later than December 15 of each year.

Revisor's Note

Section 531.028(a), Government Code, provides that the Health and Human Services Commission is responsible for planning for and managing the use of federal money "within the limits established by and subject to the General Appropriations Act." The revised law omits "within the limits established by" as redundant because, in this context, "within the limits established by" is included in the meaning of "subject to."

Revised Law

Sec. 525.0053. AUTHORITY TO TRANSFER CERTAIN APPROPRIATED AMOUNTS AMONG HEALTH AND HUMAN SERVICES AGENCIES. The commission may, subject to the General Appropriations Act, transfer amounts appropriated to health and human services agencies among the agencies to:

(1) enhance the receipt of federal money under the federal money management system the executive commissioner establishes under Section 525.0052;

(2) achieve efficiencies in the agencies' administrative support functions; and

(3) perform the functions assigned to the executive commissioner under:

(A) Subchapter A, Chapter 524; and

(B) Sections 524.0101, 524.0151, 524.0202, and 525.0254. (Gov. Code, Sec. 531.0271.)

Source Law

Sec. 531.0271. HEALTH AND HUMAN SERVICES AGENCIES OPERATING BUDGETS. The commission may, within the limits established by and subject to the General Appropriations Act, transfer amounts appropriated to health and human services agencies among the agencies to:

(1) enhance the receipt of federal money under the federal money management system established under Section 531.028;

(2) achieve efficiencies in the administrative support functions of the agencies; and

(3) perform the functions assigned to the executive commissioner under Section 531.0055.

Revisor's Note

(1) Section 531.0271, Government Code, authorizes the Health and Human Services Commission to transfer certain appropriated amounts among health and human services agencies "within the limits established by and subject to the General Appropriations Act." The revised law omits "within the limits established by" for the reason stated in the revisor's note to Section 525.0052 of this chapter.

(2) Section 531.0271, Government Code, authorizes the Health and Human Services Commission to transfer certain appropriated amounts among health and human services agencies to perform the executive commissioner's functions under Section 531.0055, Government Code. The substantive provisions of Section 531.0055 are revised in this subtitle as Subchapter A, Chapter 524, and Sections 524.0101(a), 524.0151(a)(2) and (b), 524.0202, and 525.0254. The revised law is drafted accordingly.

Revised Law

Sec. 525.0054. EFFICIENCY AUDIT OF CERTAIN ASSISTANCE PROGRAMS. (a) For purposes of this section, "efficiency audit" means an investigation of the implementation and administration of the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code, and the state temporary assistance and support services program operated under Chapter 34, Human Resources Code, to examine fiscal management, the efficiency of the use of resources, and the effectiveness of state efforts in achieving the goals of the Temporary Assistance for Needy Families program described under 42 U.S.C. Section 601(a).

(b) In 2022 and every sixth year after that year, an external auditor selected under Subsection (c) shall conduct an efficiency audit. The commission shall pay the costs associated with the audit using existing resources.

(c) The state auditor shall:

(1) not later than March 1 of the year in which an efficiency audit is required under this section, select an external auditor to conduct the audit; and

(2) ensure that the external auditor conducts the audit in accordance with this section.

(d) The external auditor shall be independent and not subject to direction from:

(1) the commission; or

(2) any other state agency that:

(A) is subject to evaluation by the auditor for purposes of this section; or

(B) receives or spends money under the programs described by Subsection (a).

(e) The external auditor shall complete the efficiency audit not later than the 90th day after the date the state auditor selects the external auditor.

(f) The Legislative Budget Board shall establish the scope of the efficiency audit and determine the areas of investigation for the audit, including:

(1) reviewing the resources dedicated to a program described by Subsection (a) to determine whether those resources:

(A) are used effectively and efficiently to achieve desired outcomes for individuals receiving benefits under the program; and

(B) are not used for purposes other than the intended goals of the program;

(2) identifying cost savings or reallocations of resources; and

(3) identifying opportunities to improve services through consolidation of essential functions, outsourcing, and elimination of duplicative efforts.

(g) Not later than November 1 of the year an efficiency audit is conducted, the external auditor shall prepare and submit a

report of the audit and recommendations for efficiency improvements to:

(1) the governor;

(2) the Legislative Budget Board;

(3) the state auditor;

(4) the executive commissioner; and

(5) the chairs of the House Human Services Committee and the Senate Health and Human Services Committee.

(h) The executive commissioner and the state auditor shall publish the report, recommendations, and full efficiency audit on the commission's and the state auditor's Internet websites. (Gov. Code, Sec. 531.005522.)

Source Law

Sec. 531.005522. EFFICIENCY AUDIT. (a) For purposes of this section, "efficiency audit" means an investigation of the implementation and administration of the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code, and the state temporary assistance and support services program operated under Chapter 34, Human Resources Code, to examine fiscal management, efficiency of the use of resources, and the effectiveness of state efforts in achieving the goals of the Temporary Assistance for Needy Families program described under 42 U.S.C. Section 601(a).

(b) In 2022 and every sixth year after that year, an external auditor selected under Subsection (e) shall conduct an efficiency audit.

(c) The commission shall pay the costs associated with an efficiency audit required under this section using existing resources.

(d) The state auditor shall ensure that the external auditor conducts the efficiency audit in accordance with the requirements of this section.

(e) Not later than March 1 of the year in which an efficiency audit is required under this section, the state auditor shall select an external auditor to conduct the efficiency audit.

(f) The external auditor shall be independent and not subject to direction from:

(1) the commission; or

(2) any other state agency subject to evaluation by the auditor for purposes of this section or that receives or spends money under the programs described by Subsection (a).

(g) The external auditor shall complete the audit not later than the 90th day after the date the auditor is selected.

(h) The Legislative Budget Board shall establish the scope of the efficiency audit and determine the areas of investigation for the audit, including:

(1) reviewing the resources dedicated to a program described by Subsection (a) to determine

whether those resources:

(A) are being used effectively and efficiently to achieve desired outcomes for individuals receiving benefits under a program; and

(B) are not being used for purposes other than the intended goals of the applicable program;

(2) identifying cost savings or reallocations of resources; and

(3) identifying opportunities for improving services through consolidation of essential functions, outsourcing, and elimination of duplicative efforts.

(i) Not later than November 1 of the year an efficiency audit is conducted, the external auditor shall prepare and submit a report of the audit and recommendations for efficiency improvements to the governor, the Legislative Budget Board, the state auditor, the executive commissioner, and the chairs of the House Human Services Committee and the Senate Health and Human Services Committee. The executive commissioner and the state auditor shall publish the report, recommendations, and full audit on the commission's and the state auditor's Internet websites.

Revised Law

Sec. 525.0055. GIFTS AND GRANTS. The commission may accept a gift or grant from a public or private source to perform any of the commission's powers or duties. (Gov. Code, Sec. 531.038.)

Source Law

Sec. 531.038. GIFTS AND GRANTS. The commission may accept a gift or grant from a public or private source to perform any of the commission's powers or duties.

SUBCHAPTER C. CONTRACTS

Revised Law

Sec. 525.0101. GENERAL CONTRACT AUTHORITY. The commission may enter into contracts as necessary to perform any of the commission's powers or duties. (Gov. Code, Sec. 531.039.)

Source Law

Sec. 531.039. CONTRACTS. The commission may enter into contracts as necessary to perform any of the commission's powers or duties.

Revised Law

Sec. 525.0102. SUBROGATION AND THIRD-PARTY REIMBURSEMENT CONTRACTS. (a) Except as provided by Subsection (d), the commission shall enter into a contract under which the contractor is authorized on behalf of the commission or a health and human services agency to recover money under a subrogation or third-party

reimbursement right the commission or agency holds that arises from payment of medical expenses. The contract must provide that:

(1) the commission or agency, as appropriate, shall compensate the contractor based on a percentage of the amount of money the contractor recovers for the commission or agency; and

(2) the contractor may represent the commission or agency in a court proceeding to recover money under a subrogation or third-party reimbursement right if:

(A) the attorney required by other law to represent the commission or agency in court approves; and

(B) the representation is cost-effective and specifically authorized by the commission.

(b) The commission shall develop a process to:

(1) identify claims for the recovery of money under a subrogation or third-party reimbursement right described by this section; and

(2) refer the identified claims to a contractor authorized under this section.

(c) A health and human services agency shall cooperate with a contractor authorized under this section on a claim the agency refers to the contractor for recovery.

(d) If the commission cannot identify a contractor who is willing to contract with the commission under this section on reasonable terms, the commission:

(1) is not required to enter into a contract under Subsection (a); and

(2) shall develop and implement alternative policies to ensure the recovery of money under a subrogation or third-party reimbursement right.

(e) The commission may allow a state agency other than a health and human services agency to be a party to the contract required by Subsection (a). If the commission allows an additional state agency to be a party to the contract, the commission shall modify the contract as necessary to reflect the services the

contractor is to provide to that agency. (Gov. Code, Sec. 531.0391.)

Source Law

Sec. 531.0391. SUBROGATION AND THIRD-PARTY REIMBURSEMENT COLLECTION CONTRACT. (a) The commission shall enter into a contract under which the contractor is authorized on behalf of the commission or a health and human services agency to recover money under a subrogation or third-party reimbursement right held by the commission or a health and human services agency arising from payment of medical expenses. The contract must provide that:

(1) the commission or agency, as appropriate, shall compensate the contractor based on a percentage of the amount of money recovered by the contractor for the commission or agency; and

(2) with the approval of the attorney required by other law to represent the commission or agency in court, the contractor may represent the commission or agency in a court proceeding to recover money under a subrogation or third-party reimbursement right if the representation is cost-effective and specifically authorized by the commission.

(b) The commission shall develop a process for identifying claims for the recovery of money under a subrogation or third-party reimbursement right described by this section and referring the claims to the contractor. A health and human services agency shall cooperate with the contractor on a claim of the agency referred to the contractor for collection.

(c) The commission is not required to enter into a contract under Subsection (a) if the commission cannot identify a contractor who is willing to contract with the commission on reasonable terms. If the commission cannot identify such a contractor, the commission shall develop and implement alternative policies to ensure the collection of money under a subrogation or third-party reimbursement right.

(d) The commission may allow a state agency other than a health and human services agency to be a party to the contract required under Subsection (a). In that case, the commission shall modify the contract as necessary to reflect the services to be provided by the contractor to the additional state agency.

Revisor's Note

Section 531.0391, Government Code, refers to both the collection of money and the recovery of money under a subrogation or third-party reimbursement right. The revised law substitutes "recovery" for "collection" for consistency of terminology, and because in context the terms are synonymous.

SUBCHAPTER D. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES

Revised Law

Sec. 525.0151. PLANNING AND DELIVERY OF HEALTH AND HUMAN

SERVICES GENERALLY. The executive commissioner shall:

(1) facilitate and enforce coordinated planning and delivery of health and human services, including:

(A) compliance with the coordinated strategic plan;

(B) colocation of services;

(C) integrated intake; and

(D) coordinated referral and case management;

(2) establish and enforce uniform regional boundaries for all health and human services agencies;

(3) carry out statewide health and human services needs surveys and forecasting;

(4) perform independent special-outcome evaluations of health and human services programs and activities; and

(5) on request of a governmental entity the executive commissioner identifies under Section 525.0155, assist the entity in implementing a coordinated plan that:

(A) may include colocation of services, integrated intake, and coordinated referral and case management; and

(B) is tailored to the entity's needs and priorities. (Gov. Code, Sec. 531.024(a) (part).)

Source Law

Sec. 531.024. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES; DATA SHARING. (a) The executive commissioner shall:

(1) facilitate and enforce coordinated planning and delivery of health and human services, including:

(A) compliance with the coordinated strategic plan;

(B) co-location of services;

(C) integrated intake; and

(D) coordinated referral and case management;

. . .

(3) establish and enforce uniform regional boundaries for all health and human services agencies;

(4) carry out statewide health and human services needs surveys and forecasting;

(5) perform independent special-outcome evaluations of health and human services programs and activities;

(6) at the request of a governmental

entity identified under Section 531.022(e), assist that entity in implementing a coordinated plan that may include co-location of services, integrated intake, and coordinated referral and case management and is tailored to the needs and priorities of that entity; and

. . .

Revised Law

Sec. 525.0152. PLANNING AND POLICY DIRECTION OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM. (a) In this section, "financial assistance program" means the financial assistance program operated under Chapter 31, Human Resources Code.

(b) The commission shall:

(1) plan and direct the financial assistance program, including the procurement, management, and monitoring of contracts necessary to implement the program; and

(2) establish requirements for and define the scope of the ongoing evaluation of the financial assistance program.

(c) The executive commissioner shall adopt rules and standards governing the financial assistance program. (Gov. Code, Sec. 531.0224; New.)

Source Law

Sec. 531.0224. PLANNING AND POLICY DIRECTION OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM. (a) The commission shall:

(1) plan and direct the financial assistance program under Chapter 31, Human Resources Code, including the procurement, management, and monitoring of contracts necessary to implement the program; and

(2) establish requirements for and define the scope of the ongoing evaluation of the financial assistance program under Chapter 31, Human Resources Code.

(b) The executive commissioner shall adopt rules and standards governing the financial assistance program under Chapter 31, Human Resources Code.

Revisor's Note

The definition of "financial assistance program" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 525.0153. ANNUAL BUSINESS SERVICES PLANS. The

commission shall develop and implement an annual business services plan for each health and human services region that:

(1) establishes performance objectives for all health and human services agencies providing services in the region; and

(2) measures agency effectiveness and efficiency in achieving those objectives. (Gov. Code, Sec. 531.0247.)

Source Law

> Sec. 531.0247. ANNUAL BUSINESS PLAN. The commission shall develop and implement an annual business services plan for each health and human services region that establishes performance objectives for all health and human services agencies providing services in the region and measures agency effectiveness and efficiency in achieving those objectives.

Revised Law

Sec. 525.0154. COORDINATED STRATEGIC PLAN AND BIENNIAL PLAN UPDATES FOR HEALTH AND HUMAN SERVICES. (a) The executive commissioner shall:

(1) develop a coordinated, six-year strategic plan for health and human services in this state; and

(2) submit a biennial update of the plan to the governor, the lieutenant governor, and the speaker of the house of representatives not later than October 1 of each even-numbered year.

(b) The coordinated strategic plan must include the following goals:

(1) developing a comprehensive, statewide approach to the planning of health and human services;

(2) creating a continuum of care for families and individuals in need of health and human services;

(3) integrating health and human services to provide for the efficient and timely delivery of those services;

(4) maximizing existing resources through effective funds management and the sharing of administrative functions;

(5) effectively using management information systems to continually improve service delivery;

(6) providing systemwide accountability through effective monitoring mechanisms;

(7) promoting teamwork among the health and human services agencies and providing incentives for creativity;

(8) fostering innovation at the local level; and

(9) encouraging full participation of fathers in programs and services relating to children.

(c) In developing the coordinated strategic plan and plan updates under this section, the executive commissioner shall consider:

(1) existing strategic plans of health and human services agencies;

(2) health and human services priorities and plans governmental entities submit under Section 525.0155;

(3) facilitation of pending reorganizations or consolidations of health and human services agencies and programs;

(4) public comment, including comment documented through public hearings conducted under Section 523.0252; and

(5) budgetary issues, including projected agency needs and projected availability of funds. (Gov. Code, Secs. 531.022(a), (b), (c), (d).)

Source Law

Sec. 531.022. COORDINATED STRATEGIC PLAN FOR HEALTH AND HUMAN SERVICES. (a) The executive commissioner shall develop a coordinated, six-year strategic plan for health and human services in this state and shall update the plan biennially.

(b) The executive commissioner shall submit each biennial update of the plan to the governor, the lieutenant governor, and the speaker of the house of representatives not later than October 1 of each even-numbered year.

(c) The plan must include the following goals:

(1) the development of a comprehensive, statewide approach to the planning of health and human services;

(2) the creation of a continuum of care for families and individuals in need of health and human services;

(3) the integration of health and human services to provide for the efficient and timely delivery of those services;

(4) the maximization of existing resources through effective funds management and the sharing of administrative functions;

(5) the effective use of management information systems to continually improve service delivery;

(6) the provision of systemwide accountability through effective monitoring mechanisms;

(7) the promotion of teamwork among the health and human services agencies and the provision of incentives for creativity;

(8) the fostering of innovation at the local level; and

(9) the encouragement of full participation of fathers in programs and services relating to children.

(d) In developing a plan and plan updates under this section, the executive commissioner shall consider:

(1) existing strategic plans of health and human services agencies;

(2) health and human services priorities and plans submitted by governmental entities under Subsection (e);

(3) facilitation of pending reorganizations or consolidations of health and human services agencies and programs;

(4) public comment, including comment documented through public hearings conducted under Section 531.036; and

(5) budgetary issues, including projected agency needs and projected availability of funds.

Revised Law

Sec. 525.0155. COORDINATION WITH LOCAL GOVERNMENTAL ENTITIES. The executive commissioner shall:

(1) identify the governmental entities that coordinate the delivery of health and human services in regions, counties, and municipalities; and

(2) request that each identified governmental entity:

(A) identify the health and human services priorities in the entity's jurisdiction and the most effective ways to deliver and coordinate services in that jurisdiction;

(B) develop a coordinated plan for delivering health and human services in the jurisdiction, including transition services that prepare special education students for adulthood; and

(C) make available to the commission the information requested under Paragraphs (A) and (B). (Gov. Code, Sec. 531.022(e).)

Source Law

(e) The executive commissioner shall identify the governmental entities that coordinate the delivery of health and human services in regions, counties, and

municipalities and request that each entity:

(1) identify the health and human services priorities in the entity's jurisdiction and the most effective ways to deliver and coordinate services in that jurisdiction;

(2) develop a coordinated plan for the delivery of health and human services in the jurisdiction, including transition services that prepare special education students for adulthood; and

(3) make the information requested under Subdivisions (1) and (2) available to the commission.

Revised Law

Sec. 525.0156. SUBMISSION AND REVIEW OF AGENCY STRATEGIC PLANS AND BIENNIAL PLAN UPDATES. (a) Each health and human services agency shall submit to the commission a strategic plan and biennial updates of the plan on a date determined by commission rule.

(b) The commission shall:

(1) review and comment on each strategic plan and biennial update a health and human services agency submits to the commission under this section; and

(2) not later than January 1 of each even-numbered year, begin formal discussions with each health and human services agency regarding that agency's strategic plan or biennial update, as appropriate. (Gov. Code, Sec. 531.023.)

Source Law

Sec. 531.023. SUBMISSION OF PLANS AND UPDATES BY AGENCIES. (a) All health and human services agencies shall submit to the commission strategic plans and biennial updates on a date to be determined by commission rule. The commission shall review and comment on the strategic plans and biennial updates.

(b) Not later than January 1 of each even-numbered year, the commission shall begin formal discussions with each health and human services agency regarding that agency's strategic plan or biennial update.

Revised Law

Sec. 525.0157. STATEWIDE NEEDS APPRAISAL PROJECT. (a) The commission may implement the Statewide Needs Appraisal Project to obtain county-specific demographic data concerning health and human services needs in this state.

(b) Any collected data must be made available for use in planning and budgeting for health and human services programs by

state agencies.

(c) The commission shall coordinate the commission's activities with the appropriate health and human services agencies. (Gov. Code, Sec. 531.025.)

Source Law

> Sec. 531.025. STATEWIDE NEEDS APPRAISAL PROJECT. (a) The commission may implement the Statewide Needs Appraisal Project to obtain county-specific demographic data concerning health and human services needs in this state. Any collected data shall be made available for use in planning and budgeting for health and human services programs by state agencies.
>
> (b) The commission shall coordinate its activities with the appropriate health and human services agencies.

Revised Law

Sec. 525.0158. STREAMLINING SERVICE DELIVERY. To integrate and streamline service delivery and facilitate access to services, the executive commissioner may:

(1) request a health and human services agency to take a specific action; and

(2) recommend the manner for accomplishing the streamlining, including requesting each agency to:

(A) simplify or automate agency procedures;

(B) coordinate service planning and management tasks between and among health and human services agencies;

(C) reallocate staff resources;

(D) waive existing rules; or

(E) take other necessary actions. (Gov. Code, Sec. 531.0241.)

Source Law

> Sec. 531.0241. STREAMLINING DELIVERY OF SERVICES. To integrate and streamline service delivery and facilitate access to services, the executive commissioner may request a health and human services agency to take a specific action and may recommend the manner in which the streamlining is to be accomplished, including requesting each health and human services agency to:
>
> (1) simplify agency procedures;
>
> (2) automate agency procedures;
>
> (3) coordinate service planning and management tasks between and among health and human services agencies;

(4) reallocate staff resources;
(5) waive existing rules; or
(6) take other necessary actions.

Revised Law

Sec. 525.0159. HOTLINE AND CALL CENTER COORDINATION. (a) The commission shall establish a process to ensure all health and human services system hotlines and call centers are necessary and appropriate. Under the process, the commission shall:

(1) develop criteria for use in assessing whether a hotline or call center serves an ongoing purpose;

(2) develop and maintain an inventory of all system hotlines and call centers;

(3) use the inventory and assessment criteria the commission develops under this subsection to periodically consolidate hotlines and call centers along appropriate functional lines;

(4) develop an approval process designed to ensure that a newly established hotline or call center, including the telephone system and contract terms for the hotline or call center, meets policies and standards the commission establishes; and

(5) develop policies and standards for hotlines and call centers that:

(A) include quality and quantity performance measures and benchmarks; and

(B) may include policies and standards for:

(i) client satisfaction with call resolution;

(ii) accuracy of information provided;

(iii) the percentage of received calls that are answered;

(iv) the amount of time a caller spends on hold; and

(v) call abandonment rates.

(b) In consolidating hotlines and call centers under Subsection (a)(3), the commission shall seek to maximize the use

and effectiveness of the commission's 2-1-1 telephone number.

(c) In developing policies and standards under Subsection (a)(5), the commission may allow varied performance measures and benchmarks for a hotline or call center based on factors affecting the capacity of the hotline or call center, including factors such as staffing levels and funding. (Gov. Code, Sec. 531.0192.)

Source Law

> Sec. 531.0192. HEALTH AND HUMAN SERVICES SYSTEM HOTLINE AND CALL CENTER COORDINATION. (a) The commission shall establish a process to ensure all health and human services system hotlines and call centers are necessary and appropriate. Under the process, the commission shall:
>
> (1) develop criteria for use in assessing whether a hotline or call center serves an ongoing purpose;
>
> (2) develop and maintain an inventory of all system hotlines and call centers;
>
> (3) use the inventory and assessment criteria developed under this subsection to periodically consolidate hotlines and call centers along appropriate functional lines;
>
> (4) develop an approval process designed to ensure that a newly established hotline or call center, including the telephone system and contract terms for the hotline or call center, meets policies and standards established by the commission; and
>
> (5) develop policies and standards for hotlines and call centers that include both quality and quantity performance measures and benchmarks and may include:
>
> (A) client satisfaction with call resolution;
>
> (B) accuracy of information provided;
>
> (C) the percentage of received calls that are answered;
>
> (D) the amount of time a caller spends on hold; and
>
> (E) call abandonment rates.
>
> (a-1) In developing policies and standards under Subsection (a)(5), the commission may allow varied performance measures and benchmarks for a hotline or call center based on factors affecting the capacity of the hotline or call center, including factors such as staffing levels and funding.
>
> (b) In consolidating hotlines and call centers under Subsection (a)(3), the commission shall seek to maximize the use and effectiveness of the commission's 2-1-1 telephone number.

Revised Law

Sec. 525.0160. COMMUNITY-BASED SUPPORT SYSTEMS. (a) Subject to Sections 524.0001(c) and (d) and 524.0202(a)(1), the commission shall assist communities in this state in developing comprehensive, community-based support systems for health and

human services. At a community's request, the commission shall provide to the community resources and assistance to enable the community to:

(1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers resulting from the policies and procedures of state health and human services agencies; and

(2) develop a system of blended funds to allow the community to customize services to fit individual community needs.

(b) At the commission's request, a health and human services agency shall provide to a community resources and assistance as necessary to perform the commission's duties under Subsection (a).

(c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the proposal to the commission for review and approval. The commission shall review the proposal to ensure that the proposed initiative:

(1) is consistent with other similar programs offered in communities; and

(2) does not duplicate other services provided in the community.

(d) In implementing this section, the commission shall consider models used in other service delivery systems, including the mental health and intellectual disability service delivery systems. (Gov. Code, Sec. 531.0248.)

Source Law

Sec. 531.0248. COMMUNITY-BASED SUPPORT SYSTEMS. (a) Subject to Section 531.0055(d), the commission shall assist communities in this state in developing comprehensive, community-based support systems for health and human services. At the request of a community, the commission shall provide resources and assistance to the community to enable the community to:

(1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers that result from the policies and procedures of state health and human services agencies; and

(2) develop a system of blended funds to allow the community to customize services to fit individual community needs.

(b) At the request of the commission, a health

and human services agency shall provide resources and assistance to a community as necessary to perform the commission's duties under Subsection (a).

(c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval. The commission shall review the initiative to ensure that the initiative is consistent with other similar programs offered in communities and does not duplicate other services provided in the community.

(d) In implementing this section, the commission shall consider models used in other service delivery systems, including the mental health and intellectual disability service delivery systems.

Revisor's Note

Section 531.0248(a), Government Code, requires the Health and Human Services Commission to assist communities in developing community-based support systems subject to Section 531.0055(d), Government Code. The relevant provisions of Section 531.0055(d) are revised in this subtitle as Sections 524.0001(c) and (d) and 524.0202(a)(1), and the revised law is drafted accordingly.

SUBCHAPTER E. HEALTH INFORMATION EXCHANGE SYSTEM

Revised Law

Sec. 525.0201. DEFINITIONS. In this subchapter:

(1) "Electronic health record" means an electronic record of an individual's aggregated health-related information that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized health care providers across two or more health care organizations.

(2) "Electronic medical record" means an electronic record of an individual's health-related information that can be created, gathered, managed, and consulted by authorized clinicians and staff within a single health care organization.

(3) "Health information exchange system" means an electronic health information exchange system created under this subchapter that moves health-related information among entities according to nationally recognized standards. (Gov. Code, Secs. 531.901(1), (2), (3).)

Source Law

Sec. 531.901. DEFINITIONS. In this subchapter:

(1) "Electronic health record" means an electronic record of aggregated health-related information concerning a person that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized health care providers across two or more health care organizations.

(2) "Electronic medical record" means an electronic record of health-related information concerning a person that can be created, gathered, managed, and consulted by authorized clinicians and staff within a single health care organization.

(3) "Health information exchange system" means a health information exchange system created under this subchapter that moves health-related information among entities according to nationally recognized standards.

Revisor's Note

(1) Sections 531.901(1) and (2), Government Code, refer to health-related information concerning a "person." Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), which applies to this code.

(2) Section 531.901(4), Government Code, defines "[l]ocal or regional health information exchange" for purposes of Subchapter V, Chapter 531, Government Code, the majority of which is revised as this subchapter. The revised law omits this definition as unnecessary because the term is not used elsewhere in Subchapter V, Chapter 531, or in the revised law in this subchapter. The omitted law reads:

> (4) "Local or regional health information exchange" means a health information exchange operating in this state that securely exchanges electronic health information, including information for patients receiving services under the child health plan program or Medicaid, among hospitals, clinics, physicians' offices, and other health care providers that are not owned by a single entity or

included in a single operational unit or network.

Revised Law

Sec. 525.0202. HEALTH INFORMATION EXCHANGE SYSTEM DEVELOPMENT. (a) The commission shall develop an electronic health information exchange system to improve the quality, safety, and efficiency of health care services provided under Medicaid and the child health plan program. In developing the system, the commission shall ensure that:

(1) the confidentiality of patients' health information is protected and patient privacy is maintained in accordance with federal and state law, including:

(A) Section 1902(a)(7), Social Security Act (42 U.S.C. Section 1396a(a)(7));

(B) the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(C) Chapter 552;

(D) Subchapter G, Chapter 241, Health and Safety Code;

(E) Section 12.003, Human Resources Code; and

(F) federal and state rules, including:

(i) 42 C.F.R. Part 431, Subpart F; and

(ii) 45 C.F.R. Part 164;

(2) appropriate information technology systems the commission and health and human services agencies use are interoperable;

(3) the system and external information technology systems are interoperable in receiving and exchanging appropriate electronic health information as necessary to enhance:

(A) the comprehensive nature of information contained in electronic health records; and

(B) health care provider efficiency by supporting integration of the information into the electronic health record health care providers use;

(4) the system and other health information systems

not described by Subdivision (3) and data warehousing initiatives are interoperable; and

(5) the system includes the elements described by Subsection (b).

(b) The health information exchange system must include the following elements:

(1) an authentication process that uses multiple forms of identity verification before allowing access to information systems and data;

(2) a formal process for establishing data-sharing agreements within the community of participating providers in accordance with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) and the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5);

(3) a method by which the commission may open or restrict access to the system during a declared state emergency;

(4) the capability of appropriately and securely sharing health information with state and federal emergency responders;

(5) compatibility with the Nationwide Health Information Network (NHIN) and other national health information technology initiatives coordinated by the Office of the National Coordinator for Health Information Technology;

(6) technology that allows for patient identification across multiple systems; and

(7) the capability of allowing a health care provider with technology that meets current national standards to access the system.

(c) The health information exchange system must be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of the Centers for Medicare and Medicaid Services and conform to other standards required under federal law. (Gov. Code, Secs. 531.903(a), (b), (d).)

Source Law

Sec. 531.903. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM. (a) The commission shall develop an electronic health information exchange system to improve the quality, safety, and efficiency of health care services provided under the child health plan program and Medicaid. In developing the system, the commission shall ensure that:

(1) the confidentiality of patients' health information is protected and the privacy of those patients is maintained in accordance with applicable federal and state law, including:

(A) Section 1902(a)(7), Social Security Act (42 U.S.C. Section 1396a(a)(7));

(B) the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(C) Chapter 552;

(D) Subchapter G, Chapter 241, Health and Safety Code;

(E) Section 12.003, Human Resources Code; and

(F) federal and state rules and regulations, including:

(i) 42 C.F.R. Part 431, Subpart F; and

(ii) 45 C.F.R. Part 164;

(2) appropriate information technology systems used by the commission and health and human services agencies are interoperable;

(3) the system and external information technology systems are interoperable in receiving and exchanging appropriate electronic health information as necessary to enhance:

(A) the comprehensive nature of the information contained in electronic health records; and

(B) health care provider efficiency by supporting integration of the information into the electronic health record used by health care providers;

(4) the system and other health information systems not described by Subdivision (3) and data warehousing initiatives are interoperable; and

(5) the system has the elements described by Subsection (b).

(b) The health information exchange system must include the following elements:

(1) an authentication process that uses multiple forms of identity verification before allowing access to information systems and data;

(2) a formal process for establishing data-sharing agreements within the community of participating providers in accordance with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) and the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5);

(3) a method by which the commission may open or restrict access to the system during a declared state emergency;

(4) the capability of appropriately and securely sharing health information with state and federal emergency responders;

(5) compatibility with the Nationwide Health Information Network (NHIN) and other national health information technology initiatives coordinated

by the Office of the National Coordinator for Health Information Technology;

(6) technology that allows for patient identification across multiple systems; and

(7) the capability of allowing a health care provider to access the system if the provider has technology that meets current national standards.

(d) The health information exchange system must be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations and conform to other standards required under federal law.

Revisor's Note

(1) Section 531.903(a)(1)(F), Government Code, refers to "federal and state rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005, Government Code (Code Construction Act), which applies to this code, a rule is defined to include a regulation.

(2) Section 531.903(d), Government Code, refers to the "Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations." The current name of the center sponsoring the quoted initiative is the "Centers for Medicare and Medicaid Services." The revised law is drafted accordingly.

Revised Law

Sec. 525.0203. HEALTH INFORMATION EXCHANGE SYSTEM IMPLEMENTATION IN STAGES. The commission shall implement the health information exchange system in stages as described by this subchapter, except that the commission may deviate from those stages if technological advances make a deviation advisable or more efficient. (Gov. Code, Sec. 531.903(c).)

Source Law

(c) The commission shall implement the health information exchange system in stages as described by this chapter, except that the commission may deviate from those stages if technological advances make a deviation advisable or more efficient.

Revisor's Note

Section 531.903(c), Government Code, refers to

the implementation of the health information exchange system in stages as described by "this chapter," meaning Chapter 531, Government Code. Chapter 531 is revised throughout Subtitle I, Title 4, Government Code. However, the relevant portions of Chapter 531 concerning the implementation of the health information exchange system in stages are revised in this subchapter, and the revised law is drafted accordingly.

Revised Law

Sec. 525.0204. HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ENCOUNTER DATA. In stage one of implementing the health information exchange system and for purposes of the implementation, the commission shall require each managed care organization with which the commission contracts under Chapter 540 or 540A for the provision of Medicaid managed care services or under Chapter 62, Health and Safety Code, for the provision of child health plan program services to submit to the commission complete and accurate encounter data not later than the 30th day after the last day of the month in which the managed care organization adjudicated the claim. (Gov. Code, Sec. 531.9051.)

Source Law

Sec. 531.9051. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ENCOUNTER DATA. In stage one of implementing the health information exchange system, the commission shall require for purposes of the implementation each managed care organization with which the commission contracts under Chapter 533 for the provision of Medicaid managed care services or Chapter 62, Health and Safety Code, for the provision of child health plan program services to submit to the commission complete and accurate encounter data not later than the 30th day after the last day of the month in which the managed care organization adjudicated the claim.

Revisor's Note

Section 531.9051, Government Code, refers to contracts between the Health and Human Services Commission and managed care organizations under Chapter 533, Government Code. The provisions of

Chapter 533 are revised in this subtitle as Chapters 540 and 540A. Throughout this chapter, the revised law is drafted accordingly.

Revised Law

Sec. 525.0205. HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ELECTRONIC PRESCRIBING. (a) In stage one of implementing the health information exchange system, the commission shall support and coordinate electronic prescribing tools health care providers and health care facilities use under Medicaid and the child health plan program.

(b) The commission shall collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that the electronic prescribing tools described by Subsection (a):

(1) are integrated with existing electronic prescribing systems otherwise in use in the public and private sectors; and

(2) to the extent feasible:

(A) provide current payer formulary information at the time a health care provider writes a prescription; and

(B) support the electronic transmission of a prescription.

(c) The commission may take any reasonable action to comply with this section, including establishing information exchanges with national electronic prescribing networks or providing health care providers with access to an Internet-based prescribing tool the commission develops.

(d) The commission shall apply for and actively pursue any waiver to the state Medicaid plan or the child health plan program from the Centers for Medicare and Medicaid Services or any other federal agency as necessary to remove an identified impediment to supporting and implementing electronic prescribing tools under this section, including the requirement for handwritten certification of certain drugs under 42 C.F.R. Section 447.512. If the commission, with assistance from the Legislative Budget Board,

determines that the implementation of an operational modification in accordance with a waiver the commission obtains as required by this subsection has resulted in a cost increase in Medicaid or the child health plan program, the commission shall take the necessary actions to reverse the operational modification. (Gov. Code, Sec. 531.906.)

Source Law

Sec. 531.906. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ELECTRONIC PRESCRIBING. (a) In stage one of implementing the health information exchange system, the commission shall support and coordinate electronic prescribing tools used by health care providers and health care facilities under the child health plan program and Medicaid.

(b) The commission shall consult and collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that the electronic prescribing tools described by Subsection (a):

(1) are integrated with existing electronic prescribing systems otherwise in use in the public and private sectors; and

(2) to the extent feasible:

(A) provide current payer formulary information at the time a health care provider writes a prescription; and

(B) support the electronic transmission of a prescription.

(c) The commission may take any reasonable action to comply with this section, including establishing information exchanges with national electronic prescribing networks or providing health care providers with access to an Internet-based prescribing tool developed by the commission.

(d) The commission shall apply for and actively pursue any waiver to the child health plan program or the state Medicaid plan from the federal Centers for Medicare and Medicaid Services or any other federal agency as necessary to remove an identified impediment to supporting and implementing electronic prescribing tools under this section, including the requirement for handwritten certification of certain drugs under 42 C.F.R. Section 447.512. If the commission, with assistance from the Legislative Budget Board, determines that the implementation of operational modifications in accordance with a waiver obtained as required by this subsection has resulted in cost increases in the child health plan program or Medicaid, the commission shall take the necessary actions to reverse the operational modifications.

Revisor's Note

Section 531.906(b), Government Code, requires the Health and Human Services Commission to "consult and collaborate with . . . physicians and other

stakeholders." The revised law omits "consult" as redundant because, in this context, "consult" is included in the meaning of "collaborate."

Revised Law

Sec. 525.0206. HEALTH INFORMATION EXCHANGE SYSTEM STAGE TWO: EXPANSION. (a) In stage two of implementing the health information exchange system and based on feedback provided by interested parties, the commission may expand the system by:

(1) providing an electronic health record for each child health plan program enrollee;

(2) including state laboratory results information in an electronic health record, including the results of newborn screenings and tests conducted under the Texas Health Steps program, based on the system developed for the health passport under Section 266.006, Family Code;

(3) improving electronic health record data-gathering capabilities to allow the record to include basic health and clinical information as the executive commissioner determines in addition to available claims information;

(4) using evidence-based technology tools to create a unique health profile to alert health care providers regarding the need for additional care, education, counseling, or health management activities for specific patients; and

(5) continuing to enhance the electronic health record created for each Medicaid recipient as technology becomes available and interoperability capabilities improve.

(b) In expanding the health information exchange system, the commission shall collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that electronic health records provided under this section support health information exchange with electronic medical records systems physicians use in the public and private sectors. (Gov. Code, Sec. 531.907.)

Source Law

Sec. 531.907. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE TWO: EXPANSION. (a) Based on feedback provided by interested parties, the commission in stage two of implementing the health information exchange system may expand the system by:

(1) providing an electronic health record for each child enrolled in the child health plan program;

(2) including state laboratory results information in an electronic health record, including the results of newborn screenings and tests conducted under the Texas Health Steps program, based on the system developed for the health passport under Section 266.006, Family Code;

(3) improving data-gathering capabilities for an electronic health record so that the record may include basic health and clinical information in addition to available claims information, as determined by the executive commissioner;

(4) using evidence-based technology tools to create a unique health profile to alert health care providers regarding the need for additional care, education, counseling, or health management activities for specific patients; and

(5) continuing to enhance the electronic health record created for each Medicaid recipient as technology becomes available and interoperability capabilities improve.

(b) In expanding the system, the commission shall consult and collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that electronic health records provided under this section support health information exchange with electronic medical records systems in use by physicians in the public and private sectors.

Revisor's Note

Section 531.907(b), Government Code, requires the Health and Human Services Commission to "consult and collaborate with . . . physicians and other stakeholders." The revised law omits "consult" for the reason stated in the revisor's note to Section 525.0205 of this chapter.

Revised Law

Sec. 525.0207. HEALTH INFORMATION EXCHANGE SYSTEM STAGE THREE: EXPANSION. In stage three of implementing the health information exchange system, the commission may expand the system by:

(1) developing evidence-based benchmarking tools for a health care provider to use in evaluating the provider's own performance on health care outcomes and overall quality of care as

compared to aggregated peer performance data; and

(2) expanding the system to include state agencies, additional health care providers, laboratories, diagnostic facilities, hospitals, and medical offices. (Gov. Code, Sec. 531.908.)

Source Law

> Sec. 531.908. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE THREE: EXPANSION. In stage three of implementing the health information exchange system, the commission may expand the system by:
>
> (1) developing evidence-based benchmarking tools that can be used by health care providers to evaluate their own performances on health care outcomes and overall quality of care as compared to aggregated performance data regarding peers; and
>
> (2) expanding the system to include state agencies, additional health care providers, laboratories, diagnostic facilities, hospitals, and medical offices.

Revised Law

Sec. 525.0208. STRATEGIES TO ENCOURAGE HEALTH INFORMATION EXCHANGE SYSTEM USE. The commission shall develop strategies to encourage health care providers to use the health information exchange system, including incentives, education, and outreach tools to increase usage. (Gov. Code, Sec. 531.909.)

Source Law

> Sec. 531.909. INCENTIVES. The commission shall develop strategies to encourage health care providers to use the health information exchange system, including incentives, education, and outreach tools to increase usage.

Revised Law

Sec. 525.0209. RULES. The executive commissioner may adopt rules to implement this subchapter. (Gov. Code, Sec. 531.911.)

Source Law

> Sec. 531.911. RULES. The executive commissioner may adopt rules to implement Sections 531.903 through 531.909.

SUBCHAPTER F. INFORMATION RESOURCES AND TECHNOLOGY

Revised Law

Sec. 525.0251. INFORMATION RESOURCES STRATEGIC PLANNING AND MANAGEMENT. (a) The commission is responsible for strategic planning for information resources at each health and human

services agency and shall direct the management of information resources at each health and human services agency.

(b) The commission shall:

(1) develop a coordinated strategic plan for information resources management that:

(A) covers a five-year period;

(B) defines objectives for information resources management at each health and human services agency;

(C) prioritizes information resources projects and implementation of new technology for all health and human services agencies;

(D) integrates planning and development of each information resources system a health and human services agency uses into a coordinated information resources management planning and development system the commission establishes;

(E) establishes standards for information resources system security and that promotes the capability of information resources systems operating with each other;

(F) achieves economies of scale and related benefits in purchasing for health and human services information resources systems; and

(G) is consistent with the state strategic plan for information resources developed under Chapter 2054;

(2) establish and ensure compliance with information resources management policies, procedures, and technical standards; and

(3) review and approve the information resources deployment review and biennial operating plan of each health and human services agency.

(c) A health and human services agency may not submit the agency's plans to the Department of Information Resources or the Legislative Budget Board under Subchapter E, Chapter 2054, until the commission approves the plans. (Gov. Code, Sec. 531.0273.)

Source Law

Sec. 531.0273. INFORMATION RESOURCES PLANNING AND MANAGEMENT. (a) The commission is responsible for strategic planning for information resources at each health and human services agency and shall direct the management of information resources at each health and human services agency. The commission shall:

(1) develop a coordinated strategic plan for information resources management that:

(A) covers a five-year period;

(B) defines objectives for information resources management at each health and human services agency;

(C) prioritizes information resources projects and implementation of new technology for all health and human services agencies;

(D) integrates planning and development of each information resources system used by a health and human services agency into a coordinated information resources management planning and development system established by the commission;

(E) establishes standards for information resources system security and that promotes the ability of information resources systems to operate with each other;

(F) achieves economies of scale and related benefits in purchasing for health and human services information resources systems; and

(G) is consistent with the state strategic plan for information resources developed under Chapter 2054;

(2) establish information resources management policies, procedures, and technical standards and ensure compliance with those policies, procedures, and standards; and

(3) review and approve the information resources deployment review and biennial operating plan of each health and human services agency.

(c) A health and human services agency may not submit its plans to the Department of Information Resources or the Legislative Budget Board under Subchapter E, Chapter 2054, until those plans are approved by the commission.

Revised Law

Sec. 525.0252. TECHNOLOGICAL SOLUTIONS POLICIES. (a) The commission shall develop and implement a policy requiring the agency commissioner and employees of each health and human services agency to research and propose appropriate technological solutions to improve the agency's ability to perform the agency's functions. The technological solutions must:

(1) ensure that the public is able to easily find information about a health and human services agency on the Internet;

(2) ensure that an individual who wants to use a health

and human services agency's services is able to:

(A) interact with the agency through the Internet; and

(B) access any service that can be effectively provided through the Internet;

(3) be cost-effective and developed through the commission's planning process; and

(4) meet federal accessibility standards for individuals with disabilities.

(b) The commission shall develop and implement the policy described by Subsection (a) in relation to the commission's functions. (Gov. Code, Secs. 531.0162(a), (b).)

Source Law

> Sec. 531.0162. USE OF TECHNOLOGY. (a) The commission shall develop and implement a policy requiring the agency commissioner and employees of each health and human services agency to research and propose appropriate technological solutions to improve the agency's ability to perform its functions. The technological solutions must:
>
> (1) ensure that the public is able to easily find information about a health and human services agency on the Internet;
>
> (2) ensure that persons who want to use a health and human services agency's services are able to:
>
> (A) interact with the agency through the Internet; and
>
> (B) access any service that can be provided effectively through the Internet;
>
> (3) be cost-effective and developed through the commission's planning process; and
>
> (4) meet federal accessibility standards for persons with disabilities.
>
> (b) The commission shall develop and implement a policy described by Subsection (a) in relation to the commission's functions.

Revised Law

Sec. 525.0253. TECHNOLOGY USE FOR ADULT PROTECTIVE SERVICES PROGRAM. (a) Subject to available appropriations, the commission shall use technology whenever possible in connection with the Department of Family and Protective Services' adult protective services program to:

(1) provide for automated collection of information necessary to evaluate program effectiveness using systems that

integrate collection of necessary information with other routine duties of caseworkers and other service providers; and

(2) consequently reduce the time required for caseworkers and other service providers to gather and report information necessary for program evaluation.

(b) The commission shall include private sector representatives in the technology planning process used to determine appropriate technology for the Department of Family and Protective Services' adult protective services program. (Gov. Code, Secs. 531.0162(c), (d).)

Source Law

(c) Subject to available appropriations, the commission shall use technology whenever possible in connection with the adult protective services program of the Department of Family and Protective Services to:

(1) provide for automated collection of information necessary to evaluate program effectiveness using systems that integrate collection of necessary information with other routine duties of caseworkers and other service providers; and

(2) consequently reduce the time that caseworkers and other service providers are required to use in gathering and reporting information necessary for program evaluation.

(d) The commission shall include representatives of the private sector in the technology planning process used to determine appropriate technology for the adult protective services program of the Department of Family and Protective Services.

Revised Law

Sec. 525.0254. ELECTRONIC SIGNATURES. (a) In this section, "transaction" has the meaning assigned by Section 322.002, Business & Commerce Code.

(b) The executive commissioner shall establish standards for the use of electronic signatures in accordance with Chapter 322, Business & Commerce Code, with respect to any transaction in connection with the administration of health and human services programs.

(c) The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section. (Gov. Code, Secs. 531.0055(j), (m).)

Source Law

(j) The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section.

(m) The executive commissioner shall establish standards for the use of electronic signatures in accordance with the Uniform Electronic Transactions Act (Chapter 322, Business & Commerce Code), with respect to any transaction, as defined by Section 322.002, Business & Commerce Code, in connection with the administration of health and human services programs.

Revisor's Note

Section 531.0055(j), Government Code, requires the executive commissioner of the Health and Human Services Commission to adopt rules to implement the executive commissioner's authority under "this section," meaning Section 531.0055, Government Code. The substantive provisions of Section 531.0055 are revised as Subchapter A and Sections 524.0101, 524.0151, and 524.0202 of Chapter 524 in this subtitle and as Section 525.0254 of this chapter. The revised law, however, substitutes a reference to only "this section," meaning Section 525.0254 of this chapter, for the reference to "this section" in Section 531.0055(j) and does not include a reference to Subchapter A, Chapter 524, and Sections 524.0101, 524.0151, and 524.0202 in this subtitle because the substance of Section 531.0055(j) is also revised with those provisions as appropriate.

Revised Law

Sec. 525.0255. HEALTH AND HUMAN SERVICES SYSTEM INTERNET WEBSITES. The commission shall establish a process to ensure that Internet websites across the health and human services system are developed and maintained according to standard criteria for uniformity, efficiency, and technical capabilities. Under the process, the commission shall:

(1) develop and maintain an inventory of all health

and human services system Internet websites; and

(2) on an ongoing basis, evaluate the inventory the commission maintains under Subdivision (1) to:

(A) determine whether any Internet websites should be consolidated to improve public access to those websites' content and, if appropriate, consolidate those websites; and

(B) ensure that the Internet websites comply with the standard criteria. (Gov. Code, Sec. 531.0164.)

Source Law

> Sec. 531.0164. HEALTH AND HUMAN SERVICES SYSTEM INTERNET WEBSITE COORDINATION. The commission shall establish a process to ensure Internet websites across the health and human services system are developed and maintained according to standard criteria for uniformity, efficiency, and technical capabilities. Under the process, the commission shall:
>
> (1) develop and maintain an inventory of all health and human services system Internet websites;
>
> (2) on an ongoing basis, evaluate the inventory maintained under Subdivision (1) to:
>
> (A) determine whether any of the Internet websites should be consolidated to improve public access to those websites' content; and
>
> (B) ensure the Internet websites comply with the standard criteria; and
>
> (3) if appropriate, consolidate the websites identified under Subdivision (2)(A).

Revised Law

Sec. 525.0256. AUTOMATION STANDARDS FOR DATA SHARING. The executive commissioner, with the Department of Information Resources, shall develop automation standards for computer systems to enable health and human services agencies, including agencies operating at a local level, to share pertinent data. (Gov. Code, Sec. 531.024(a) (part).)

Source Law

> Sec. 531.024. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES; DATA SHARING. (a) The executive commissioner shall:
>
> . . .
>
> (2) develop with the Department of Information Resources automation standards for computer systems to enable health and human services agencies, including agencies operating at a local level, to share pertinent data;
>
> . . .

Revised Law

Sec. 525.0257. ELECTRONIC EXCHANGE OF HEALTH INFORMATION; BIENNIAL REPORT. (a) In this section, "health care provider" includes a physician.

(b) The executive commissioner shall ensure that:

(1) all information systems available for the commission or a health and human services agency to use in sending protected health information to a health care provider or receiving protected health information from a health care provider, and for which planning or procurement begins on or after September 1, 2015, are capable of sending or receiving the information in accordance with the applicable data exchange standards developed by the appropriate standards development organization accredited by the American National Standards Institute;

(2) if national data exchange standards do not exist for a system described by Subdivision (1), the commission makes every effort to ensure that the system is interoperable with the national standards for electronic health record systems; and

(3) the commission and each health and human services agency establish an interoperability standards plan for all information systems that exchange protected health information with health care providers.

(c) Not later than December 1 of each even-numbered year, the executive commissioner shall report to the governor and the Legislative Budget Board on the commission's and the health and human services agencies' measurable progress in ensuring that the information systems described by Subsection (b) are interoperable with one another and meet the appropriate standards specified by that subsection. The report must include an assessment of the progress made in achieving commission goals related to the exchange of health information, including facilitating care coordination among the agencies, ensuring quality improvement, and realizing cost savings. (Gov. Code, Secs. 531.0162(e), (f), (h) (part).)

Source Law

(e) The executive commissioner shall ensure that:

(1) all information systems available for use by the commission or a health and human services agency in sending protected health information to a health care provider or receiving protected health information from a health care provider, and for which planning or procurement begins on or after September 1, 2015, are capable of sending or receiving that information in accordance with the applicable data exchange standards developed by the appropriate standards development organization accredited by the American National Standards Institute;

(2) if national data exchange standards do not exist for a system described by Subdivision (1), the commission makes every effort to ensure the system is interoperable with the national standards for electronic health record systems; and

(3) the commission and each health and human services agency establish an interoperability standards plan for all information systems that exchange protected health information with health care providers.

(f) Not later than December 1 of each even-numbered year, the executive commissioner shall report to the governor and the Legislative Budget Board on the commission's and the health and human services agencies' measurable progress in ensuring that the information systems described in Subsection (e) are interoperable with one another and meet the appropriate standards specified by that subsection. The report must include an assessment of the progress made in achieving commission goals related to the exchange of health information, including facilitating care coordination among the agencies, ensuring quality improvement, and realizing cost savings.

(h) In this section, "health care provider" and . . . include a physician.

SUBCHAPTER G. STUDIES, REPORTS, AND PUBLICATIONS

Revised Law

Sec. 525.0301. BIENNIAL REFERENCE GUIDE. (a) The commission shall:

(1) publish a biennial reference guide describing available public health and human services in this state; and

(2) make the guide available to all interested parties and agencies.

(b) The reference guide must include a dictionary of uniform terms and services. (Gov. Code, Sec. 531.040.)

Source Law

Sec. 531.040. REFERENCE GUIDE; DICTIONARY. (a) The commission shall publish a biennial reference

guide describing available public health and human services in this state and shall make the guide available to all interested parties and agencies.

(b) The reference guide must include a dictionary of uniform terms and services.

Revised Law

Sec. 525.0302. CONSOLIDATION OF REPORTS. The commission may consolidate any annual or biennial reports required to be made under this chapter or another law if:

(1) the consolidated report is submitted not later than the earliest deadline for the submission of any component of the report; and

(2) each person required to receive a component of the consolidated report receives the report, and the report identifies the component the person was required to receive. (Gov. Code, Sec. 531.014.)

Source Law

Sec. 531.014. CONSOLIDATION OF REPORTS. The commission may consolidate any annual or biennial reports required to be made under this chapter or another law if:

(1) the consolidated report is submitted not later than the earliest deadline for the submission of any component of the consolidated report; and

(2) each person required to receive a component of the consolidated report receives the consolidated report and the consolidated report identifies the component of the report the person was required to receive.

Revisor's Note

Section 531.014, Government Code, refers to reports required to be made under "this chapter," meaning Chapter 531, Government Code, "or another law." Chapter 531 is revised throughout Subtitle I, Title 4, Government Code, including in this chapter. The revised law retains the reference to "this chapter or another law" because the provisions of Chapter 531 that are not revised in this chapter are included within the meaning of "another law."

Revised Law

Sec. 525.0303. ANNUAL REPORT ON SAFEGUARDING PROTECTED

HEALTH INFORMATION. (a) The commission, in consultation with the Department of State Health Services, the Texas Medical Board, and the Texas Department of Insurance, shall explore and evaluate new developments in safeguarding protected health information.

(b) Not later than December 1 of each year, the commission shall report to the legislature on:

(1) new developments in safeguarding protected health information; and

(2) recommendations for implementing safeguards within the commission. (Gov. Code, Sec. 531.0994.)

Source Law

> Sec. 531.0994. STUDY; ANNUAL REPORT. (a) The commission, in consultation with the Department of State Health Services, the Texas Medical Board, and the Texas Department of Insurance, shall explore and evaluate new developments in safeguarding protected health information.
>
> (b) Not later than December 1 each year, the commission shall report to the legislature on new developments in safeguarding protected health information and recommendations for the implementation of safeguards within the commission.

CHAPTER 526. ADDITIONAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

SUBCHAPTER A. INTERNET WEBSITES, ELECTRONIC RESOURCES, AND OTHER TECHNOLOGY


Sec. 526.0001. DEFINITIONS . . . . . 151

Sec. 526.0002. INTERNET WEBSITE FOR HEALTH AND HUMAN SERVICES INFORMATION . . . . . 152

Sec. 526.0003. INFORMATION ON LONG-TERM CARE SERVICES . . . 155

Sec. 526.0004. TEXAS INFORMATION AND REFERRAL NETWORK . . . 159

Sec. 526.0005. INTERNET WEBSITE FOR HEALTH AND HUMAN SERVICES REFERRAL INFORMATION . . . . . 162

Sec. 526.0006. INTERNET WEBSITE FOR CHILD-CARE AND EDUCATION SERVICES REFERRAL INFORMATION . . . . . 163

Sec. 526.0007. INTERNET WEBSITE FOR REFERRAL INFORMATION ON HOUSING OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS . . . . . 166

Sec. 526.0008. COMPLIANCE WITH NATIONAL ELECTRONIC DATA INTERCHANGE STANDARDS FOR HEALTH CARE INFORMATION . . . . . 170
Sec. 526.0009. TECHNICAL ASSISTANCE FOR HUMAN SERVICES PROVIDERS . . . . . 172
Sec. 526.0010. INFORMATION RESOURCES MANAGER REPORTS . . . . 173
SUBCHAPTER B. PROGRAMS AND SERVICES PROVIDED OR ADMINISTERED BY COMMISSION
Sec. 526.0051. RESTRICTIONS ON AWARDS TO FAMILY PLANNING SERVICE PROVIDERS . . . . . 173
Sec. 526.0052. INFORMATION FOR CERTAIN ENROLLEES IN HEALTHY TEXAS WOMEN PROGRAM . . . . . 174
Sec. 526.0053. VACCINES FOR CHILDREN PROGRAM PROVIDER ENROLLMENT; IMMUNIZATION REGISTRY . . . . . 176
Sec. 526.0054. PRIOR AUTHORIZATION FOR HIGH-COST MEDICAL SERVICES AND PROCEDURES . . . . . 177
Sec. 526.0055. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS . . . . . 178
Sec. 526.0056. PILOT PROGRAM TO PREVENT SPREAD OF INFECTIOUS OR COMMUNICABLE DISEASES . . . . 179
Sec. 526.0057. APPLICATION REQUIREMENT FOR COLONIAS PROJECTS . . . . . 179
Sec. 526.0058. RULES REGARDING REFUGEE RESETTLEMENT . . . . 181
Sec. 526.0059. PROHIBITED AWARD OF CONTRACTS TO MANAGED CARE ORGANIZATIONS FOR CERTAIN CRIMINAL CONVICTIONS . . . . . 183
SUBCHAPTER C. COORDINATION OF QUALITY INITIATIVES
Sec. 526.0101. DEFINITION . . . . . 184
Sec. 526.0102. OPERATIONAL PLAN TO COORDINATE MAJOR QUALITY INITIATIVES . . . . . 184
Sec. 526.0103. REVISION AND EVALUATION OF MAJOR QUALITY INITIATIVES . . . . . 186
Sec. 526.0104. INCENTIVES FOR MAJOR QUALITY INITIATIVE COORDINATION . . . . . 186

SUBCHAPTER D. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND
Sec. 526.0151. DEFINITION . . . . . 186
Sec. 526.0152. AUTHORITY TO OBTAIN FEDERAL WAIVER . . . . . 187
Sec. 526.0153. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND ESTABLISHED . . . . . 192
Sec. 526.0154. DEPOSITS TO FUND . . . . . 192
Sec. 526.0155. USE OF FUND IN GENERAL; RULES FOR ALLOCATION . . . . . 193
Sec. 526.0156. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS . . . . . 194
Sec. 526.0157. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE . . . . . 196
Sec. 526.0158. INFRASTRUCTURE IMPROVEMENTS . . . . . 197
SUBCHAPTER E. LONG-TERM CARE FACILITIES
Sec. 526.0201. DEFINITION . . . . . 199
Sec. 526.0202. INFORMAL DISPUTE RESOLUTION FOR CERTAIN LONG-TERM CARE FACILITIES . . . . . 199
Sec. 526.0203. LONG-TERM CARE FACILITIES COUNCIL . . . . . 203
Sec. 526.0204. COUNCIL DUTIES; REPORT . . . . . 205
SUBCHAPTER F. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS; ADMINISTRATIVE PENALTY
Sec. 526.0251. RULES . . . . . 207
Sec. 526.0252. NOTICE OF FAILURE TO REPORT; ADMINISTRATIVE PENALTY . . . . . 208
Sec. 526.0253. NOTICE OF INCOMPLETE OR INACCURATE REPORT; ADMINISTRATIVE PENALTY . . . . . 208
Sec. 526.0254. REQUIREMENTS FOR ATTORNEY GENERAL NOTIFICATION . . . . . 209
Sec. 526.0255. ATTORNEY GENERAL NOTICE TO HOSPITAL . . . . . 210
Sec. 526.0256. PENALTY PAID OR HEARING REQUESTED . . . . . 210
Sec. 526.0257. HEARING . . . . . 211
Sec. 526.0258. OPTIONS FOLLOWING DECISION: PAY OR APPEAL . . . . . 212
Sec. 526.0259. DECISION BY COURT . . . . . 213

Sec. 526.0260. RECOVERY OF PENALTY . . . . . 214
SUBCHAPTER G. RURAL HOSPITAL INITIATIVES
Sec. 526.0301. STRATEGIC PLAN FOR RURAL HOSPITAL SERVICES; REPORT . . . . . 214
Sec. 526.0302. RURAL HOSPITAL ADVISORY COMMITTEE . . . . . 216
Sec. 526.0303. COLLABORATION WITH OFFICE OF RURAL AFFAIRS . . . . . 217
SUBCHAPTER H. MEDICAL TRANSPORTATION
Sec. 526.0351. DEFINITIONS . . . . . 217
Sec. 526.0352. DUTY TO PROVIDE MEDICAL TRANSPORTATION SERVICES . . . . . 218
Sec. 526.0353. APPLICABILITY . . . . . 219
Sec. 526.0354. COMMISSION SUPERVISION OF MEDICAL TRANSPORTATION PROGRAM . . . . . 220
Sec. 526.0355. CONTRACT FOR PUBLIC TRANSPORTATION SERVICES . . . . . 221
Sec. 526.0356. RULES FOR NONEMERGENCY TRANSPORTATION SERVICES; COMPLIANCE . . . . . 222
Sec. 526.0357. MEMORANDUM OF UNDERSTANDING; DRIVER AND VEHICLE INFORMATION . . . . . 223
Sec. 526.0358. MEDICAL TRANSPORTATION SERVICES SUBCONTRACTS . . . . . 224
Sec. 526.0359. CERTAIN PROVIDERS PROHIBITED FROM PROVIDING NONEMERGENCY TRANSPORTATION SERVICES . . . . . 226
Sec. 526.0360. CERTAIN WHEELCHAIR-ACCESSIBLE VEHICLES AUTHORIZED . . . . . 226
SUBCHAPTER I. CASEWORKERS AND PROGRAM PERSONNEL
Sec. 526.0401. CASELOAD STANDARDS FOR DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES . . . . . 226
Sec. 526.0402. JOINT TRAINING FOR CERTAIN CASEWORKERS . . . 229
Sec. 526.0403. COORDINATION AND APPROVAL OF CASELOAD ESTIMATES . . . . . 230

Sec. 526.0404. DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM: CAREER LADDER FOR INTERVENERS . . . . . 231
SUBCHAPTER J. LICENSING, LISTING, OR REGISTRATION OF CERTAIN ENTITIES
Sec. 526.0451. APPLICABILITY . . . . . 236
Sec. 526.0452. REQUIRED APPLICATION INFORMATION . . . . . 237
Sec. 526.0453. APPLICATION DENIAL BASED ON ADVERSE AGENCY DECISION . . . . . 238
Sec. 526.0454. RECORD OF FINAL DECISION . . . . . 239
SUBCHAPTER K. CHILDREN AND FAMILIES
Sec. 526.0501. SUBSTITUTE CARE PROVIDER OUTCOME STANDARDS . . . . . 241
Sec. 526.0502. REPORT ON DELIVERY OF HEALTH AND HUMAN SERVICES TO YOUNG TEXANS . . . . . 243
Sec. 526.0503. POOLED FUNDING FOR FOSTER CARE PREVENTIVE SERVICES . . . . . 243
Sec. 526.0504. PARTICIPATION BY FATHERS . . . . . 245
Sec. 526.0505. PROHIBITED PUNITIVE ACTION FOR FAILURE TO IMMUNIZE . . . . . 246
Sec. 526.0506. INVESTIGATION UNIT FOR CHILD-CARE FACILITIES OPERATING ILLEGALLY . . . . . 247
SUBCHAPTER L. TEXAS HOME VISITING PROGRAM
Sec. 526.0551. DEFINITIONS . . . . . 247
Sec. 526.0552. RULES . . . . . 248
Sec. 526.0553. STRATEGIC PLAN; ELIGIBILITY . . . . . 248
Sec. 526.0554. TYPES OF HOME VISITING PROGRAMS . . . . . 249
Sec. 526.0555. OUTCOMES . . . . . 251
Sec. 526.0556. EVALUATION OF HOME VISITING PROGRAM . . . . . 252
Sec. 526.0557. FUNDING . . . . . 253
Sec. 526.0558. REPORTS TO LEGISLATURE . . . . . 254
SUBCHAPTER M. SERVICE MEMBERS, DEPENDENTS, AND VETERANS
Sec. 526.0601. SERVICES FOR SERVICE MEMBERS . . . . . 255

Sec. 526.0602. INTEREST OR OTHER WAITING LIST FOR CERTAIN SERVICE MEMBERS AND DEPENDENTS . . . . . 256
Sec. 526.0603. MEMORANDUM OF UNDERSTANDING REGARDING PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM; MAXIMIZATION OF BENEFITS . . . . . 259
SUBCHAPTER N. PLAN TO SUPPORT GUARDIANSHIPS
Sec. 526.0651. DEFINITIONS . . . . . 261
Sec. 526.0652. PLAN ESTABLISHMENT . . . . . 262
Sec. 526.0653. GUARDIANSHIP PROGRAM GRANT REQUIREMENTS . . . 262
SUBCHAPTER O. ASSISTANCE PROGRAM FOR DOMESTIC VICTIMS OF TRAFFICKING
Sec. 526.0701. DEFINITIONS . . . . . 265
Sec. 526.0702. VICTIM ASSISTANCE PROGRAM . . . . . 265
Sec. 526.0703. GRANT PROGRAM . . . . . 267
Sec. 526.0704. TRAINING PROGRAMS . . . . . 268
Sec. 526.0705. FUNDING . . . . . 269
SUBCHAPTER P. AGING ADULTS WITH VISUAL IMPAIRMENTS
Sec. 526.0751. OUTREACH CAMPAIGNS FOR AGING ADULTS WITH VISUAL IMPAIRMENTS . . . . . 269
Sec. 526.0752. RULES . . . . . 271
Sec. 526.0753. COMMISSION SUPPORT . . . . . 271

CHAPTER 526. ADDITIONAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

SUBCHAPTER A. INTERNET WEBSITES, ELECTRONIC RESOURCES, AND OTHER TECHNOLOGY

Revised Law

Sec. 526.0001. DEFINITIONS. In this subchapter:

(1) "Council" means the Records Management Interagency Coordinating Council.

(2) "Network" means the Texas Information and Referral Network. (New.)

Revisor's Note

The definitions of "council" and "network" are added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

Revised Law

Sec. 526.0002. INTERNET WEBSITE FOR HEALTH AND HUMAN SERVICES INFORMATION. (a) The commission, in cooperation with the Department of Information Resources, shall maintain through the state electronic Internet portal project established by the department a generally accessible and interactive Internet website that contains information for the public regarding the services and programs each health and human services agency provides or administers in this state. The commission shall establish the website in such a manner that allows it to be located easily through electronic means.

(b) The Internet website must:

(1) include information that is:

(A) presented in a concise and easily understandable and accessible format; and

(B) organized by the type of service provided rather than by the agency or provider delivering the service;

(2) provide eligibility criteria for each health and human services agency program;

(3) provide application forms for each of the public assistance programs administered by a health and human services agency, including forms for:

(A) the financial assistance program under Chapter 31, Human Resources Code;

(B) Medicaid; and

(C) the nutritional assistance program under Chapter 33, Human Resources Code;

(4) to avoid duplication of functions and efforts, provide a link to an Internet website maintained by the network

under Section 526.0005;

(5) provide the telephone number and, to the extent available, the e-mail address for each health and human services agency and local health and human services provider;

(6) be designed in a manner that allows a member of the public to electronically:

(A) send questions about each agency's programs or services; and

(B) receive the agency's responses to those questions; and

(7) be updated at least quarterly.

(c) In designing the Internet website, the commission shall comply with any state standards for Internet websites that are prescribed by the Department of Information Resources or any other state agency.

(d) The commission shall ensure that:

(1) the Internet website's design and applications:

(A) comply with generally acceptable standards for Internet accessibility for individuals with disabilities; and

(B) contain appropriate controls for information security; and

(2) the Internet website does not contain any confidential information, including any confidential information regarding a client of a human services provider.

(e) A health and human services agency, the network, and the Department of Information Resources shall cooperate with the commission to the extent necessary to enable the commission to perform its duties under this section. (Gov. Code, Secs. 531.0317(b), (c), (d), (e), (f).)

Source Law

(b) The commission, in cooperation with the Department of Information Resources, shall establish and maintain through the state electronic Internet portal project established by the Department of Information Resources a generally accessible and interactive Internet site that contains information for the public regarding the services and programs

provided or administered by each of the health and human services agencies throughout the state. The commission shall establish the site in such a manner that it can be located easily through electronic means.

(c) The Internet site must:

(1) contain information that is:

(A) in a concise and easily understandable and accessible format; and

(B) organized by the type of service provided rather than by the agency or provider delivering the service;

(2) contain eligibility criteria for each agency program;

(3) contain application forms for each of the public assistance programs administered by health and human services agencies, including application forms for:

(A) financial assistance under Chapter 31, Human Resources Code;

(B) Medicaid; and

(C) nutritional assistance under Chapter 33, Human Resources Code;

(4) to avoid duplication of functions and efforts, provide a link that provides access to a site maintained by the Texas Information and Referral Network under Section 531.0313;

(5) contain the telephone number and, to the extent available, the electronic mail address for each health and human services agency and local provider of health and human services;

(6) be designed in a manner that allows a member of the public to send questions about each agency's programs or services electronically and receive responses to the questions from the agency electronically; and

(7) be updated at least quarterly.

(d) In designing the Internet site, the commission shall comply with any state standards for Internet sites that are prescribed by the Department of Information Resources or any other state agency.

(e) The commission shall ensure that:

(1) the Internet site does not contain any confidential information, including any confidential information regarding a client of a human services provider; and

(2) the Internet site's design and applications comply with generally acceptable standards for Internet accessibility for persons with disabilities and contain appropriate controls for information security.

(f) A health and human services agency, the Texas Information and Referral Network, and the Department of Information Resources shall cooperate with the commission to the extent necessary to enable the commission to perform its duties under this section.

Revisor's Note

(1) Section 531.0317(a), Government Code, defines the term "Internet." The revised law omits the definition as unnecessary. Section 311.011(a), Government Code (Code Construction Act), applicable to

the revised law, provides that words and phrases shall be read in context and construed according to the rules of grammar and common usage. The definition is consistent with the meaning of that term in common usage and does not establish a technical or particular meaning of the term. The omitted law reads:

> Sec. 531.0317. HEALTH AND HUMAN SERVICES INFORMATION MADE AVAILABLE THROUGH THE INTERNET. (a) In this section, "Internet" means the largest nonproprietary, nonprofit cooperative public computer network, popularly known as the Internet.

(2) Section 531.0317(b), Government Code, requires the Health and Human Services Commission to "establish" and maintain an Internet website containing certain information for the public. The revised law omits "establish" as executed because the commission has established the website.

(3) Sections 531.0317(b), (c), (d), and (e), Government Code, refer to the Health and Human Services Commission's "Internet site." Throughout this subchapter, the revised law substitutes the term "Internet website" for "Internet site" because the terms are synonymous and "Internet website" is more commonly used.

(4) Section 531.0317(e)(2), Government Code, refers to persons with disabilities. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to this code.

Revised Law

Sec. 526.0003. INFORMATION ON LONG-TERM CARE SERVICES. (a)

The Internet website maintained under Section 526.0002 must include information for consumers concerning long-term care services. The information must:

(1) be presented in a manner that is easily accessible to and understandable by a consumer; and

(2) allow a consumer to make informed choices concerning long-term care services and include:

(A) an explanation of the manner in which long-term care service delivery is administered in different counties through different programs the commission operates so that an individual can easily understand the service options available in the area in which that individual lives; and

(B) for the STAR+PLUS Medicaid managed care program, information in an accessible format, such as a table, that allows a consumer to evaluate the performance of each participating plan issuer, including for each issuer:

(i) the enrollment in each county;

(ii) additional "value-added" services provided;

(iii) a summary of the financial statistical report required under Section 540.0211;

(iv) complaint information;

(v) any sanction or penalty imposed by any state agency, including a sanction or penalty imposed by the commission or the Texas Department of Insurance;

(vi) consumer satisfaction information; and

(vii) other data, including relevant data from reports of external quality review organizations, that may be used by the consumer to evaluate the quality of the services provided.

(b) In addition to providing the information required by this section through the Internet website, the commission shall, on request by a consumer without Internet access, provide the consumer

with a printed copy of the information from the Internet website. The commission may charge a reasonable fee for printing the information. The executive commissioner by rule shall establish the fee amount. (Gov. Code, Sec. 531.0318.)

Source Law

Sec. 531.0318. LONG-TERM CARE CONSUMER INFORMATION MADE AVAILABLE THROUGH THE INTERNET. (a) The Internet site maintained under Section 531.0317 must include information for consumers concerning long-term care services that complies with this section. The Internet site maintained by the Department of Aging and Disability Services must also include, or provide a link to, the information required by this section.

(b) The information for consumers required by this section must:

(1) be presented in a manner that is easily accessible to, and understandable by, a consumer; and

(2) allow a consumer to make informed choices concerning long-term care services and include:

(A) an explanation of the manner in which long-term care service delivery is administered in different counties through different programs operated by the commission and by the Department of Aging and Disability Services, so that an individual can easily understand the service options available in the area in which that individual lives; and

(B) for the Star + Plus Medicaid managed care program, information that allows a consumer to evaluate the performance of each participating plan issuer, including for each issuer, in an accessible format such as a table:

(i) the enrollment in each county;

(ii) additional "value-added" services provided;

(iii) a summary of the financial statistical report required under Subchapter A, Chapter 533;

(iv) complaint information;

(v) any sanction or penalty imposed by any state agency, including a sanction or penalty imposed by the commission or the Texas Department of Insurance;

(vi) information concerning consumer satisfaction; and

(vii) other data, including relevant data from reports of external quality review organizations, that may be used by the consumer to evaluate the quality of the services provided.

(c) In addition to providing the information required by this section through the Internet, the commission or the Department of Aging and Disability Services shall, on request by a consumer without Internet access, provide the consumer with a printed copy of the information from the website. The commission or department may charge a reasonable fee for printing the information. The executive commissioner shall establish the fee by rule.

Revisor's Note

(1) Section 531.0318(a), Government Code, requires that "[t]he Internet site maintained by the Department of Aging and Disability Services must also include, or provide a link to, the information required by this section." Sections 531.0318(b) and (c), Government Code, also refer to the "Department of Aging and Disability Services." The Department of Aging and Disability Services was abolished September 1, 2017, in accordance with Section 531.0202(b), Government Code, which is executed law that expired September 1, 2023. The revised law therefore omits the quoted language from Sections 531.0318(a), (b), and (c), and, throughout this chapter, omits references to the "Department of Aging and Disability Services" as obsolete.

(2) Section 531.0318(a), Government Code, requires that an Internet website include information "that complies with this section." The revised law omits the quoted language as unnecessary because the requirements of Section 531.0318, which is revised as this section, apply by their own terms.

(3) Section 531.0318(b)(2)(B)(iii), Government Code, refers to the financial statistical report required under "Subchapter A, Chapter 533," meaning Subchapter A, Chapter 533, Government Code. The provisions of Subchapter A, Chapter 533, are revised in this subtitle throughout Chapters 540 and 540A. To account for the revision, the reference would need to contain an exhaustive list of every provision derived from Subchapter A, Chapter 533, making the law cumbersome and difficult to read. Additionally, in Subchapter A, Chapter 533, the term "financial statistical report" is used only in Section 533.0051,

which is revised in this subtitle as Section 540.0211. For these reasons, the revised law substitutes "Section 540.0211" for "Subchapter A, Chapter 533."

(4) Section 531.0318(c), Government Code, refers to information the Health and Human Services Commission provides through the "Internet." The revised law substitutes the term "Internet website" for "Internet" because, in context, the term "Internet" refers to the commission's Internet website maintained under Section 531.0317, Government Code, and for consistency in terminology used in the subchapter.

Revised Law

Sec. 526.0004. TEXAS INFORMATION AND REFERRAL NETWORK. (a) The Texas Information and Referral Network is responsible for developing, coordinating, and implementing a statewide information and referral network that integrates existing community-based structures with state and local agencies. The network must:

(1) include information relating to transportation services provided to clients of state and local agencies;

(2) be capable of assisting with statewide disaster response and emergency management, including through the use of interstate agreements with out-of-state call centers to ensure preparedness and responsiveness;

(3) include technology capable of communicating with clients of state and local agencies using electronic text messaging; and

(4) include a publicly accessible Internet-based system to provide real-time, searchable data about the location and number of clients of state and local agencies using the system and the types of requests the clients made.

(b) The commission shall cooperate with the council and the comptroller to establish a single method of categorizing information about health and human services to be used by the

council and the network. The network, in cooperation with the council and the comptroller, shall ensure that:

(1) information relating to health and human services is included in each residential telephone directory published by a for-profit publisher and distributed to the public at minimal or no cost; and

(2) the single method of categorizing information about health and human services is used in the directory.

(c) A health and human services agency or a public or private entity receiving state-appropriated funds to provide health and human services shall provide the council and the network with information about the health and human services the agency or entity provides for inclusion in the statewide information and referral network, residential telephone directories described by Subsection (b), and any other materials produced under the council's or the network's direction. The agency or entity shall provide the information in the format the council or the network requires and shall update the information at least quarterly or as required by the council or the network.

(d) The Texas Department of Housing and Community Affairs shall provide the network with information regarding the department's housing and community affairs programs for inclusion in the statewide information and referral network. The department shall provide the information in a form the commission determines and shall update the information at least quarterly.

(e) Each local workforce development board, the Texas Head Start State Collaboration Office, and each school district shall provide the network with information regarding eligibility for and availability of child-care and education services as defined by Section 526.0006 for inclusion in the statewide information and referral network. The local workforce development boards, Texas Head Start State Collaboration Office, and school districts shall provide the information in a form the executive commissioner determines. (Gov. Code, Sec. 531.0312.)

Source Law

Sec. 531.0312. TEXAS INFORMATION AND REFERRAL NETWORK. (a) The Texas Information and Referral Network at the commission is the program responsible for the development, coordination, and implementation of a statewide information and referral network that integrates existing community-based structures with state and local agencies. The network must:

(1) include information relating to transportation services provided to clients of state and local agencies;

(2) be capable of assisting with statewide disaster response and emergency management, including through the use of interstate agreements with out-of-state call centers to ensure preparedness and responsiveness;

(3) include technology capable of communicating with clients of state and local agencies using electronic text messaging; and

(4) include a publicly accessible Internet-based system to provide real-time, searchable data about the location and number of clients of state and local agencies using the system and the types of requests made by the clients.

(b) The commission shall cooperate with the Records Management Interagency Coordinating Council and the comptroller to establish a single method of categorizing information about health and human services to be used by the Records Management Interagency Coordinating Council and the Texas Information and Referral Network. The network, in cooperation with the council and the comptroller, shall ensure that:

(1) information relating to health and human services is included in each residential telephone directory published by a for-profit publisher and distributed to the public at minimal or no cost; and

(2) the single method of categorizing information about health and human services is used in a residential telephone directory described by Subdivision (1).

(c) A health and human services agency or a public or private entity receiving state-appropriated funds to provide health and human services shall provide the Texas Information and Referral Network and the Records Management Interagency Coordinating Council with information about the health and human services provided by the agency or entity for inclusion in the statewide information and referral network, residential telephone directories described by Subsection (b), and any other materials produced under the direction of the network or the council. The agency or entity shall provide the information in the format required by the Texas Information and Referral Network or the Records Management Interagency Coordinating Council and shall update the information at least quarterly or as required by the network or the council.

(d) The Texas Department of Housing and Community Affairs shall provide the Texas Information and Referral Network with information regarding the department's housing and community affairs programs for inclusion in the statewide information and referral network. The department shall provide the information in a form determined by the commission and

shall update the information at least quarterly.

(e) Each local workforce development board, the Texas Head Start State Collaboration Office, and each school district shall provide the Texas Information and Referral Network with information regarding eligibility for and availability of child-care and education services for inclusion in the statewide information and referral network. The local workforce development boards, Texas Head Start State Collaboration Office, and school districts shall provide the information in a form determined by the executive commissioner. In this subsection, "child-care and education services" has the meaning assigned by Section 531.03131.

Revised Law

Sec. 526.0005. INTERNET WEBSITE FOR HEALTH AND HUMAN SERVICES REFERRAL INFORMATION. (a) The network may develop an Internet website to provide information to the public regarding the health and human services provided by public or private entities throughout this state.

(b) The material on the network Internet website must be:

(1) geographically indexed, including by type of service provided within each geographic area; and

(2) designed to inform an individual about the health and human services provided in the area in which the individual lives.

(c) The Internet website may contain:

(1) links to the Internet websites of any local health and human services provider;

(2) the name, address, and telephone number of organizations providing health and human services in a county and a description of the type of services those organizations provide; and

(3) any other information that educates the public about the health and human services provided in a county.

(d) The network shall coordinate with the Department of Information Resources to maintain the Internet website through the state electronic Internet portal project established by the department. (Gov. Code, Secs. 531.0313(a), (b), (c), (d).)

Source Law

Sec. 531.0313. ELECTRONIC ACCESS TO HEALTH AND

HUMAN SERVICES REFERRAL INFORMATION. (a) The Texas Information and Referral Network may develop an Internet site to provide information to the public regarding the health and human services provided by public or private entities throughout the state.

(b) The material in the Texas Information and Referral Network Internet site must be geographically indexed and designed to inform an individual about the health and human services provided in the area where the individual lives. The material must be further indexed by type of service provided within each geographic area.

(c) The Internet site may contain links to the Internet sites of any local provider of health and human services and may contain:

(1) the name, address, and phone number of organizations providing health and human services in a county;

(2) a description of the type of services provided by those organizations; and

(3) any other information to educate the public about the health and human services provided in a county.

(d) The Texas Information and Referral Network shall coordinate with the Department of Information Resources to maintain the Internet site through the state electronic Internet portal project established by the Department of Information Resources.

Revisor's Note

Section 531.0313(e), Government Code, defines the term "Internet." The revised law omits the definition for the reason stated in Revisor's Note (1) to Section 526.0002 of this chapter. The omitted law reads:

> (e) In this section, "Internet" means the largest nonproprietary, nonprofit cooperative public computer network, popularly known as the Internet.

Revised Law

Sec. 526.0006. INTERNET WEBSITE FOR CHILD-CARE AND EDUCATION SERVICES REFERRAL INFORMATION. (a) In this section, "child-care and education services" means:

(1) subsidized child-care services administered by the Texas Workforce Commission and local workforce development boards and funded wholly or partly by federal child-care development funds;

(2) child-care and education services provided by a Head Start or Early Head Start program provider;

(3) child-care and education services provided by a

school district through a prekindergarten or after-school program; and

(4) any other government-funded child-care and education services, other than education and services a school district provides as part of the general program of public education, designed to educate or provide care for children younger than 13 years of age in middle-income or low-income families.

(b) In addition to providing health and human services information, the network Internet website established under Section 526.0005 must provide information to the public regarding child-care and education services public or private entities provide throughout this state. The Internet website will serve as a single point of access through which an individual may be directed toward information regarding the manner of or location for applying for all child-care and education services available in the individual's community.

(c) To the extent resources are available, the Internet website must:

(1) be geographically indexed and designed to inform an individual about the child-care and education services provided in the area in which the individual lives;

(2) contain prescreening questions to determine an individual's or family's probable eligibility for child-care and education services; and

(3) be designed in a manner that allows network staff to:

(A) provide an applicant with the telephone number, physical address, and e-mail address of the:

(i) nearest Head Start or Early Head Start office or center and local workforce development center; and

(ii) appropriate school district; and

(B) send an e-mail message to each appropriate entity described by Paragraph (A) containing each applicant's name and contact information and a description of the services for which

the applicant is applying.

(d) On receipt of an e-mail message from the network under Subsection (c)(3)(B), each applicable entity shall:

(1) contact the applicant to verify information regarding the applicant's eligibility for available child-care and education services; and

(2) on certifying the applicant's eligibility, match the applicant with entities providing those services in the applicant's community, including local workforce development boards, local child-care providers, or a Head Start or Early Head Start program provider.

(e) The child-care resource and referral network described by Chapter 310, Labor Code, and each entity providing child-care and education services in this state, including local workforce development boards, the Texas Education Agency, school districts, Head Start and Early Head Start program providers, municipalities, counties, and other political subdivisions of this state, shall cooperate with the network as necessary to administer this section. (Gov. Code, Sec. 531.03131.)

Source Law

Sec. 531.03131. ELECTRONIC ACCESS TO CHILD-CARE AND EDUCATION SERVICES REFERRAL INFORMATION. (a) In this section, "child-care and education services" means:

(1) subsidized child-care services administered by the Texas Workforce Commission and local workforce development boards and funded wholly or partly by federal child-care development funds;

(2) child-care and education services provided by a Head Start or Early Head Start program provider;

(3) child-care and education services provided by a school district through a prekindergarten or after-school program; and

(4) any other government-funded child-care and education services, other than education and services provided by a school district as part of the general program of public and secondary education, designed to educate or provide care for children under the age of 13 in middle-income or low-income families.

(b) In addition to providing health and human services information, the Texas Information and Referral Network Internet site established under Section 531.0313 shall provide information to the public regarding child-care and education services provided by public or private entities throughout the

state. The Internet site will serve as a single point of access through which a person may be directed on how or where to apply for all child-care and education services available in the person's community.

(c) To the extent resources are available, the Internet site must:

(1) be geographically indexed and designed to inform an individual about the child-care and education services provided in the area where the person lives;

(2) contain prescreening questions to determine a person's or family's probable eligibility for child-care and education services; and

(3) be designed in a manner that allows staff of the Texas Information and Referral Network to:

(A) provide an applicant with the telephone number, physical address, and electronic mail address of the nearest Head Start or Early Head Start office or center and local workforce development center and the appropriate school district; and

(B) send an electronic mail message to each appropriate entity described by Paragraph (A) containing the name of and contact information for each applicant and a description of the services the applicant is applying for.

(d) On receipt of an electronic mail message from the Texas Information and Referral Network under Subsection (c)(3)(B), each entity shall contact the applicant to verify information regarding the applicant's eligibility for available child-care and education services and, on certifying eligibility, shall match the applicant with entities providing those services in the applicant's community, including local workforce development boards, local child-care providers, or a Head Start or Early Head Start program provider.

(e) The child-care resource and referral network under Chapter 310, Labor Code, and each entity providing child-care and education services in this state, including local workforce development boards, the Texas Education Agency, school districts, Head Start and Early Head Start program providers, municipalities, counties, and other political subdivisions of this state, shall cooperate with the Texas Information and Referral Network as necessary in the administration of this section.

Revisor's Note

Section 531.03131(b), Government Code, states that the Texas Information and Referral Network Internet website "shall" provide certain information. The revised law substitutes "must" for "shall," because, in context, "must" is the more commonly used term where no duty is imposed on a person or entity and the subject of the sentence is an inanimate object.

Revised Law

Sec. 526.0007. INTERNET WEBSITE FOR REFERRAL INFORMATION ON

HOUSING OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS. (a) The commission shall make available through the network Internet website established under Section 526.0005 information regarding housing options for individuals with mental illness provided by public or private entities throughout this state. The Internet website serves as a single point of access through which an individual may be directed toward information regarding the manner of or where to apply for housing for individuals with mental illness in the individual's community. In this subsection, "private entity" includes any provider of housing specifically for individuals with mental illness other than a state agency, county, municipality, or other political subdivision of this state, regardless of whether the provider accepts payment for providing housing for those individuals.

(b) To the extent resources are available, the Internet website must be geographically indexed and designed to inform an individual about the housing options for individuals with mental illness provided in the area in which the individual lives.

(c) The Internet website must contain a searchable listing of available housing options for individuals with mental illness by type with a definition for each type of housing and an explanation of the populations of individuals with mental illness generally served by that type of housing. The list must include the following types of housing for individuals with mental illness:

(1) state hospitals;

(2) step-down units in state hospitals;

(3) community hospitals;

(4) private psychiatric hospitals;

(5) an inpatient treatment service provider in the network of service providers assembled by a local mental health authority under Section 533.035(c), Health and Safety Code;

(6) assisted living facilities;

(7) continuing care facilities;

(8) boarding homes;

(9) emergency shelters for individuals who are homeless;

(10) transitional housing intended to move individuals who are homeless to permanent housing;

(11) supportive housing or long-term, community-based affordable housing that provides supportive services;

(12) general residential operations, as defined by Section 42.002, Human Resources Code; and

(13) residential treatment centers or a type of general residential operation that provides services to children with emotional disorders in a structured and supportive environment.

(d) For each housing facility named in the listing of available housing options for individuals with mental illness, the Internet website must indicate whether the provider operating the housing facility is licensed by this state.

(e) The Internet website must display a disclaimer that the information provided is for informational purposes only and is not an endorsement or recommendation of any type of housing or any housing facility.

(f) Each entity providing housing specifically for individuals with mental illness in this state, including the commission, counties, municipalities, other political subdivisions of this state, and private entities, shall cooperate with the network as necessary to administer this section. (Gov. Code, Sec. 531.03132.)

Source Law

Sec. 531.03132. ELECTRONIC ACCESS TO REFERRAL INFORMATION ABOUT HOUSING OPTIONS FOR PERSONS WITH MENTAL ILLNESS. (a) The commission shall make available through the Texas Information and Referral Network Internet site established under Section 531.0313 information regarding housing options for persons with mental illness provided by public or private entities throughout the state. The Internet site will serve as a single point of access through which a person may be directed on how or where to apply for housing for persons with mental illness in the person's community. In this subsection, "private entity" includes any provider of housing specifically

for persons with mental illness other than a state agency, municipality, county, or other political subdivision of this state, regardless of whether the provider accepts payment for providing housing for persons with mental illness.

(b) To the extent resources are available, the Internet site must be geographically indexed and designed to inform a person about the housing options for persons with mental illness provided in the area where the person lives.

(c) The Internet site must contain a searchable listing of available housing options for persons with mental illness by type, with a definition for each type of housing and an explanation of the populations of persons with mental illness generally served by that type of housing. The list must contain at a minimum the following types of housing for persons with mental illness:

(1) state hospitals;

(2) step-down units in state hospitals;

(3) community hospitals;

(4) private psychiatric hospitals;

(5) a provider of inpatient treatment services in the network of service providers assembled by a local mental health authority under Section 533.035(e), Health and Safety Code;

(6) assisted living facilities;

(7) continuing care facilities;

(8) boarding homes;

(9) emergency shelters for homeless persons;

(10) transitional housing intended to move homeless persons to permanent housing;

(11) supportive housing, or long-term, community-based affordable housing that provides supportive services;

(12) general residential operations, as defined by Section 42.002, Human Resources Code; and

(13) residential treatment centers, or a type of general residential operation that provides services to children with emotional disorders in a structured and supportive environment.

(d) For each housing facility named in the listing of available housing options for persons with mental illness, the Internet site must indicate whether the provider that operates the housing facility is licensed by the state.

(e) The Internet site must display a disclaimer that the information provided is for informational purposes only and is not an endorsement or recommendation of any type of housing or any housing facility.

(f) Each entity providing housing specifically for persons with mental illness in this state, including the Department of State Health Services, municipalities, counties, other political subdivisions of this state, and private entities, shall cooperate with the Texas Information and Referral Network as necessary in the administration of this section.

Revisor's Note

(1) Section 531.03132(c), Government Code, refers to a list that must "contain at a minimum" certain types of housing. The revised law substitutes

"include" for "contain at a minimum" because, in context, the meaning is the same and "include" is the more commonly used term, and Section 311.005(13), Government Code (Code Construction Act), provides that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

(2) Section 531.03132(c)(5), Government Code, refers to a provider of inpatient treatment services in the network of service providers assembled by a local mental health authority under "Section 533.035(e)." The quoted citation is a drafting error because it is clear from the context the network of service providers assembled by a local mental health authority is the network described by Section 533.035(c), Health and Safety Code. The revised law is drafted accordingly.

(3) Section 531.03132(f), Government Code, refers to entities providing housing for individuals with mental illness in this state, "including the Department of State Health Services." The powers and duties of that department regarding client services were transferred to the Health and Human Services Commission in accordance with Section 531.0201(a)(2)(C), Government Code, which is executed law that expired September 1, 2023. The revised law therefore substitutes "commission" for "Department of State Health Services."

Revised Law

Sec. 526.0008. COMPLIANCE WITH NATIONAL ELECTRONIC DATA INTERCHANGE STANDARDS FOR HEALTH CARE INFORMATION. Each health and human services agency and other state agency that acts as a health care provider or a claims payer for the provision of health care shall:

(1) process information related to health care in compliance with national data interchange standards adopted under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), within the applicable deadline established under federal law or federal regulations; or

(2) demonstrate to the commission the reasons the agency should not be required to comply with Subdivision (1), and to the extent allowed under federal law, obtain the commission's approval to:

(A) comply with the standards at a later date; or

(B) not comply with one or more of the standards.

(Gov. Code, Sec. 531.0315.)

Source Law

Sec. 531.0315. IMPLEMENTING NATIONAL ELECTRONIC DATA INTERCHANGE STANDARDS FOR HEALTH CARE INFORMATION. (a) Each health and human services agency and every other state agency that acts as a health care provider or a claims payer for the provision of health care shall:

(1) process information related to health care in compliance with national data interchange standards adopted under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), and its subsequent amendments, within the applicable deadline established under federal law or federal regulations; or

(2) demonstrate to the commission the reasons the agency should not be required to comply with Subdivision (1), and obtain the commission's approval, to the extent allowed under federal law:

(A) to comply with the standards at a later date; or

(B) to not comply with one or more of the standards.

Revisor's Note

Section 531.0315(a)(1), Government Code, refers to 42 U.S.C. Section 1320d et seq. "and its subsequent amendments." The revised law omits the quoted language because under Section 311.027, Government Code (Code Construction Act), which applies to the revised law, a reference to a statute applies to all reenactments, revisions, or amendments of that

statute, unless expressly provided otherwise.

Revised Law

Sec. 526.0009. TECHNICAL ASSISTANCE FOR HUMAN SERVICES PROVIDERS. (a) A health and human services agency shall, in conjunction with the Department of Information Resources, coordinate and enhance the agency's existing Internet website to provide technical assistance for human services providers. The commission shall take the lead and ensure involvement of the agencies with the greatest potential to produce cost savings.

(b) Assistance provided under this section:

(1) must include information on the impact of federal and state welfare reform changes on human services providers;

(2) may include information in the following subjects:

(A) case management;

(B) contract management;

(C) financial management;

(D) performance measurement and evaluation;

(E) research; and

(F) other matters the commission considers appropriate; and

(3) may not include any confidential information regarding a client of a human services provider. (Gov. Code, Sec. 531.013.)

Source Law

Sec. 531.013. ELECTRONIC AVAILABILITY OF TECHNICAL ASSISTANCE. (a) Health and human services agencies shall, in conjunction with the Department of Information Resources, coordinate and enhance their existing Internet sites to provide technical assistance for human services providers. The commission shall take the lead and ensure involvement of agencies with the greatest potential for cost savings.

(b) Assistance under this section may include information in the following subjects:

(1) case management;
(2) contract management;
(3) financial management;
(4) performance measurement and evaluation;
(5) research; and
(6) other matters the commission considers appropriate.

(c) Assistance under this section must include information on the impact of federal and state welfare reform changes on human services providers.

(d) Assistance under this section may not include any confidential information regarding a client of a human services provider.

Revised Law

Sec. 526.0010. INFORMATION RESOURCES MANAGER REPORTS. Notwithstanding Section 2054.075(b), the information resources manager of a health and human services agency shall report directly to the executive commissioner or a deputy executive commissioner the executive commissioner designates. (Gov. Code, Sec. 531.02731.)

Source Law

Sec. 531.02731. REPORT OF INFORMATION RESOURCES MANAGER TO COMMISSION. Notwithstanding Section 2054.075(b), the information resources manager of a health and human services agency shall report directly to the executive commissioner or a deputy executive commissioner designated by the executive commissioner.

SUBCHAPTER B. PROGRAMS AND SERVICES PROVIDED OR ADMINISTERED BY COMMISSION

Revised Law

Sec. 526.0051. RESTRICTIONS ON AWARDS TO FAMILY PLANNING SERVICE PROVIDERS. (a) Notwithstanding any other law, money appropriated to the commission for the purpose of providing family planning services must be awarded:

(1) to eligible entities in the following order of descending priority:

(A) public entities that provide family planning services, including state, county, and local community health clinics and federally qualified health centers;

(B) nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services; and

(C) nonpublic entities that provide family planning services but do not provide comprehensive primary and preventive care services; or

(2) as otherwise directed by the legislature in the

General Appropriations Act.

(b) Notwithstanding Subsection (a), the commission shall, in compliance with federal law, ensure distribution of funds for family planning services in a manner that does not severely limit or eliminate access to those services in any region of this state. (Gov. Code, Sec. 531.0025.)

Source Law

> Sec. 531.0025. RESTRICTIONS ON AWARDS TO FAMILY PLANNING SERVICE PROVIDERS. (a) Notwithstanding any other law, money appropriated to the Department of State Health Services for the purpose of providing family planning services must be awarded:
>
> (1) to eligible entities in the following order of descending priority:
>
> (A) public entities that provide family planning services, including state, county, and local community health clinics and federally qualified health centers;
>
> (B) nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services; and
>
> (C) nonpublic entities that provide family planning services but do not provide comprehensive primary and preventive care services; or
>
> (2) as otherwise directed by the legislature in the General Appropriations Act.
>
> (b) Notwithstanding Subsection (a), the Department of State Health Services shall, in compliance with federal law, ensure distribution of funds for family planning services in a manner that does not severely limit or eliminate access to those services in any region of the state.

Revisor's Note

Section 531.0025, Government Code, refers to money appropriated to the "Department of State Health Services" for the purpose of providing family planning services. The revised law substitutes "commission" for "Department of State Health Services" for the reason stated in Revisor's Note (3) to Section 526.0007.

Revised Law

Sec. 526.0052. INFORMATION FOR CERTAIN ENROLLEES IN HEALTHY TEXAS WOMEN PROGRAM. (a) In this section, "Healthy Texas Women program" means a program the commission operates that is substantially similar to the demonstration project operated under former Section 32.0248, Human Resources Code, and that is intended

to expand access to preventive health and family planning services for women in this state.

(b) This section applies to a woman who is automatically enrolled in the Healthy Texas Women program following a pregnancy for which the woman received Medicaid, but who is no longer eligible to participate in Medicaid.

(c) After a woman to whom this section applies is enrolled in the Healthy Texas Women program, the commission shall provide to the woman:

(1) information about the Healthy Texas Women program, including the services provided under the program; and

(2) a list of health care providers who participate in the Healthy Texas Women program and are located in the same geographical area in which the woman resides.

(d) The commission shall consult with the Texas Maternal Mortality and Morbidity Review Committee established under Chapter 34, Health and Safety Code, to improve the process for providing the information required by Subsection (c), including by determining:

(1) the best time for providing the information; and

(2) the manner of providing the information, including the information about health care providers described by Subsection (c)(2). (Gov. Code, Sec. 531.0995.)

Source Law

Sec. 531.0995. INFORMATION FOR CERTAIN ENROLLEES IN THE HEALTHY TEXAS WOMEN PROGRAM. (a) In this section, "Healthy Texas Women program" means a program operated by the commission that is substantially similar to the demonstration project operated under former Section 32.0248, Human Resources Code, and that is intended to expand access to preventive health and family planning services for women in this state.

(b) This section applies to a woman who is automatically enrolled in the Healthy Texas Women program following a pregnancy for which the woman received Medicaid, but who is no longer eligible to participate in Medicaid.

(c) After a woman described by Subsection (b) is enrolled in the Healthy Texas Women program, the commission shall provide to the woman:

(1) information about the Healthy Texas Women program, including the services provided under the program; and

(2) a list of health care providers who

participate in the Healthy Texas Women program and are located in the same geographical area in which the woman resides.

(d) The commission shall consult with the Maternal Mortality and Morbidity Task Force established under Chapter 34, Health and Safety Code, to improve the process for providing the information required by Subsection (c), including by determining:

(1) the best time for providing the information; and

(2) the manner by which the information should be provided, including the information about health care providers described by Subsection (c)(2).

Revisor's Note

Section 531.0995(d), Government Code, requires the commission to consult with the "Maternal Mortality and Morbidity Task Force" established under Chapter 34, Health and Safety Code. The revised law substitutes "Texas Maternal Mortality and Morbidity Review Committee" for the quoted language to reflect a change in the entity's name made by Chapter 601 (S.B. 750), Acts of the 86th Legislature, Regular Session, 2019, amending Chapter 34, Health and Safety Code.

Revised Law

Sec. 526.0053. VACCINES FOR CHILDREN PROGRAM PROVIDER ENROLLMENT; IMMUNIZATION REGISTRY. (a) In this section, "vaccines for children program" means the program the Department of State Health Services operates under 42 U.S.C. Section 1396s.

(b) The commission shall ensure that a provider may enroll in the vaccines for children program on the same form the provider completes to apply as a Medicaid health care provider.

(c) The commission shall allow providers to:

(1) report vaccines administered under the vaccines for children program to the immunization registry established under Section 161.007, Health and Safety Code; and

(2) use the immunization registry, including individually identifiable information in accordance with state and federal law, to determine whether a child received an immunization. (Gov. Code, Sec. 531.064.)

Source Law

Sec. 531.064. VACCINES FOR CHILDREN PROGRAM PROVIDER ENROLLMENT AND REIMBURSEMENT. (a) In this section, "vaccines for children program" means the program operated by the Department of State Health Services under authority of 42 U.S.C. Section 1396s, as amended.

(b) The commission shall ensure that a provider can enroll in the vaccines for children program on the same form the provider completes to apply as a Medicaid health care provider.

(c) The commission shall allow providers to report vaccines administered under the vaccines for children program to the immunization registry established under Section 161.007, Health and Safety Code, and to use the immunization registry, including individually identifiable information in accordance with state and federal law, to determine whether a child has received an immunization.

Revisor's Note

Section 531.064(a), Government Code, refers to a program operated under the authority of 42 U.S.C. Section 1396s, "as amended." The revised law omits the quoted language for the reason stated in the revisor's note to Section 526.0008 of this chapter.

Revised Law

Sec. 526.0054. PRIOR AUTHORIZATION FOR HIGH-COST MEDICAL SERVICES AND PROCEDURES. (a) The commission may:

(1) evaluate and implement, as appropriate, procedures, policies, and methodologies to require prior authorization for high-cost medical services and procedures; and

(2) contract with qualified service providers or organizations to perform those functions.

(b) A procedure, policy, or methodology implemented under this section must comply with any prohibitions in state or federal law on limits in the amount, duration, or scope of medically necessary services for Medicaid recipients who are children. (Gov. Code, Sec. 531.075.)

Source Law

Sec. 531.075. PRIOR AUTHORIZATION FOR HIGH-COST MEDICAL SERVICES. The commission may evaluate and implement, as appropriate, procedures, policies, and methodologies to require prior authorization for high-cost medical services and procedures and may contract with qualified service providers or

organizations to perform those functions. Any such program shall recognize any prohibitions in state or federal law on limits in the amount, duration, or scope of medically necessary services for children on Medicaid.

Revisor's Note

(1) Section 531.075, Government Code, states that a program "shall" recognize certain prohibitions on limiting Medicaid services. The revised law substitutes "must" for "shall" for the reason stated in the revisor's note to Section 526.0006.

(2) Section 531.075, Government Code, requires "[a]ny such program" to "recognize" certain prohibitions on limiting Medicaid services. For clarity and the convenience of the reader, the revised law substitutes "[a] procedure, policy, or methodology implemented under this section" for "any such program" because it is clear from the context that "program" refers to a procedure, policy, or methodology implemented under the section. For clarity and the convenience of the reader, the revised law also substitutes "comply with" for "recognize" because, in context, the meaning is the same and "comply with" is more commonly used.

Revised Law

Sec. 526.0055. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) The commission shall identify state or federal non-Medicaid programs that provide health care services to individuals whose health care needs could be met by providing customized benefits through a system of care that is used under a Medicaid tailored benefit package implemented under Section 532.0351.

(b) If the commission determines it is feasible and to the extent permitted by federal and state law, the commission shall:

(1) provide the health care services for individuals described by Subsection (a) through the applicable Medicaid

tailored benefit package; and

(2) if appropriate or necessary to provide the services as required by Subdivision (1), develop and implement a system of blended funding methodologies to provide the services in that manner. (Gov. Code, Sec. 531.0971.)

Source Law

> Sec. 531.0971. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) The commission shall identify state or federal non-Medicaid programs that provide health care services to persons whose health care needs could be met by providing customized benefits through a system of care that is used under a Medicaid tailored benefit package implemented under Section 531.097.
>
> (b) If the commission determines that it is feasible and to the extent permitted by federal and state law, the commission shall:
>
> (1) provide the health care services for persons identified under Subsection (a) through the applicable Medicaid tailored benefit package; and
>
> (2) if appropriate or necessary to provide the services as required by Subdivision (1), develop and implement a system of blended funding methodologies to provide the services in that manner.

Revised Law

Sec. 526.0056. PILOT PROGRAM TO PREVENT SPREAD OF INFECTIOUS OR COMMUNICABLE DISEASES. The commission may provide guidance to the local health authority of Bexar County in establishing a pilot program funded by the county to prevent the spread of HIV, hepatitis B, hepatitis C, and other infectious and communicable diseases. The program may include a disease control program that provides for the anonymous exchange of used hypodermic needles and syringes. (Gov. Code, Sec. 531.0972.)

Source Law

> Sec. 531.0972. PILOT PROGRAM TO PREVENT THE SPREAD OF CERTAIN INFECTIOUS OR COMMUNICABLE DISEASES. The commission may provide guidance to the local health authority of Bexar County in establishing a pilot program funded by the county to prevent the spread of HIV, hepatitis B, hepatitis C, and other infectious and communicable diseases. The program may include a disease control program that provides for the anonymous exchange of used hypodermic needles and syringes.

Revised Law

Sec. 526.0057. APPLICATION REQUIREMENT FOR COLONIAS PROJECTS. (a) In this section, "colonia" means a geographic area

that:

(1) is an economically distressed area as defined by Section 17.921, Water Code;

(2) is located in a county any part of which is within 62 miles of an international border; and

(3) consists of 11 or more dwellings located in proximity to each other in an area that may be described as a community or neighborhood.

(b) The commission shall require an applicant for funds under any project the commission funds that provides assistance to colonias to submit to the commission any existing colonia classification number for each colonia that may be served by the project proposed in the application.

(c) The commission may contact the secretary of state or the secretary of state's representative to obtain a classification number for a colonia that does not have a classification number. On request of the commission, the secretary of state or the secretary of state's representative shall assign a classification number to the colonia. (Gov. Code, Sec. 531.0141.)

Source Law

Sec. 531.0141. APPLICATION REQUIREMENT FOR COLONIAS PROJECTS. (a) In this section, "colonia" means a geographic area that:

(1) is an economically distressed area as defined by Section 17.921, Water Code;

(2) is located in a county any part of which is within 62 miles of an international border; and

(3) consists of 11 or more dwellings that are located in close proximity to each other in an area that may be described as a community or neighborhood.

(d) Regarding any projects funded by the commission that provide assistance to colonias, the commission shall require an applicant for the funds to submit to the commission a colonia classification number, if one exists, for each colonia that may be served by the project proposed in the application. If a colonia does not have a classification number, the commission may contact the secretary of state or the secretary of state's representative to obtain the classification number. On request of the commission, the secretary of state or the secretary of state's representative shall assign a classification number to the colonia.

Revised Law

Sec. 526.0058. RULES REGARDING REFUGEE RESETTLEMENT. (a) In this section, "local resettlement agency" and "national voluntary agency" have the meanings assigned by 45 C.F.R. Section 400.2.

(b) The executive commissioner shall adopt rules to ensure that:

(1) any refugee placement report required under a federal refugee resettlement program includes local governmental and community input; and

(2) governmental entities and officials are provided with related information.

(c) In adopting the rules, the executive commissioner shall, to the extent permitted by federal law, ensure that meetings are convened at least quarterly in the communities proposed for refugee placement at which representatives of local resettlement agencies have an opportunity to consult with and obtain feedback regarding proposed refugee placement from:

(1) local governmental entities and officials, including:

(A) municipal and county officials;

(B) local school district officials; and

(C) representatives of local law enforcement agencies; and

(2) other community stakeholders, including:

(A) major providers under the local health care system; and

(B) major employers of refugees.

(d) In adopting the rules, the executive commissioner shall, to the extent permitted by federal law, ensure that:

(1) a local resettlement agency:

(A) considers all feedback obtained in meetings conducted under Subsection (c) before preparing a proposed annual report on the placement of refugees for purposes of 8 U.S.C. Section

1522(b)(7)(E);

(B) informs the state and local governmental entities and officials and community stakeholders described by Subsection (c) of the proposed annual report; and

(C) develops a final annual report for the national voluntary agencies and the commission that includes a summary regarding the manner in which stakeholder input contributed to the report; and

(2) the commission:

(A) obtains from local resettlement agencies the preliminary number of refugees the local resettlement agencies recommended to the national voluntary agencies for placement in communities throughout this state and provides that information to local governmental entities and officials in those communities; and

(B) obtains from the United States Department of State or other appropriate federal agency the number of refugees apportioned to this state and provides that information and information regarding the number of refugees intended to be placed in each community in this state to local governmental entities and officials in those communities. (Gov. Code, Sec. 531.0411.)

Source Law

Sec. 531.0411. RULES REGARDING REFUGEE RESETTLEMENT. (a) In this section, "local resettlement agency" and "national voluntary agency" have the meanings assigned by 45 C.F.R. Section 400.2.

(b) The executive commissioner shall adopt rules to ensure that local governmental and community input is included in any refugee placement report required under a federal refugee resettlement program and that governmental entities and officials are provided with related information. In adopting rules under this section, the executive commissioner shall, to the extent permitted under federal law, ensure that:

(1) meetings are convened, at least quarterly, in the communities proposed for refugee placement at which representatives of local resettlement agencies have an opportunity to consult with and obtain feedback from local governmental entities and officials, including municipal and county officials, local school district officials, and representatives of local law enforcement agencies, and from other community stakeholders, including major providers under the local health care system and major employers of refugees, regarding proposed refugee placement;

(2) a local resettlement agency:

(A) considers all feedback obtained in meetings conducted under Subdivision (1) before preparing a proposed annual report on the placement of refugees for purposes of 8 U.S.C. Section 1522(b)(7)(E);

(B) informs the state and local governmental entities and officials and community stakeholders described under Subdivision (1) of the proposed annual report; and

(C) develops a final annual report for the national voluntary agencies and the commission that includes a summary regarding how stakeholder input contributed to the report; and

(3) the commission:

(A) obtains from local resettlement agencies the preliminary number of refugees the local resettlement agencies recommended to the national voluntary agencies for placement in communities throughout this state and provides that information to local governmental entities and officials in those communities; and

(B) obtains from the United States Department of State or other appropriate federal agency the number of refugees apportioned to this state and provides that information and information regarding the number of refugees intended to be placed in each community in this state to local governmental entities and officials in those communities.

Revised Law

Sec. 526.0059. PROHIBITED AWARD OF CONTRACTS TO MANAGED CARE ORGANIZATIONS FOR CERTAIN CRIMINAL CONVICTIONS. The commission may not contract with a managed care organization, including a health maintenance organization, or a pharmacy benefit manager if, in the preceding three years, the organization or manager, in connection with a bid, proposal, or contract with the commission, was subject to a final judgment by a court of competent jurisdiction resulting in:

(1) a conviction for:

(A) a criminal offense under state or federal law related to the delivery of an item or service;

(B) a criminal offense under state or federal law related to neglect or abuse of patients in connection with the delivery of an item or service; or

(C) a felony offense under state or federal law related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

(2) the imposition of a penalty or fine in the amount

of $500,000 or more in a state or federal administrative proceeding based on a conviction for a criminal offense under state or federal law. (Gov. Code, Sec. 531.0696.)

Source Law

> Sec. 531.0696. CONSIDERATIONS IN AWARDING CERTAIN CONTRACTS. The commission may not contract with a managed care organization, including a health maintenance organization, or a pharmacy benefit manager if, in the preceding three years, the organization or pharmacy benefit manager, in connection with a bid, proposal, or contract with the commission, was subject to a final judgment by a court of competent jurisdiction resulting in a conviction for a criminal offense under state or federal law:
>
> (1) related to the delivery of an item or service;
>
> (2) related to neglect or abuse of patients in connection with the delivery of an item or service;
>
> (3) consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or
>
> (4) resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

SUBCHAPTER C. COORDINATION OF QUALITY INITIATIVES

Revised Law

Sec. 526.0101. DEFINITION. In this subchapter, "waiver" means the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315). (New.)

Revisor's Note

> The definition of "waiver" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 526.0102. OPERATIONAL PLAN TO COORDINATE MAJOR QUALITY INITIATIVES. (a) The commission shall develop and implement a comprehensive, coordinated operational plan to ensure a consistent approach across the major quality initiatives of the health and human services system for improving the quality of health care. The plan must include broad goals for improving the quality of health care in this state, including health care services provided through

Medicaid.

(b) The plan may evaluate:

(1) the Delivery System Reform Incentive Payment (DSRIP) program under the waiver;

(2) enhancing funding to disproportionate share hospitals in this state;

(3) Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. Section 18052);

(4) enhancing uncompensated care pool payments to hospitals in this state under the waiver;

(5) home and community-based services state plan options under Section 1915(i) of the Social Security Act (42 U.S.C. Section 1396n(i)); and

(6) a contingency plan in the event the commission does not obtain an extension or renewal of the uncompensated care pool provisions or any other provisions of the granted waiver. (Gov. Code, Sec. 531.451.)

Source Law

> Sec. 531.451. OPERATIONAL PLAN TO COORDINATE INITIATIVES. (a) The commission shall develop and implement a comprehensive, coordinated operational plan to ensure a consistent approach across the major quality initiatives of the health and human services system for improving the quality of health care.
>
> (b) The operational plan developed under this section must include broad goals for the improvement of the quality of health care in this state, including health care services provided through Medicaid.
>
> (c) The operational plan under this section may evaluate: the Delivery System Reform Incentive Payment (DSRIP) program under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), enhancing funding to disproportionate share hospitals in the state, Section 1332 of 42 U.S.C. Section 18052, enhancing uncompensated care pool payments to hospitals in the state under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), home and community-based services state plan options under Section 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n), and a contingency plan in the event the commission does not obtain an extension or renewal of the uncompensated care pool provisions or any other provisions of the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social

Security Act (42 U.S.C. Section 1315).

Revised Law

Sec. 526.0103. REVISION AND EVALUATION OF MAJOR QUALITY INITIATIVES. Notwithstanding other law, the commission shall revise major quality initiatives of the health and human services system in accordance with the operational plan and health care quality improvement goals developed under Section 526.0102. To the extent possible, the commission shall ensure that outcome measure data is collected and reported consistently across all major quality initiatives to improve the evaluation of the initiatives' statewide impact. (Gov. Code, Sec. 531.452.)

Source Law

> Sec. 531.452. REVISION OF MAJOR INITIATIVES. Notwithstanding any other law, the commission shall revise major quality initiatives of the health and human services system in accordance with the operational plan and health care quality improvement goals developed under Section 531.451. To the extent it is possible, the commission shall ensure that outcome measure data is collected and reported consistently across all major quality initiatives to improve the evaluation of the initiatives' statewide impact.

Revised Law

Sec. 526.0104. INCENTIVES FOR MAJOR QUALITY INITIATIVE COORDINATION. The commission shall consider and, if appropriate, develop in accordance with this subchapter, incentives that promote coordination among the various major quality initiatives, including projects and initiatives approved under the granted waiver. (Gov. Code, Sec. 531.453.)

Source Law

> Sec. 531.453. INCENTIVES FOR INITIATIVE COORDINATION. The commission shall consider and, if the commission determines it appropriate, develop incentives that promote coordination among the various major quality initiatives in accordance with this subchapter, including projects and initiatives approved under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315).

SUBCHAPTER D. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND

Revised Law

Sec. 526.0151. DEFINITION. In this subchapter, "fund"

means the Texas health opportunity pool trust fund established under Section 526.0153. (Gov. Code, Sec. 531.501.)

Source Law

Sec. 531.501. DEFINITION. In this subchapter, "fund" means the Texas health opportunity pool trust fund established under Section 531.503.

Revised Law

Sec. 526.0152. AUTHORITY TO OBTAIN FEDERAL WAIVER. (a) The executive commissioner may seek a waiver under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan to allow the commission to more efficiently and effectively use federal money paid to this state under various programs to defray costs associated with providing uncompensated health care in this state by using that federal money, appropriated state money to the extent necessary, and any other money described by this section for purposes consistent with this subchapter.

(b) The executive commissioner may include the following federal money in the waiver:

(1) money provided under:

(A) the disproportionate share hospitals program;

(B) the upper payment limit supplemental payment program; or

(C) both;

(2) money provided by the federal government in lieu of some or all of the payments provided under one or both of the programs described by Subdivision (1);

(3) any combination of funds authorized to be pooled by Subdivisions (1) and (2); and

(4) any other money available for that purpose, including:

(A) federal money and money identified under Subsection (c);

(B) gifts, grants, or donations for that purpose;

(C) local funds received by this state through

intergovernmental transfers; and

(D) if approved in the waiver, federal money obtained through the use of certified public expenditures.

(c) The commission shall seek to optimize federal funding by:

(1) identifying health care-related state and local funds and program expenditures that, before September 1, 2011, are not being matched with federal money; and

(2) exploring the feasibility of:

(A) certifying or otherwise using those funds and expenditures as state expenditures for which this state may receive federal matching money; and

(B) depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 526.0154, or substituting that federal matching money for federal money that otherwise would be received under the disproportionate share hospitals and upper payment limit supplemental payment programs as a match for local funds received by this state through intergovernmental transfers.

(d) The terms of a waiver approved under this section must:

(1) include safeguards to ensure that the total amount of federal money provided under the disproportionate share hospitals or upper payment limit supplemental payment program that is deposited as provided by Section 526.0154 is, for a particular state fiscal year, at least equal to the greater of the annualized amount provided to this state under those supplemental payment programs during:

(A) state fiscal year 2011, excluding retroactive payment amounts provided during that state fiscal year; or

(B) the state fiscal years during which the waiver is in effect; and

(2) allow this state to develop a methodology for allocating money in the fund to:

(A) supplement Medicaid hospital reimbursements under a waiver that includes terms consistent with, or that produce revenues consistent with, disproportionate share hospital and upper payment limit principles;

(B) reduce the number of individuals in this state who do not have health benefits coverage; and

(C) maintain and enhance the community public health infrastructure provided by hospitals.

(e) In seeking a waiver under this section, the executive commissioner shall attempt to:

(1) obtain maximum flexibility in the use of the money in the fund for purposes consistent with this subchapter;

(2) include an annual adjustment to the aggregate caps under the upper payment limit supplemental payment program to account for inflation, population growth, and other appropriate demographic factors that affect the ability of residents of this state to obtain health benefits coverage;

(3) ensure, for the term of the waiver, that the aggregate caps under the upper payment limit supplemental payment program for each of the three classes of hospitals are not less than the aggregate caps applied during state fiscal year 2007; and

(4) to the extent allowed by federal law, including federal regulations, and federal waiver authority, preserve the federal supplemental payment program payments made to hospitals, the state match with respect to which is funded by intergovernmental transfers or certified public expenditures that are used to optimize Medicaid payments to safety net providers for uncompensated care, and preserve allocation methods for those payments, unless the need for the payments is revised through measures that reduce the Medicaid shortfall or uncompensated care costs.

(f) The executive commissioner shall seek broad-based stakeholder input in the development of the waiver under this section and shall provide information to stakeholders regarding the

terms of the waiver for which the executive commissioner seeks federal approval. (Gov. Code, Sec. 531.502.)

Source Law

Sec. 531.502. DIRECTION TO OBTAIN FEDERAL WAIVER. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan to allow the commission to more efficiently and effectively use federal money paid to this state under various programs to defray costs associated with providing uncompensated health care in this state by using that federal money, appropriated state money to the extent necessary, and any other money described by this section for purposes consistent with this subchapter.

(b) The executive commissioner may include the following federal money in the waiver:

(1) money provided under the disproportionate share hospitals or upper payment limit supplemental payment program, or both;

(2) money provided by the federal government in lieu of some or all of the payments under one or both of those programs;

(3) any combination of funds authorized to be pooled by Subdivisions (1) and (2); and

(4) any other money available for that purpose, including:

(A) federal money and money identified under Subsection (c);

(B) gifts, grants, or donations for that purpose;

(C) local funds received by this state through intergovernmental transfers; and

(D) if approved in the waiver, federal money obtained through the use of certified public expenditures.

(c) The commission shall seek to optimize federal funding by:

(1) identifying health care related state and local funds and program expenditures that, before September 1, 2011, are not being matched with federal money; and

(2) exploring the feasibility of:

(A) certifying or otherwise using those funds and expenditures as state expenditures for which this state may receive federal matching money; and

(B) depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 531.504, or substituting that federal matching money for federal money that otherwise would be received under the disproportionate share hospitals and upper payment limit supplemental payment programs as a match for local funds received by this state through intergovernmental transfers.

(d) The terms of a waiver approved under this section must:

(1) include safeguards to ensure that the total amount of federal money provided under the disproportionate share hospitals or upper payment limit supplemental payment program that is deposited as provided by Section 531.504 is, for a particular state fiscal year, at least equal to the greater of the

annualized amount provided to this state under those supplemental payment programs during state fiscal year 2011, excluding amounts provided during that state fiscal year that are retroactive payments, or the state fiscal years during which the waiver is in effect; and

(2) allow for the development by this state of a methodology for allocating money in the fund to:

(A) be used to supplement Medicaid hospital reimbursements under a waiver that includes terms that are consistent with, or that produce revenues consistent with, disproportionate share hospital and upper payment limit principles;

(B) reduce the number of persons in this state who do not have health benefits coverage; and

(C) maintain and enhance the community public health infrastructure provided by hospitals.

(e) In a waiver under this section, the executive commissioner shall seek to:

(1) obtain maximum flexibility with respect to using the money in the fund for purposes consistent with this subchapter;

(2) include an annual adjustment to the aggregate caps under the upper payment limit supplemental payment program to account for inflation, population growth, and other appropriate demographic factors that affect the ability of residents of this state to obtain health benefits coverage;

(3) ensure, for the term of the waiver, that the aggregate caps under the upper payment limit supplemental payment program for each of the three classes of hospitals are not less than the aggregate caps that applied during state fiscal year 2007; and

(4) to the extent allowed by federal law, including federal regulations, and federal waiver authority, preserve the federal supplemental payment program payments made to hospitals, the state match with respect to which is funded by intergovernmental transfers or certified public expenditures that are used to optimize Medicaid payments to safety net providers for uncompensated care, and preserve allocation methods for those payments, unless the need for the payments is revised through measures that reduce the Medicaid shortfall or uncompensated care costs.

(f) The executive commissioner shall seek broad-based stakeholder input in the development of the waiver under this section and shall provide information to stakeholders regarding the terms and components of the waiver for which the executive commissioner seeks federal approval.

Revisor's Note

Section 531.502(f), Government Code, refers to the "terms and components" of a waiver. In this section, the revised law omits "and components" from the quoted phrase because, in context, the meaning of "components" is included in the meaning of "terms."

Revised Law

Sec. 526.0153. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND ESTABLISHED. (a) Subject to approval of the waiver authorized by Section 526.0152, the Texas health opportunity pool trust fund is created as a trust fund outside the state treasury to be held by the comptroller and administered by the commission as trustee on behalf of residents of this state who do not have private health benefits coverage and health care providers providing uncompensated care to those individuals.

(b) The commission may spend money in the fund only for purposes consistent with this subchapter and the terms of the waiver authorized by Section 526.0152. (Gov. Code, Sec. 531.503.)

Source Law

> Sec. 531.503. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL TRUST FUND. Subject to approval of the waiver authorized by Section 531.502, the Texas health opportunity pool trust fund is created as a trust fund outside the state treasury to be held by the comptroller and administered by the commission as trustee on behalf of residents of this state who do not have private health benefits coverage and health care providers providing uncompensated care to those persons. The commission may make expenditures of money in the fund only for purposes consistent with this subchapter and the terms of the waiver authorized by Section 531.502.

Revised Law

Sec. 526.0154. DEPOSITS TO FUND. (a) The comptroller shall deposit in the fund:

(1) federal money provided to this state under the disproportionate share hospitals supplemental payment program, the hospital upper payment limit supplemental payment program, or both, other than money provided under those programs to state-owned and -operated hospitals, and all other nonsupplemental payment program federal money provided to this state that is included in the waiver authorized by Section 526.0152; and

(2) state money appropriated to the fund.

(b) The commission and comptroller may accept gifts, grants, and donations from any source, and receive intergovernmental transfers, for purposes consistent with this

subchapter and the terms of the waiver authorized by Section 526.0152. The comptroller shall deposit a gift, grant, or donation made for those purposes in the fund.

(c) Any intergovernmental transfer received, including associated federal matching funds, shall be used, if feasible, for the purposes intended by the transferring entity and in accordance with the terms of the waiver authorized by Section 526.0152. (Gov. Code, Sec. 531.504.)

Source Law

> Sec. 531.504. DEPOSITS TO FUND. (a) The comptroller shall deposit in the fund:
>
> (1) federal money provided to this state under the disproportionate share hospitals supplemental payment program or the hospital upper payment limit supplemental payment program, or both, other than money provided under those programs to state-owned and operated hospitals, and all other non-supplemental payment program federal money provided to this state that is included in the waiver authorized by Section 531.502; and
>
> (2) state money appropriated to the fund.
>
> (b) The commission and comptroller may accept gifts, grants, and donations from any source, and receive intergovernmental transfers, for purposes consistent with this subchapter and the terms of the waiver. The comptroller shall deposit a gift, grant, or donation made for those purposes in the fund. Any intergovernmental transfer received, including associated federal matching funds, shall be used, if feasible, for the purposes intended by the transferring entity and in accordance with the terms of the waiver.

Revised Law

Sec. 526.0155. USE OF FUND IN GENERAL; RULES FOR ALLOCATION. (a) Except as otherwise provided by the terms of a waiver authorized by Section 526.0152, money in the fund may be used:

(1) subject to Section 526.0156, to provide to health care providers reimbursements that:

(A) are based on the providers' costs related to providing uncompensated care; and

(B) compensate the providers for at least a portion of those costs;

(2) to reduce the number of individuals in this state who do not have health benefits coverage;

(3) to reduce the need for uncompensated health care provided by hospitals in this state; and

(4) for any other purpose specified by this subchapter or the waiver.

(b) On approval of the waiver authorized by Section 526.0152, the executive commissioner shall:

(1) seek input from a broad base of stakeholder representatives on the development of rules with respect to and for the administration of the fund; and

(2) by rule develop a methodology for allocating money in the fund that is consistent with the terms of the waiver. (Gov. Code, Sec. 531.505.)

Source Law

> Sec. 531.505. USE OF FUND IN GENERAL; RULES FOR ALLOCATION. (a) Except as otherwise provided by the terms of a waiver authorized by Section 531.502, money in the fund may be used:
>
> (1) subject to Section 531.506, to provide reimbursements to health care providers that:
>
> (A) are based on the providers' costs related to providing uncompensated care; and
>
> (B) compensate the providers for at least a portion of those costs;
>
> (2) to reduce the number of persons in this state who do not have health benefits coverage;
>
> (3) to reduce the need for uncompensated health care provided by hospitals in this state; and
>
> (4) for any other purpose specified by this subchapter or the waiver.
>
> (b) On approval of the waiver, the executive commissioner shall:
>
> (1) seek input from a broad base of stakeholder representatives on the development of rules with respect to, and the administration of, the fund; and
>
> (2) by rule develop a methodology for allocating money in the fund that is consistent with the terms of the waiver.

Revised Law

Sec. 526.0156. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Except as otherwise provided by the terms of a waiver authorized by Section 526.0152 and subject to Subsections (b) and (c), money in the fund may be allocated to hospitals in this state and political subdivisions of this state to defray the costs of providing uncompensated health care.

(b) To be eligible for money allocated from the fund under

this section, a hospital or political subdivision must use a portion of the money to implement strategies that will reduce the need for uncompensated inpatient and outpatient care, including care provided in a hospital emergency room. The strategies may include:

(1) fostering improved access for patients to primary care systems or other programs that offer those patients medical homes, including the following programs:

(A) regional or local health care programs;

(B) programs to provide premium subsidies for health benefits coverage; and

(C) other programs to increase access to health benefits coverage; and

(2) creating health care systems efficiencies, such as using electronic medical records systems.

(c) The allocation methodology the executive commissioner develops under Section 526.0155(b) must specify the percentage of the money from the fund allocated to a hospital or political subdivision that the hospital or political subdivision must use for strategies described by Subsection (b). (Gov. Code, Sec. 531.506.)

Source Law

Sec. 531.506. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Except as otherwise provided by the terms of a waiver authorized by Section 531.502 and subject to Subsections (b) and (c), money in the fund may be allocated to hospitals in this state and political subdivisions of this state to defray the costs of providing uncompensated health care in this state.

(b) To be eligible for money from the fund under this section, a hospital or political subdivision must use a portion of the money to implement strategies that will reduce the need for uncompensated inpatient and outpatient care, including care provided in a hospital emergency room. Strategies that may be implemented by a hospital or political subdivision, as applicable, include:

(1) fostering improved access for patients to primary care systems or other programs that offer those patients medical homes, including the following programs:

(A) regional or local health care programs;

(B) programs to provide premium subsidies for health benefits coverage; and

(C) other programs to increase access

to health benefits coverage; and

(2) creating health care systems efficiencies, such as using electronic medical records systems.

(c) The allocation methodology adopted by the executive commissioner under Section 531.505(b) must specify the percentage of the money from the fund allocated to a hospital or political subdivision that the hospital or political subdivision must use for strategies described by Subsection (b).

Revised Law

Sec. 526.0157. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Except as otherwise provided by the terms of a waiver authorized by Section 526.0152, money in the fund that is available to reduce the number of individuals in this state who do not have health benefits coverage or to reduce the need for uncompensated health care provided by hospitals in this state may be used for purposes relating to increasing access to health benefits coverage for individuals with low income, including:

(1) providing premium payment assistance to those individuals through a premium payment assistance program developed under this section;

(2) making contributions to health savings accounts for those individuals; and

(3) providing other financial assistance to those individuals through alternate mechanisms established by hospitals in this state or political subdivisions of this state that meet certain commission-specified criteria.

(b) The commission and the Texas Department of Insurance shall jointly develop a premium payment assistance program designed to assist individuals described by Subsection (a) in obtaining and maintaining health benefits coverage. The program may provide assistance in the form of payments for all or part of the premiums for that coverage. In developing the program, the executive commissioner shall adopt rules establishing:

(1) eligibility criteria for the program;

(2) the amount of premium payment assistance that will be provided under the program;

(3) the process by which that assistance will be paid;

and

(4) the mechanism for measuring and reporting the number of individuals who obtained health insurance or other health benefits coverage as a result of the program.

(c) The commission shall implement the premium payment assistance program developed under Subsection (b), subject to availability of money in the fund for that purpose. (Gov. Code, Sec. 531.507.)

Source Law

Sec. 531.507. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Except as otherwise provided by the terms of a waiver authorized by Section 531.502, money in the fund that is available to reduce the number of persons in this state who do not have health benefits coverage or to reduce the need for uncompensated health care provided by hospitals in this state may be used for purposes relating to increasing access to health benefits coverage for low-income persons, including:

(1) providing premium payment assistance to those persons through a premium payment assistance program developed under this section;

(2) making contributions to health savings accounts for those persons; and

(3) providing other financial assistance to those persons through alternate mechanisms established by hospitals in this state or political subdivisions of this state that meet certain criteria, as specified by the commission.

(b) The commission and the Texas Department of Insurance shall jointly develop a premium payment assistance program designed to assist persons described by Subsection (a) in obtaining and maintaining health benefits coverage. The program may provide assistance in the form of payments for all or part of the premiums for that coverage. In developing the program, the executive commissioner shall adopt rules establishing:

(1) eligibility criteria for the program;

(2) the amount of premium payment assistance that will be provided under the program;

(3) the process by which that assistance will be paid; and

(4) the mechanism for measuring and reporting the number of persons who obtained health insurance or other health benefits coverage as a result of the program.

(c) The commission shall implement the premium payment assistance program developed under Subsection (b), subject to availability of money in the fund for that purpose.

Revised Law

Sec. 526.0158. INFRASTRUCTURE IMPROVEMENTS. (a) Except as otherwise provided by the terms of a waiver authorized by Section

526.0152 and subject to Subsection (c), money in the fund may be used for purposes related to developing and implementing initiatives to improve the infrastructure of local provider networks that provide services to Medicaid recipients and individuals with low income and without health benefits coverage in this state.

(b) The infrastructure improvements may include developing and implementing a system for maintaining medical records in an electronic format.

(c) Not more than 10 percent of the total amount of the money in the fund used in a state fiscal year for purposes other than providing reimbursements to hospitals for uncompensated health care may be used for infrastructure improvements described by Subsection (b).

(d) Money from the fund may not be used to finance the construction, improvement, or renovation of a building or land unless the commission approves the construction, improvement, or renovation in accordance with rules the executive commissioner adopts for that purpose. (Gov. Code, Sec. 531.508.)

Source Law

Sec. 531.508. INFRASTRUCTURE IMPROVEMENTS. (a) Except as otherwise provided by the terms of a waiver authorized by Section 531.502 and subject to Subsection (c), money in the fund may be used for purposes related to developing and implementing initiatives to improve the infrastructure of local provider networks that provide services to Medicaid recipients and low-income uninsured persons in this state.

(b) Infrastructure improvements under this section may include developing and implementing a system for maintaining medical records in an electronic format.

(c) Not more than 10 percent of the total amount of the money in the fund used in a state fiscal year for purposes other than providing reimbursements to hospitals for uncompensated health care may be used for infrastructure improvements described by Subsection (b).

(d) Money from the fund may not be used to finance the construction, improvement, or renovation of a building or land unless the construction, improvement, or renovation is approved by the commission, according to rules adopted by the executive commissioner for that purpose.

Revisor's Note

Section 531.508(a), Government Code, refers to "uninsured" persons in this state. The revised law substitutes "without health benefits coverage" for "uninsured" because, in context, the meaning is the same and "without health benefits coverage" is more commonly used.

SUBCHAPTER E. LONG-TERM CARE FACILITIES

Revised Law

Sec. 526.0201. DEFINITION. In this subchapter, "council" means the Long-Term Care Facilities Council. (Gov. Code, Sec. 531.0581(a)(1).)

Source Law

Sec. 531.0581. LONG-TERM CARE FACILITIES COUNCIL. (a) In this section:

(1) "Council" means the Long-Term Care Facilities Council.

Revisor's Note

Section 531.0581(a), Government Code, provides definitions for "this section." The revised law substitutes "this subchapter" for "this section" because the provisions of Section 531.0581 are revised as Subchapter E of this chapter.

Revised Law

Sec. 526.0202. INFORMAL DISPUTE RESOLUTION FOR CERTAIN LONG-TERM CARE FACILITIES. (a) The executive commissioner by rule shall establish an informal dispute resolution process in accordance with this section. The process must:

(1) provide for adjudication by an appropriate disinterested person of disputes relating to a proposed commission enforcement action or related proceeding under:

(A) Section 32.021(d), Human Resources Code; or

(B) Chapter 242, 247, or 252, Health and Safety Code; and

(2) require:

(A) a facility to request informal dispute resolution not later than the 10th calendar day after the commission notifies the facility of the violation of a standard or standards; and

(B) the completion of the process not later than:

(i) the 30th calendar day after receipt of a request for informal dispute resolution from a facility, other than an assisted living facility; or

(ii) the 90th calendar day after receipt of a request from an assisted living facility for informal dispute resolution.

(b) As part of the informal dispute resolution process, the commission shall contract with an appropriate disinterested person to adjudicate disputes between a facility licensed under Chapter 242 or 247, Health and Safety Code, and the commission concerning a statement of violations the commission prepares in connection with a survey the commission conducts of the facility. The contracting person shall adjudicate all disputes described by this subsection. The informal dispute resolution process for the statement of violations must require:

(1) the surveyor who conducted the survey for which the statement was prepared to be available to clarify or answer questions asked by the contracting person or by the facility related to the facility or statement; and

(2) the commission's review of the facility's informal dispute resolution request for a standard of care violation to be conducted by a registered nurse with long-term care experience.

(c) Section 2009.053 does not apply to the commission's selection of an appropriate disinterested person under Subsection (b).

(d) The executive commissioner shall adopt rules to adjudicate claims in contested cases.

(e) The commission may not delegate to another state agency the commission's responsibility to administer the informal dispute

resolution process.

(f) The rules adopted under Subsection (a) that relate to a dispute described by Section 247.051(a), Health and Safety Code, must incorporate the requirements of Section 247.051, Health and Safety Code. (Gov. Code, Sec. 531.058.)

Source Law

Sec. 531.058. INFORMAL DISPUTE RESOLUTION FOR CERTAIN LONG-TERM CARE FACILITIES. (a) [as amended Acts 85th Leg., R.S., Ch. 590] The executive commissioner by rule shall establish an informal dispute resolution process in accordance with this section. The process must provide for adjudication by an appropriate disinterested person of disputes relating to a proposed enforcement action or related proceeding of the commission under Section 32.021(d), Human Resources Code, or under Chapter 242, 247, or 252, Health and Safety Code. The informal dispute resolution process must require:

(1) an institution or facility to request informal dispute resolution not later than the 10th calendar day after notification by the commission of the violation of a standard or standards; and

(2) the completion of the process not later than:

(A) the 30th calendar day after receipt of a request from an institution or facility, other than an assisted living facility, for informal dispute resolution; or

(B) the 90th calendar day after receipt of a request from an assisted living facility for informal dispute resolution.

(a) [as amended Acts 85th Leg., R.S., Ch. 836] The executive commissioner by rule shall establish an informal dispute resolution process in accordance with this section. The process must provide for adjudication by an appropriate disinterested person of disputes relating to a proposed enforcement action or related proceeding of the commission under Section 32.021(d), Human Resources Code, or the Department of Aging and Disability Services or its successor agency under Chapter 242, 247, or 252, Health and Safety Code. The informal dispute resolution process must require:

(1) an institution or facility to request informal dispute resolution not later than the 10th calendar day after notification by the commission or department, as applicable, of the violation of a standard or standards; and

(2) the commission to complete the process not later than:

(A) the 30th calendar day after receipt of a request from an institution or facility, other than an assisted living facility, for informal dispute resolution; or

(B) the 90th calendar day after receipt of a request from an assisted living facility for informal dispute resolution.

(a-1) As part of the informal dispute resolution process established under this section, the commission shall contract with an appropriate disinterested person to adjudicate disputes between an institution or facility licensed under Chapter 242, Health and

Safety Code, or a facility licensed under Chapter 247, Health and Safety Code, and the commission concerning a statement of violations prepared by the commission in connection with a survey conducted by the commission of the institution or facility. Section 2009.053 does not apply to the selection of an appropriate disinterested person under this subsection. The person with whom the commission contracts shall adjudicate all disputes described by this subsection. The informal dispute resolution process for the statement of violations must require:

(1) the surveyor who conducted the survey for which the statement was prepared to be available to clarify or answer questions related to the facility or the statement that are asked by the person reviewing the dispute or by the facility; and

(2) the commission's review of the institution's or facility's informal dispute resolution request to be conducted by a registered nurse with long-term care experience for a standard of care violation.

(b) The executive commissioner shall adopt rules to adjudicate claims in contested cases.

(c) The commission may not delegate its responsibility to administer the informal dispute resolution process established by this section to another state agency.

(d) The rules adopted by the executive commissioner under Subsection (a) that relate to a dispute described by Section 247.051(a), Health and Safety Code, must incorporate the requirements of Section 247.051, Health and Safety Code.

Revisor's Note

(1) Section 531.058(a), Government Code, as amended by Section 2, Chapter 590 (S.B. 924), Acts of the 85th Legislature, Regular Session, 2017, refers to a proposed enforcement action or related proceeding of the Health and Human Services Commission under certain laws. Section 531.058(a), Government Code, as amended by Section 1, Chapter 836 (H.B. 2025), Acts of the 85th Legislature, Regular Session, 2017, refers to a proposed enforcement action or related proceeding of the commission or Department of Aging and Disability Services under those same laws. For the reason stated in Revisor's Note (1) to Section 526.0003 of this chapter, the revised law omits the references to the department and because of those omissions the statutes may be harmonized. Section 311.025, Government Code (Code Construction Act), provides that if amendments to the same statute are enacted at the same session of

the legislature, the amendments shall be harmonized, if possible, so that effect may be given to each. Therefore, the revised law is drafted accordingly and refers only to the commission.

(2) Section 531.058(a)(1), Government Code, refers to an "institution or facility." The revised law omits "institution" because Section 105.001(6), Health and Safety Code, defines a facility as an institution licensed under Chapter 242 of that code, and "facility" is the more commonly used term.

Revised Law

Sec. 526.0203. LONG-TERM CARE FACILITIES COUNCIL. (a) In this section, "long-term care facility" means a facility subject to regulation under Section 32.021(d), Human Resources Code, or Chapter 242, 247, or 252, Health and Safety Code.

(b) The executive commissioner shall establish a long-term care facilities council as a permanent advisory committee to the commission. The council is composed of the following members the executive commissioner appoints:

(1) at least one member who is a for-profit nursing facility provider;

(2) at least one member who is a nonprofit nursing facility provider;

(3) at least one member who is an assisted living services provider;

(4) at least one member responsible for survey enforcement within the state survey and certification agency;

(5) at least one member responsible for survey inspection within the state survey and certification agency;

(6) at least one member of the state agency responsible for informal dispute resolution;

(7) at least one member with expertise in Medicaid quality-based payment systems for long-term care facilities;

(8) at least one member who is a practicing medical

director of a long-term care facility;

(9) at least one member who is a physician with expertise in infectious disease or public health; and

(10) at least one member who is a community-based provider at an intermediate care facility for individuals with intellectual or developmental disabilities licensed under Chapter 252, Health and Safety Code.

(c) The executive commissioner shall designate a council member to serve as presiding officer. The council members shall elect any other necessary officers.

(d) A council member serves at the will of the executive commissioner.

(e) The council shall meet at the call of the executive commissioner.

(f) A council member is not entitled to reimbursement of expenses or to compensation for service on the council.

(g) Chapter 2110 does not apply to the council. (Gov. Code, Secs. 531.0581(a)(2), (b), (c), (d), (e), (f), (i).)

Source Law

Sec. 531.0581. LONG-TERM CARE FACILITIES COUNCIL. (a) In this section:

(2) "Long-term care facility" means a facility subject to regulation under Section 32.021(d), Human Resources Code, or Chapter 242, 247, or 252, Health and Safety Code.

(b) The executive commissioner shall establish a Long-Term Care Facilities Council as a permanent advisory committee to the commission. The council is composed of the following members appointed by the executive commissioner:

(1) at least one member who is a for-profit nursing facility provider;

(2) at least one member who is a nonprofit nursing facility provider;

(3) at least one member who is an assisted living services provider;

(4) at least one member responsible for survey enforcement within the state survey and certification agency;

(5) at least one member responsible for survey inspection within the state survey and certification agency;

(6) at least one member of the state agency responsible for informal dispute resolution;

(7) at least one member with expertise in Medicaid quality-based payment systems for long-term care facilities;

(8) at least one member who is a practicing medical director of a long-term care facility;

(9) at least one member who is a physician with expertise in infectious disease or public health; and

(10) at least one member who is a community-based provider at an intermediate care facility for individuals with intellectual or developmental disabilities licensed under Chapter 252, Health and Safety Code.

(c) The executive commissioner shall designate a member of the council to serve as presiding officer. The members of the council shall elect any other necessary officers.

(d) A member of the council serves at the will of the executive commissioner.

(e) The council shall meet at the call of the executive commissioner.

(f) A member of the council is not entitled to reimbursement of expenses or to compensation for service on the council.

(i) Chapter 2110 does not apply to the council.

Revised Law

Sec. 526.0204. COUNCIL DUTIES; REPORT. (a) In this section, "long-term care facility" has the meaning assigned by Section 526.0203.

(b) The council shall:

(1) study and make recommendations regarding a consistent survey and informal dispute resolution process for long-term care facilities, Medicaid quality-based payment systems for those facilities, and the allocation of Medicaid beds in those facilities;

(2) study and make recommendations regarding best practices and protocols to make survey, inspection, and informal dispute resolution processes more efficient and less burdensome on long-term care facilities;

(3) recommend uniform standards for those processes;

(4) study and make recommendations regarding Medicaid quality-based payment systems and a rate-setting methodology for long-term care facilities; and

(5) study and make recommendations relating to the allocation of and need for Medicaid beds in long-term care facilities, including studying and making recommendations relating to:

(A) the effectiveness of rules adopted by the executive commissioner relating to the procedures for certifying and decertifying Medicaid beds in long-term care facilities; and

(B) the need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds in long-term care facilities.

(c) Not later than January 1 of each odd-numbered year, the council shall submit a report on the council's findings and recommendations to the executive commissioner, the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate legislative committees. (Gov. Code, Secs. 531.0581(a)(2), (g), (h).)

Source Law

Sec. 531.0581. LONG-TERM CARE FACILITIES COUNCIL. (a) In this section:

(2) "Long-term care facility" means a facility subject to regulation under Section 32.021(d), Human Resources Code, or Chapter 242, 247, or 252, Health and Safety Code.

(g) The council shall study and make recommendations regarding a consistent survey and informal dispute resolution process for long-term care facilities, Medicaid quality-based payment systems for those facilities, and the allocation of Medicaid beds in those facilities. The council shall:

(1) study and make recommendations regarding best practices and protocols to make survey, inspection, and informal dispute resolution processes more efficient and less burdensome on long-term care facilities;

(2) recommend uniform standards for those processes;

(3) study and make recommendations regarding Medicaid quality-based payment systems and a rate-setting methodology for long-term care facilities; and

(4) study and make recommendations relating to the allocation of and need for Medicaid beds in long-term care facilities, including studying and making recommendations relating to:

(A) the effectiveness of rules adopted by the executive commissioner relating to the procedures for certifying and decertifying Medicaid beds in long-term care facilities; and

(B) the need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds in long-term care facilities.

(h) Not later than January 1 of each odd-numbered year, the council shall submit a report on the council's findings and recommendations to the executive commissioner, the governor, the lieutenant

governor, the speaker of the house of representatives, and the chairs of the appropriate legislative committees.

SUBCHAPTER F. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS; ADMINISTRATIVE PENALTY

Revised Law

Sec. 526.0251. RULES. The executive commissioner shall adopt rules providing for:

(1) a standard definition of "uncompensated hospital care";

(2) a methodology for hospitals in this state to use in computing the cost of uncompensated hospital care that incorporates a standard set of adjustments to a hospital's initial computation of the cost that accounts for all funding streams that:

(A) are not patient-specific; and

(B) are used to offset the hospital's initially computed amount of uncompensated hospital care; and

(3) procedures for hospitals to use in reporting the cost of uncompensated hospital care to the commission and in analyzing that cost, which may include procedures by which the commission may periodically verify the completeness and accuracy of the reported information. (Gov. Code, Secs. 531.551(a), (b).)

Source Law

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS. (a) The executive commissioner shall adopt rules providing for:

(1) a standard definition of "uncompensated hospital care";

(2) a methodology to be used by hospitals in this state to compute the cost of that care that incorporates a standard set of adjustments to a hospital's initial computation of the cost of uncompensated hospital care that account for all funding streams that:

(A) are not patient-specific; and

(B) are used to offset the hospital's initially computed amount of uncompensated care; and

(3) procedures to be used by those hospitals to report the cost of that care to the commission and to analyze that cost.

(b) The rules adopted by the executive commissioner under Subsection (a)(3) may provide for procedures by which the commission may periodically verify the completeness and accuracy of the information reported by hospitals.

Revised Law

Sec. 526.0252. NOTICE OF FAILURE TO REPORT; ADMINISTRATIVE PENALTY. (a) The commission shall notify the attorney general of a hospital's failure to report the cost of uncompensated hospital care on or before the report due date in accordance with rules adopted under Section 526.0251(3).

(b) On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in the amount of $1,000 for each day after the report due date that the hospital has not submitted the report, not to exceed $10,000. (Gov. Code, Sec. 531.551(c).)

Source Law

> (c) The commission shall notify the attorney general of a hospital's failure to report the cost of uncompensated care on or before the date the report was due in accordance with rules adopted under Subsection (a)(3). On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in the amount of $1,000 for each day after the date the report was due that the hospital has not submitted the report, not to exceed $10,000.

Revised Law

Sec. 526.0253. NOTICE OF INCOMPLETE OR INACCURATE REPORT; ADMINISTRATIVE PENALTY. (a) If the commission determines that a hospital submitted a report with incomplete or inaccurate information using a procedure adopted under Section 526.0251(3), the commission shall:

(1) notify the hospital of the specific information the hospital must submit; and

(2) prescribe a date by which the hospital must provide that information.

(b) If the hospital fails to submit the specified information on or before the date the commission prescribes, the commission shall notify the attorney general of that failure.

(c) On receipt of the commission's notice, the attorney general shall impose an administrative penalty on the hospital in an amount not to exceed $10,000. In determining the amount of the penalty to be imposed, the attorney general shall consider:

(1) the seriousness of the violation;

(2) whether the hospital had previously committed a violation; and

(3) the amount necessary to deter the hospital from committing future violations. (Gov. Code, Sec. 531.551(d).)

Source Law

> (d) If the commission determines through the procedures adopted under Subsection (b) that a hospital submitted a report with incomplete or inaccurate information, the commission shall notify the hospital of the specific information the hospital must submit and prescribe a date by which the hospital must provide that information. If the hospital fails to submit the specified information on or before the date prescribed by the commission, the commission shall notify the attorney general of that failure. On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in an amount not to exceed $10,000. In determining the amount of the penalty to be imposed, the attorney general shall consider:
>
> (1) the seriousness of the violation;
>
> (2) whether the hospital had previously committed a violation; and
>
> (3) the amount necessary to deter the hospital from committing future violations.

Revised Law

Sec. 526.0254. REQUIREMENTS FOR ATTORNEY GENERAL NOTIFICATION. The commission's notification to the attorney general under Section 526.0252 or 526.0253 must include the facts on which the commission based the determination that the hospital failed to submit a report or failed to completely and accurately report information, as applicable. (Gov. Code, Sec. 531.551(e).)

Source Law

> (e) A report by the commission to the attorney general under Subsection (c) or (d) must state the facts on which the commission based its determination that the hospital failed to submit a report or failed to completely and accurately report information, as applicable.

Revisor's Note

Section 531.551(e), Government Code, refers to a "report by the commission to the attorney general." For clarity and the convenience of the reader, the revised law substitutes "[t]he commission's notification to the attorney general" for the quoted

language because it is clear from the context that the Health and Human Services Commission notifies the attorney general related to a hospital's report under Section 531.551, Government Code, rather than providing a report to the attorney general.

Revised Law

Sec. 526.0255. ATTORNEY GENERAL NOTICE TO HOSPITAL. The attorney general shall give written notice of the commission's notification to the attorney general under Section 526.0252 or 526.0253 to the hospital that is the subject of the notification. The notice must include:

(1) a brief summary of the alleged violation;

(2) a statement of the amount of the administrative penalty to be imposed; and

(3) a statement of the hospital's right to a hearing on the alleged violation, the amount of the penalty, or both. (Gov. Code, Sec. 531.551(f).)

Source Law

(f) The attorney general shall give written notice of the commission's report to the hospital alleged to have failed to comply with a requirement. The notice must include a brief summary of the alleged violation, a statement of the amount of the administrative penalty to be imposed, and a statement of the hospital's right to a hearing on the alleged violation, the amount of the penalty, or both.

Revisor's Note

Section 531.551(f), Government Code, refers to "the commission's report." For the reasons stated in the revisor's note to Section 526.0254, the revised law substitutes "the commission's notification" for the quoted language.

Revised Law

Sec. 526.0256. PENALTY PAID OR HEARING REQUESTED. Not later than the 20th day after the date the attorney general sends the notice under Section 526.0255, the hospital receiving the notice must submit a written request for a hearing or remit the

amount of the administrative penalty to the attorney general. Failure to timely request a hearing or remit the amount of the administrative penalty results in a waiver of the right to a hearing under this section. (Gov. Code, Sec. 531.551(g) (part).)

Source Law

> (g) Not later than the 20th day after the date the notice is sent under Subsection (f), the hospital must make a written request for a hearing or remit the amount of the administrative penalty to the attorney general. Failure to timely request a hearing or remit the amount of the administrative penalty results in a waiver of the right to a hearing under this section. . . .

Revised Law

Sec. 526.0257. HEARING. (a) If a hospital requests a hearing in accordance with Section 526.0256, the attorney general shall conduct the hearing in accordance with Chapter 2001.

(b) If the hearing results in a finding that a violation has occurred, the attorney general shall:

(1) provide to the hospital written notice of:

(A) the findings established at the hearing; and

(B) the amount of the penalty; and

(2) enter an order requiring the hospital to pay the amount of the penalty.

(c) An order entered by the attorney general under this section is subject to judicial review as a contested case under Chapter 2001. (Gov. Code, Secs. 531.551(g) (part), (i).)

Source Law

> (g) . . . If the hospital timely requests a hearing, the attorney general shall conduct the hearing in accordance with Chapter 2001, Government Code. If the hearing results in a finding that a violation has occurred, the attorney general shall:
>
> (1) provide to the hospital written notice of:
>
> (A) the findings established at the hearing; and
>
> (B) the amount of the penalty; and
>
> (2) enter an order requiring the hospital to pay the amount of the penalty.
>
> (i) The attorney general's order is subject to judicial review as a contested case under Chapter 2001, Government Code.

Revisor's Note

Section 531.551(i), Government Code, refers to the "attorney general's order." For clarity and the convenience of the reader, the revised law substitutes "order entered by the attorney general under this section" for "attorney general's order" because it is clear from the context the order is the order entered by the attorney general under Section 531.551(g), which is revised as this section, and that description is consistent with the description used elsewhere in Section 531.551, Government Code.

Revised Law

Sec. 526.0258. OPTIONS FOLLOWING DECISION: PAY OR APPEAL. Not later than the 30th day after the date the hospital receives the order entered by the attorney general under Section 526.0257, the hospital shall:

(1) pay the amount of the administrative penalty;

(2) remit the amount of the penalty to the attorney general for deposit in an escrow account and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both; or

(3) without paying the amount of the penalty:

(A) file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both; and

(B) file with the court a sworn affidavit stating that the hospital is financially unable to pay the amount of the penalty. (Gov. Code, Sec. 531.551(h).)

Source Law

(h) Not later than the 30th day after the date the hospital receives the order entered by the attorney general under Subsection (g), the hospital shall:

(1) pay the amount of the administrative penalty;

(2) remit the amount of the penalty to the attorney general for deposit in an escrow account and file a petition for judicial review contesting the

occurrence of the violation, the amount of the penalty, or both; or

(3) without paying the amount of the penalty, file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both and file with the court a sworn affidavit stating that the hospital is financially unable to pay the amount of the penalty.

Revised Law

Sec. 526.0259. DECISION BY COURT. (a) If a hospital paid an administrative penalty imposed under this subchapter and on review a court does not sustain the occurrence of the violation or finds that the amount of the penalty should be reduced, the attorney general shall remit the appropriate amount to the hospital not later than the 30th day after the date the court's judgment becomes final.

(b) If the court sustains the occurrence of the violation:

(1) the court:

(A) shall order the hospital to pay the amount of the administrative penalty; and

(B) may award to the attorney general the attorney's fees and court costs the attorney general incurred in defending the action; and

(2) the attorney general shall remit the amount of the penalty to the comptroller for deposit in the general revenue fund.

(Gov. Code, Secs. 531.551(j), (k).)

Source Law

(j) If the hospital paid the penalty and on review the court does not sustain the occurrence of the violation or finds that the amount of the administrative penalty should be reduced, the attorney general shall remit the appropriate amount to the hospital not later than the 30th day after the date the court's judgment becomes final.

(k) If the court sustains the occurrence of the violation:

(1) the court:

(A) shall order the hospital to pay the amount of the administrative penalty; and

(B) may award to the attorney general the attorney's fees and court costs incurred by the attorney general in defending the action; and

(2) the attorney general shall remit the amount of the penalty to the comptroller for deposit in the general revenue fund.

Revised Law

Sec. 526.0260. RECOVERY OF PENALTY. If a hospital does not pay the amount of an administrative penalty imposed under this subchapter after the attorney general's order becomes final for all purposes, the attorney general may enforce the penalty as provided by law for legal judgments. (Gov. Code, Sec. 531.551(l).)

Source Law

(l) If the hospital does not pay the amount of the administrative penalty after the attorney general's order becomes final for all purposes, the attorney general may enforce the penalty as provided by law for legal judgments.

SUBCHAPTER G. RURAL HOSPITAL INITIATIVES

Revised Law

Sec. 526.0301. STRATEGIC PLAN FOR RURAL HOSPITAL SERVICES; REPORT. (a) The commission shall develop and implement a strategic plan to ensure that the citizens in this state residing in rural areas have access to hospital services.

(b) The strategic plan must include:

(1) a proposal for using at least one of the following methods to ensure access to hospital services in the rural areas of this state:

(A) an enhanced cost reimbursement methodology for the payment of rural hospitals participating in the Medicaid managed care program in conjunction with a supplemental payment program for rural hospitals to cover costs incurred in providing services to recipients;

(B) a hospital rate enhancement program applicable only to rural hospitals;

(C) a reduction of punitive actions under Medicaid that require reimbursement for Medicaid payments made to a rural hospital provider, a reduction of the frequency of payment reductions under Medicaid made to rural hospitals, and an enhancement of payments made under merit-based programs or similar programs for rural hospitals;

(D) a reduction of state regulatory-related

costs related to the commission's review of rural hospitals; or

(E) in accordance with rules the Centers for Medicare and Medicaid Services adopts, the establishment of a minimum fee schedule that applies to payments made to rural hospitals by Medicaid managed care organizations; and

(2) target dates for achieving goals related to the proposal described by Subdivision (1).

(c) Not later than November 1 of each even-numbered year, the commission shall submit a report regarding the commission's development and implementation of the strategic plan to:

(1) the legislature;

(2) the governor; and

(3) the Legislative Budget Board. (Gov. Code, Secs. 531.201(a), (b), (d).)

Source Law

Sec. 531.201. STRATEGIC PLAN; REPORT. (a) The commission shall develop and implement a strategic plan to ensure that the citizens of this state residing in rural areas have access to hospital services.

(b) The strategic plan must include:

(1) a proposal for using at least one of the following methods to ensure access to hospital services in the rural areas of this state:

(A) an enhanced cost reimbursement methodology for the payment of rural hospitals participating in the Medicaid managed care program in conjunction with a supplemental payment program for rural hospitals to cover costs incurred in providing services to recipients;

(B) a hospital rate enhancement program that applies only to rural hospitals;

(C) a reduction of punitive actions under the Medicaid program that require reimbursement for Medicaid payments made to the provider, if the provider is a rural hospital, a reduction of the frequency of payment reductions under the Medicaid program made to rural hospitals, and an enhancement of payments made under merit-based programs or similar programs for rural hospitals;

(D) a reduction of state regulatory-related costs related to the commission's review of rural hospitals; or

(E) in accordance with rules adopted by the Centers for Medicare and Medicaid Services, the establishment of a minimum fee schedule that applies to payments made by managed care organizations to rural hospitals; and

(2) target dates for achieving goals related to the proposal described by Subdivision (1).

(d) Not later than November 1 of each even-numbered year, the commission shall submit a

report regarding the commission's development and implementation of the strategic plan described by Subsection (b) to:

(1) the legislature;

(2) the governor; and

(3) the Legislative Budget Board.

Revisor's Note

Section 531.201(c), Government Code, requires the Health and Human Services Commission to submit the strategic plan developed under Subsection (b) to the Legislative Budget Board for review and comment not later than January 1, 2020, and prohibits implementation of proposals under the plan before the board approves the plan. Because the commission submitted the plan and the board approved the plan as required, the revised law omits that provision as executed. The omitted law reads:

> (c) Not later than January 1, 2020, the commission shall submit the strategic plan developed under Subsection (b) to the Legislative Budget Board for review and comment. The commission may not begin implementation of the proposal contained in the strategic plan until the strategic plan is approved by the Legislative Budget Board.

Revised Law

Sec. 526.0302. RURAL HOSPITAL ADVISORY COMMITTEE. (a) The commission shall establish the rural hospital advisory committee, either as an advisory committee or as a subcommittee of the hospital payment advisory committee, to advise the commission on issues relating specifically to rural hospitals.

(b) The rural hospital advisory committee is composed of interested individuals the executive commissioner appoints. Section 2110.002 does not apply to the advisory committee.

(c) An advisory committee member serves without compensation. (Gov. Code, Sec. 531.202.)

Source Law

Sec. 531.202. ADVISORY COMMITTEE ON RURAL HOSPITALS. (a) The commission shall establish the Rural Hospital Advisory Committee, either as another advisory committee or as a subcommittee of the Hospital Payment Advisory Committee, to advise the

commission on issues relating specifically to rural hospitals.

(b) The Rural Hospital Advisory Committee is composed of interested persons appointed by the executive commissioner. Section 2110.002 does not apply to the advisory committee.

(c) A member of the advisory committee serves without compensation.

Revised Law

Sec. 526.0303. COLLABORATION WITH OFFICE OF RURAL AFFAIRS. The commission shall collaborate with the Office of Rural Affairs to ensure that this state is pursuing to the fullest extent possible federal grants, funding opportunities, and support programs available to rural hospitals as administered by the Health Resources and Services Administration and the Office of Minority Health in the United States Department of Health and Human Services. (Gov. Code, Sec. 531.203.)

Source Law

Sec. 531.203. COLLABORATION WITH OFFICE OF RURAL AFFAIRS. The commission shall collaborate with the Office of Rural Affairs to ensure that this state is pursuing to the fullest extent possible federal grants, funding opportunities, and support programs available to rural hospitals as administered by the Health Resources and Services Administration and the Office of Minority Health in the United States Department of Health and Human Services.

SUBCHAPTER H. MEDICAL TRANSPORTATION

Revised Law

Sec. 526.0351. DEFINITIONS. In this subchapter:

(1) "Medical transportation program" means the program that provides nonemergency transportation services to recipients under Medicaid, subject to Section 526.0353, the children with special health care needs program, and the transportation for indigent cancer patients program, who have no other means of transportation.

(2) "Nonemergency transportation service" means nonemergency medical transportation services authorized under:

(A) for a Medicaid recipient, the state Medicaid plan; and

(B) for a recipient under another program described by Subdivision (1), that program.

(3) "Regional contracted broker" means an entity that contracts with the commission to provide or arrange for the provision of nonemergency transportation services under the medical transportation program.

(4) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code. (Gov. Code, Sec. 531.02414(a).)

Source Law

Sec. 531.02414. NONEMERGENCY TRANSPORTATION SERVICES UNDER MEDICAL TRANSPORTATION PROGRAM. (a) In this section:

(1) "Medical transportation program" means the program that provides nonemergency transportation services to recipients under Medicaid, subject to Subsection (a-1), the children with special health care needs program, and the transportation for indigent cancer patients program, who have no other means of transportation.

(1-a) "Nonemergency transportation service" means nonemergency medical transportation services authorized under:

(A) for a Medicaid recipient, the state Medicaid plan; and

(B) for a recipient under another program described by Subdivision (1), that program.

(2) "Regional contracted broker" means an entity that contracts with the commission to provide or arrange for the provision of nonemergency transportation services under the medical transportation program.

(3) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

Revisor's Note

Section 531.02414(a), Government Code, provides definitions applicable "[i]n this section." The revised law substitutes "[i]n this subchapter," meaning Subchapter H of this chapter, for the quoted language because Section 531.02414, Government Code, is revised as part of Subchapter H, Chapter 526, Government Code. Although Section 531.0057, Government Code, is also revised as part of Subchapter H, that section does not include the terms defined in Section 526.0351.

Revised Law

Sec. 526.0352. DUTY TO PROVIDE MEDICAL TRANSPORTATION

SERVICES. (a) The commission shall provide medical transportation services for clients of eligible health and human services programs.

(b) The commission may contract with any public or private transportation provider or with any regional transportation broker for the provision of public transportation services. (Gov. Code, Sec. 531.0057.)

Source Law

> Sec. 531.0057. MEDICAL TRANSPORTATION SERVICES. (a) The commission shall provide medical transportation services for clients of eligible health and human services programs.
>
> (b) The commission may contract with any public or private transportation provider or with any regional transportation broker for the provision of public transportation services.

Revised Law

Sec. 526.0353. APPLICABILITY. Sections 526.0354-526.0360 do not apply to the provision of nonemergency transportation services to a Medicaid recipient who is enrolled in a managed care plan offered by a Medicaid managed care organization. (Gov. Code, Sec. 531.02414(a-1).)

Source Law

> (a-1) Subject to Section 533.002571(i), this section does not apply to the provision of nonemergency transportation services on or after September 1, 2020, to a Medicaid recipient who is enrolled in a managed care plan offered by a Medicaid managed care organization.

Revisor's Note

(1) Section 531.02414(a-1), Government Code, states the applicability of that section is subject to Section 533.002571(i), Government Code. The revised law omits the reference to Section 533.002571(i) because that subsection expired on September 1, 2023, which preceded the effective date of this revision.

(2) Section 531.02414(a-1), Government Code, states that Section 531.02414, Government Code, does not apply to the nonemergency transportation services provided to certain recipients "on or after September

1, 2020." The revised law omits the quoted language as unnecessary because the specified date has passed, and any future provision of nonemergency transportation services would necessarily occur after that date.

Revised Law

Sec. 526.0354. COMMISSION SUPERVISION OF MEDICAL TRANSPORTATION PROGRAM. Notwithstanding any other law, the commission:

(1) shall directly supervise the administration and operation of the medical transportation program under this subchapter; and

(2) may not delegate the commission's duty to supervise the medical transportation program to any other person, including through a contract with the Texas Department of Transportation for the department to assume any of the commission's responsibilities relating to the provision of services through that program. (Gov. Code, Secs. 531.02414(b), (c).)

Source Law

(b) Notwithstanding any other law, the commission shall directly supervise the administration and operation of the medical transportation program under this section.

(c) Notwithstanding any other law, the commission may not delegate the commission's duty to supervise the medical transportation program to any other person, including through a contract with the Texas Department of Transportation for the department to assume any of the commission's responsibilities relating to the provision of services through that program.

Revisor's Note

Section 531.02414(b), Government Code, provides that the Health and Human Services Commission shall supervise the medical transportation program under "this section." Throughout this subchapter, the revised law substitutes "this subchapter," meaning Subchapter H of this chapter, for the quoted language because Section 531.02414, Government Code, is revised as part of Subchapter H, Chapter 526, Government Code.

Although Section 531.0057, Government Code, is also revised as part of Subchapter H, Section 531.0057 does not include any provision governing the medical transportation program.

Revised Law

Sec. 526.0355. CONTRACT FOR PUBLIC TRANSPORTATION SERVICES. Subject to Subchapter B, Chapter 540A, the commission may contract for the provision of public transportation services, as defined by Section 461.002, Transportation Code, under the medical transportation program, with:

(1) a public transportation provider, as defined by Section 461.002, Transportation Code;

(2) a private transportation provider; or

(3) a regional transportation broker. (Gov. Code, Sec. 531.02414(d).)

Source Law

(d) Subject to Section 533.00257, the commission may contract with a public transportation provider, as defined by Section 461.002, Transportation Code, a private transportation provider, or a regional transportation broker for the provision of public transportation services, as defined by Section 461.002, Transportation Code, under the medical transportation program.

Revisor's Note

Section 531.02414(d), Government Code, authorizes the Health and Human Services Commission to contract with a transportation provider for the provision of certain services under the medical transportation program subject to Section 533.00257, Government Code. The provisions of Section 533.00257 relating to the delivery of medical transportation program services through a managed transportation delivery model are revised in this subtitle as Subchapter B, Chapter 540A, and the revised law is drafted accordingly.

Revised Law

Sec. 526.0356. RULES FOR NONEMERGENCY TRANSPORTATION SERVICES; COMPLIANCE. (a) The executive commissioner shall adopt rules to ensure the safe and efficient provision of nonemergency transportation services under this subchapter. The rules must:

(1) include minimum standards regarding the physical condition and maintenance of motor vehicles used to provide the services, including standards regarding the accessibility of motor vehicles by individuals with disabilities;

(2) require a regional contracted broker to:

(A) verify that each motor vehicle operator providing the services or seeking to provide the services has a valid driver's license;

(B) check the driving record information maintained by the Department of Public Safety under Subchapter C, Chapter 521, Transportation Code, of each motor vehicle operator providing the services or seeking to provide the services; and

(C) check the public criminal record information maintained by the Department of Public Safety and made available to the public through the department's Internet website of each motor vehicle operator providing the services or seeking to provide the services; and

(3) include training requirements for motor vehicle operators providing the services through a regional contracted broker, including training on:

(A) passenger safety;

(B) passenger assistance;

(C) assistive devices, including wheelchair lifts, tie-down equipment, and child safety seats;

(D) sensitivity and diversity;

(E) customer service;

(F) defensive driving techniques; and

(G) prohibited behavior by motor vehicle operators.

(b) Except as provided by Section 526.0358, the commission shall require compliance with the rules adopted under Subsection (a) in any contract entered into with a regional contracted broker to provide nonemergency transportation services under the medical transportation program. (Gov. Code, Secs. 531.02414(e), (f).)

Source Law

> (e) The executive commissioner shall adopt rules to ensure the safe and efficient provision of nonemergency transportation services under this section. The rules must include:
>
> (1) minimum standards regarding the physical condition and maintenance of motor vehicles used to provide the services, including standards regarding the accessibility of motor vehicles by persons with disabilities;
>
> (2) a requirement that a regional contracted broker verify that each motor vehicle operator providing the services or seeking to provide the services has a valid driver's license;
>
> (3) a requirement that a regional contracted broker check the driving record information maintained by the Department of Public Safety under Subchapter C, Chapter 521, Transportation Code, of each motor vehicle operator providing the services or seeking to provide the services;
>
> (4) a requirement that a regional contracted broker check the public criminal record information maintained by the Department of Public Safety and made available to the public through the department's Internet website of each motor vehicle operator providing the services or seeking to provide the services; and
>
> (5) training requirements for motor vehicle operators providing the services through a regional contracted broker, including training on the following topics:
>
> (A) passenger safety;
>
> (B) passenger assistance;
>
> (C) assistive devices, including wheelchair lifts, tie-down equipment, and child safety seats;
>
> (D) sensitivity and diversity;
>
> (E) customer service;
>
> (F) defensive driving techniques; and
>
> (G) prohibited behavior by motor vehicle operators.
>
> (f) Except as provided by Subsection (j), the commission shall require compliance with the rules adopted under Subsection (e) in any contract entered into with a regional contracted broker to provide nonemergency transportation services under the medical transportation program.

Revised Law

Sec. 526.0357. MEMORANDUM OF UNDERSTANDING; DRIVER AND VEHICLE INFORMATION. (a) The commission shall enter into a memorandum of understanding with the Texas Department of Motor

Vehicles and the Department of Public Safety for purposes of obtaining the motor vehicle registration and driver's license information of a medical transportation services provider, including a regional contracted broker and a subcontractor of the broker, to confirm the provider complies with applicable requirements adopted under Section 526.0356(a).

(b) The commission shall establish a process by which medical transportation services providers, including providers under a managed transportation delivery model, that contract with the commission may request and obtain the information described by Subsection (a) to ensure that subcontractors providing medical transportation services meet applicable requirements adopted under Section 526.0356(a). (Gov. Code, Secs. 531.02414(g), (h).)

Source Law

> (g) The commission shall enter into a memorandum of understanding with the Texas Department of Motor Vehicles and the Department of Public Safety for purposes of obtaining the motor vehicle registration and driver's license information of a provider of medical transportation services, including a regional contracted broker and a subcontractor of the broker, to confirm that the provider complies with applicable requirements adopted under Subsection (e).
>
> (h) The commission shall establish a process by which providers of medical transportation services, including providers under a managed transportation delivery model, that contract with the commission may request and obtain the information described under Subsection (g) for purposes of ensuring that subcontractors providing medical transportation services meet applicable requirements adopted under Subsection (e).

Revised Law

Sec. 526.0358. MEDICAL TRANSPORTATION SERVICES SUBCONTRACTS. (a) A regional contracted broker may subcontract with a transportation network company to provide services under this subchapter. A rule or other requirement the executive commissioner adopts under Section 526.0356(a) does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. The commission or the regional contracted broker may not require a motor vehicle operator who is part of the subcontracted transportation network company's

network to enroll as a Medicaid provider to provide services under this subchapter.

(b) The commission or a regional contracted broker that subcontracts with a transportation network company under Subsection (a) may require the transportation network company or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

(c) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a regional contracted broker under Subsection (a) and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this subchapter. The commission and the regional contracted broker may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this subchapter. (Gov. Code, Secs. 531.02414(j), (k), (l).)

Source Law

> (j) A regional contracted broker may subcontract with a transportation network company to provide services under this section. A rule or other requirement adopted by the executive commissioner under Subsection (e) does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. The commission or the regional contracted broker may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this section.
>
> (k) The commission or a regional contracted broker that subcontracts with a transportation network company under Subsection (j) may require the transportation network company or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.
>
> (l) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a regional contracted broker under Subsection (j) and

who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this section. The commission and the regional contracted broker may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this section.

Revised Law

Sec. 526.0359. CERTAIN PROVIDERS PROHIBITED FROM PROVIDING NONEMERGENCY TRANSPORTATION SERVICES. Emergency medical services personnel and emergency medical services vehicles, as those terms are defined by Section 773.003, Health and Safety Code, may not provide nonemergency transportation services under the medical transportation program. (Gov. Code, Sec. 531.02414(i).)

Source Law

(i) Emergency medical services personnel and emergency medical services vehicles, as those terms are defined by Section 773.003, Health and Safety Code, may not provide nonemergency transportation services under the medical transportation program.

Revised Law

Sec. 526.0360. CERTAIN WHEELCHAIR-ACCESSIBLE VEHICLES AUTHORIZED. For purposes of this section and Sections 526.0354-526.0359 and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under Sections 526.0354-526.0359 may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code. (Gov. Code, Sec. 531.02414(m).)

Source Law

(m) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

SUBCHAPTER I. CASEWORKERS AND PROGRAM PERSONNEL

Revised Law

Sec. 526.0401. CASELOAD STANDARDS FOR DEPARTMENT OF FAMILY

AND PROTECTIVE SERVICES. (a) In this section:

(1) "Caseload standards" means the minimum and maximum number of cases that an employee can reasonably be expected to perform in a normal work month based on the number of cases handled by or the number of different job functions performed by the employee.

(2) "Professional caseload standards" means caseload standards for employees of health and human services agencies that are established or are recommended for establishment by:

(A) management studies conducted for health and human services agencies; or

(B) an authority or association, including:

(i) the Child Welfare League of America;

(ii) the National Eligibility Workers Association;

(iii) the National Association of Social Workers; and

(iv) associations of state health and human services agencies.

(b) Subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, the executive commissioner may establish caseload standards and other standards relating to caseloads for each category of caseworker the Department of Family and Protective Services employs.

(c) In establishing standards under this section, the executive commissioner shall:

(1) ensure that the standards are based on the caseworker's actual duties;

(2) ensure that the caseload standards are reasonable and achievable;

(3) ensure that the standards are consistent with existing professional caseload standards;

(4) consider standards developed by other states for caseworkers in similar positions of employment; and

(5) ensure that the standards are consistent with existing caseload standards of other state agencies.

(d) Subject to the availability of funds the legislature appropriates:

(1) the commissioner of the Department of Family and Protective Services shall use the standards established under this section to determine the number of personnel to assign as caseworkers for the department; and

(2) the Department of Family and Protective Services shall use the standards established to assign caseloads to individual caseworkers the department employs.

(e) Nothing in this section may be construed to create a cause of action. (Gov. Code, Secs. 531.001(1), (5), 531.048; New.)

Source Law

Sec. 531.001. DEFINITIONS. In this subtitle:

(1) "Caseload standards" means the minimum and maximum number of cases that an employee can reasonably be expected to perform in a normal work month based on the number of cases handled by or the number of different job functions performed by the employee.

(5) "Professional caseload standards" means caseload standards that are established or are recommended for establishment for employees of health and human services agencies by management studies conducted for health and human services agencies or by an authority or association, including the Child Welfare League of America, the National Eligibility Workers Association, the National Association of Social Workers, and associations of state health and human services agencies.

Sec. 531.048. CASELOAD STANDARDS. (a) The executive commissioner may establish caseload standards and other standards relating to caseloads for each category of caseworker employed by the Department of Family and Protective Services.

(b) In establishing standards under this section, the executive commissioner shall:

(1) ensure the standards are based on the actual duties of the caseworker;

(2) ensure the caseload standards are reasonable and achievable;

(3) ensure the standards are consistent with existing professional caseload standards;

(4) consider standards developed by other states for caseworkers in similar positions of employment; and

(5) ensure the standards are consistent with existing caseload standards of other state agencies.

(c) Subject to the availability of funds

appropriated by the legislature, the commissioner of the Department of Family and Protective Services shall use the standards established by the executive commissioner under this section to determine the number of personnel to assign as caseworkers for the department.

(d) Subject to the availability of funds appropriated by the legislature, the Department of Family and Protective Services shall use the standards established by the executive commissioner to assign caseloads to individual caseworkers employed by the department.

(f) Nothing in this section may be construed to create a cause of action.

Revisor's Note

(1) Section 531.001, Government Code, provides definitions that apply "[i]n this subtitle," meaning Subtitle I, Title 4, Government Code, including definitions of "caseload standards" and "professional caseload standards." The definitions of "caseload standards" and "professional caseload standards" are revised in this section to apply only to this section, rather than the entire subtitle, because the terms are used only in provisions of Subtitle I that are revised in this section.

(2) Section 531.048(a), Government Code, refers to the executive commissioner of the Health and Human Services Commission establishing caseload standards for each category of caseworker employed by the Department of Family and Protective Services. Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, redesignated and transferred to the department certain powers and duties previously transferred to the commission. Therefore, the revised law adds language to clarify that the performance of that duty is subject to Chapter 316.

Revised Law

Sec. 526.0402. JOINT TRAINING FOR CERTAIN CASEWORKERS. (a) The executive commissioner shall provide for joint training for health and human services caseworkers whose clients are children, including caseworkers employed by:

(1) the commission;

(2) the Department of State Health Services;

(3) a local mental health authority; and

(4) a local intellectual and developmental disability authority.

(b) The joint training must be designed to increase a caseworker's knowledge and awareness of the services available to children at each health and human services agency or local mental health or intellectual and developmental disability authority, including long-term care programs and services available under a Section 1915(c) waiver program. (Gov. Code, Sec. 531.02491.)

Source Law

Sec. 531.02491. JOINT TRAINING FOR CERTAIN CASEWORKERS. (a) The executive commissioner shall provide for joint training for health and human services caseworkers whose clients are children, including caseworkers employed by:

(1) the commission;

(2) the Department of Aging and Disability Services;

(3) the Department of State Health Services;

(4) a local mental health authority; and

(5) a local intellectual and developmental disability authority.

(b) Training provided under this section must be designed to increase a caseworker's knowledge and awareness of the services available to children at each health and human services agency or local mental health or intellectual and developmental disability authority, including long-term care programs and services available under a Section 1915(c) waiver program.

Revisor's Note

Section 531.02491, Government Code, requires the executive commissioner of the Health and Human Services Commission to provide joint training for caseworkers employed by several entities, including "the Department of Aging and Disability Services." The revised law omits the quoted language for the reasons stated in Revisor's Note (1) to Section 526.0003.

Revised Law

Sec. 526.0403. COORDINATION AND APPROVAL OF CASELOAD ESTIMATES. (a) The commission shall coordinate and approve

caseload estimates for programs health and human services agencies administer.

(b) To implement this section, the commission shall:

(1) adopt uniform guidelines for health and human services agencies to use in estimating each agency's caseload, with allowances given for those agencies for which exceptions from the guidelines may be necessary;

(2) assemble a single set of economic and demographic data and provide that data to each health and human services agency to use in estimating the agency's caseload; and

(3) seek advice from health and human services agencies, the Legislative Budget Board, the governor's budget office, the comptroller, and other relevant agencies as needed to coordinate the caseload estimating process. (Gov. Code, Sec. 531.0274.)

Source Law

> Sec. 531.0274. COORDINATION AND APPROVAL OF CASELOAD ESTIMATES. (a) The commission shall coordinate and approve caseload estimates made for programs administered by health and human services agencies.
>
> (b) To implement this section, the commission shall:
>
> (1) adopt uniform guidelines to be used by health and human services agencies in estimating their caseloads, with allowances given for those agencies for which exceptions from the guidelines may be necessary;
>
> (2) assemble a single set of economic and demographic data and provide that data to each health and human services agency to be used in estimating its caseloads; and
>
> (3) seek advice from health and human services agencies, the Legislative Budget Board, the governor's budget office, the comptroller, and other relevant agencies as needed to coordinate the caseload estimating process.

Revised Law

Sec. 526.0404. DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM: CAREER LADDER FOR INTERVENERS. (a) In this section:

(1) "Deaf-blind-related course work" means educational courses designed to improve a student's:

(A) knowledge of deaf-blindness and its effect on

learning;

(B) knowledge of the intervention role and ability to facilitate the intervention process;

(C) knowledge of communication areas relevant to deaf-blindness, including methods, adaptations, and use of assistive technology, and ability to facilitate development and use of communication skills for an individual who is deaf-blind;

(D) knowledge of the effect deaf-blindness has on an individual's psychological, social, and emotional development and ability to facilitate the emotional well-being of an individual who is deaf-blind;

(E) knowledge of and issues related to sensory systems and ability to facilitate the use of the senses;

(F) knowledge of motor skills, movement, orientation, and mobility strategies and ability to facilitate orientation and mobility skills;

(G) knowledge of the effect additional disabilities have on an individual who is deaf-blind and ability to provide appropriate support; or

(H) professionalism and knowledge of ethical issues relevant to the intervener role.

(2) "Program" means the deaf-blind with multiple disabilities (DBMD) waiver program.

(b) The executive commissioner by rule shall adopt a career ladder for individuals who provide intervener services under the program. The rules must provide a system under which each individual may be classified based on the individual's level of training, education, and experience, as one of the following:

(1) Intervener;

(2) Intervener I;

(3) Intervener II; or

(4) Intervener III.

(c) The rules must require that:

(1) an Intervener:

(A) complete any orientation or training course required to be completed by any individual who provides direct care services to recipients of services under the program;

(B) hold a high school diploma or a high school equivalency certificate;

(C) have at least two years of experience working with individuals with developmental disabilities;

(D) have the ability to proficiently communicate in the functional language of the individual who is deaf-blind; and

(E) meet all direct-care worker qualifications as determined by the program;

(2) an Intervener I:

(A) meet the requirements of an Intervener under Subdivision (1);

(B) have at least six months of experience working with individuals who are deaf-blind; and

(C) have completed at least eight semester credit hours, plus a one-hour practicum in deaf-blind-related course work, at an accredited college or university;

(3) an Intervener II:

(A) meet the requirements of an Intervener I;

(B) have at least nine months of experience working with individuals who are deaf-blind; and

(C) have completed an additional 10 semester credit hours in deaf-blind-related course work at an accredited college or university; and

(4) an Intervener III:

(A) meet the requirements of an Intervener II;

(B) have at least one year of experience working with individuals who are deaf-blind; and

(C) hold an associate's or bachelor's degree from an accredited college or university in a course of study with a focus on deaf-blind-related course work.

(d) Notwithstanding Subsections (b) and (c), the executive

commissioner may adopt a career ladder under this section based on credentialing standards for interveners developed by the Academy for Certification of Vision Rehabilitation and Education Professionals or any other private credentialing entity as the executive commissioner determines appropriate.

(e) The compensation an intervener receives for providing services under the program must be based on and commensurate with the intervener's career ladder classification. (Gov. Code, Sec. 531.0973; New.)

Source Law

Sec. 531.0973. DEAF-BLIND WITH MULTIPLE DISABILITIES WAIVER PROGRAM: CAREER LADDER FOR INTERVENERS. (a) In this section, "deaf-blind-related course work" means educational courses designed to improve a student's:

(1) knowledge of deaf-blindness and its effect on learning;

(2) knowledge of the role of intervention and ability to facilitate the intervention process;

(3) knowledge of areas of communication relevant to deaf-blindness, including methods, adaptations, and use of assistive technology, and ability to facilitate a deaf-blind person's development and use of communication skills;

(4) knowledge of the effect that deaf-blindness has on a person's psychological, social, and emotional development and ability to facilitate the emotional well-being of a deaf-blind person;

(5) knowledge of and issues related to sensory systems and ability to facilitate the use of the senses;

(6) knowledge of motor skills, movement, orientation, and mobility strategies and ability to facilitate orientation and mobility skills;

(7) knowledge of the effect that additional disabilities have on a deaf-blind person and ability to provide appropriate support; or

(8) professionalism and knowledge of ethical issues relevant to the role of an intervener.

(b) The executive commissioner by rule shall adopt a career ladder for persons who provide intervener services under the deaf-blind with multiple disabilities waiver program. The rules must provide a system under which each person may be classified based on the person's level of training, education, and experience, as one of the following:

(1) Intervener;

(2) Intervener I;

(3) Intervener II; or

(4) Intervener III.

(c) The rules adopted by the executive commissioner under Subsection (b) must, at a minimum, require that:

(1) an Intervener:

(A) complete any orientation or training course that is required to be completed by any

person who provides direct care services to recipients of services under the deaf-blind with multiple disabilities waiver program;

(B) hold a high school diploma or a high school equivalency certificate;

(C) have at least two years of experience working with individuals with developmental disabilities;

(D) have the ability to proficiently communicate in the functional language of the deaf-blind person; and

(E) meet all direct-care worker qualifications as determined by the deaf-blind with multiple disabilities waiver program;

(2) an Intervener I:

(A) meet the requirements of an Intervener under Subdivision (1);

(B) have at least six months of experience working with deaf-blind persons; and

(C) have completed at least eight semester credit hours, plus a one-hour practicum in deaf-blind-related course work, at an accredited college or university;

(3) an Intervener II:

(A) meet the requirements of an Intervener I;

(B) have at least nine months of experience working with deaf-blind persons; and

(C) have completed an additional 10 semester credit hours in deaf-blind-related course work at an accredited college or university; and

(4) an Intervener III:

(A) meet the requirements of an Intervener II;

(B) have at least one year of experience working with deaf-blind persons; and

(C) hold an associate's or bachelor's degree from an accredited college or university in a course of study with a focus on deaf-blind-related course work.

(d) Notwithstanding Subsections (b) and (c), the executive commissioner may adopt a career ladder under this section based on credentialing standards for interveners developed by the Academy for Certification of Vision Rehabilitation and Education Professionals or any other private credentialing entity that the executive commissioner determines is appropriate.

(e) The compensation that an intervener receives for providing services under the deaf-blind with multiple disabilities waiver program must be based on and commensurate with the intervener's career ladder classification.

Revisor's Note

(1) Section 531.0973(c), Government Code, refers to a list of requirements that an individual who provides intervener services must meet "at a minimum." The revised law omits the quoted language as unnecessary because each requirement listed in Section 531.0973(c) applies by its own terms and because the

absence of the language does not imply that the list may not contain additional requirements.

(2) The definition of "program" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

SUBCHAPTER J. LICENSING, LISTING, OR REGISTRATION OF CERTAIN ENTITIES

Revised Law

Sec. 526.0451. APPLICABILITY. (a) This subchapter applies only to the final licensing, listing, or registration decisions of a health and human services agency with respect to a person under the law authorizing the agency to regulate the following:

(1) a youth camp licensed under Chapter 141, Health and Safety Code;

(2) a home and community support services agency licensed under Chapter 142, Health and Safety Code;

(3) a hospital licensed under Chapter 241, Health and Safety Code;

(4) a facility licensed under Chapter 242, Health and Safety Code;

(5) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(6) a special care facility licensed under Chapter 248, Health and Safety Code;

(7) an intermediate care facility licensed under Chapter 252, Health and Safety Code;

(8) a chemical dependency treatment facility licensed under Chapter 464, Health and Safety Code;

(9) a mental hospital or mental health facility licensed under Chapter 577, Health and Safety Code;

(10) a child-care facility or child-placing agency licensed under or a family home listed or registered under Chapter 42, Human Resources Code; or

(11) a day activity and health services facility licensed under Chapter 103, Human Resources Code.

(b) This subchapter does not apply to an agency decision that did not result in a final order or that was reversed on appeal. (Gov. Code, Sec. 531.951.)

Source Law

Sec. 531.951. APPLICABILITY. (a) This subchapter applies only to the final licensing, listing, or registration decisions of a health and human services agency with respect to a person under the law authorizing the agency to regulate the following types of persons:

(1) a youth camp licensed under Chapter 141, Health and Safety Code;

(2) a home and community support services agency licensed under Chapter 142, Health and Safety Code;

(3) a hospital licensed under Chapter 241, Health and Safety Code;

(4) an institution licensed under Chapter 242, Health and Safety Code;

(5) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(6) a special care facility licensed under Chapter 248, Health and Safety Code;

(7) an intermediate care facility licensed under Chapter 252, Health and Safety Code;

(8) a chemical dependency treatment facility licensed under Chapter 464, Health and Safety Code;

(9) a mental hospital or mental health facility licensed under Chapter 577, Health and Safety Code;

(10) a child-care facility or child-placing agency licensed under or a family home listed or registered under Chapter 42, Human Resources Code; or

(11) a day activity and health services facility licensed under Chapter 103, Human Resources Code.

(b) This subchapter does not apply to an agency decision that did not result in a final order or that was reversed on appeal.

Revisor's Note

Section 531.951(a)(4), Government Code, refers to "an institution" licensed under Chapter 242, Health and Safety Code. For the reasons stated in Revisor's Note (2) to Section 526.0202, the revised law substitutes "a facility" for the quoted language.

Revised Law

Sec. 526.0452. REQUIRED APPLICATION INFORMATION. An applicant submitting an initial or renewal application for a

license, including a renewal license or a license that does not expire, a listing, or a registration described by Section 526.0451 must include with the application a written statement of:

(1) the name of any person who is or will be a controlling person, as the applicable agency regulating the person determines, of the entity for which the license, listing, or registration is sought; and

(2) any other relevant information required by rules the executive commissioner adopts. (Gov. Code, Sec. 531.954.)

Source Law

> Sec. 531.954. REQUIRED APPLICATION INFORMATION. An applicant submitting an initial or renewal application for a license, including a renewal license or a license that does not expire, a listing, or a registration described under Section 531.951 must include with the application a written statement of:
>
> (1) the name of any person who is or will be a controlling person, as determined by the applicable agency regulating the person, of the entity for which the license, listing, or registration is sought; and
>
> (2) any other relevant information required by executive commissioner rule.

Revised Law

Sec. 526.0453. APPLICATION DENIAL BASED ON ADVERSE AGENCY DECISION. A health and human services agency that regulates a person to whom this subchapter applies may deny an application for a license, including a renewal license or a license that does not expire, a listing, or a registration described by Section 526.0451, if:

(1) any of the following persons are listed in a record maintained under Section 526.0454:

(A) the applicant;

(B) a person listed on the application; or

(C) a person the applicable regulating agency determines to be a controlling person of an entity for which the license, including a renewal license or a license that does not expire, the listing, or the registration is sought; and

(2) the agency's action resulting in the person being listed in a record maintained under Section 526.0454 is based on:

(A) an act or omission that resulted in physical or mental harm to an individual in the care of the applicant or person;

(B) a threat to the health, safety, or well-being of an individual in the care of the applicant or person;

(C) the physical, mental, or financial exploitation of an individual in the care of the applicant or person; or

(D) the agency's determination that the applicant or person has committed an act or omission that renders the applicant unqualified or unfit to fulfill the obligations of the license, listing, or registration. (Gov. Code, Sec. 531.953.)

Source Law

> Sec. 531.953. DENIAL OF APPLICATION BASED ON ADVERSE AGENCY DECISION. A health and human services agency that regulates a person described by Section 531.951 may deny an application for a license, including a renewal license or a license that does not expire, a listing, or a registration included in that section if:
>
> (1) any of the following persons are listed in a record maintained under Section 531.952:
>
> (A) the applicant;
>
> (B) a person listed on the application; or
>
> (C) a person determined by the applicable regulating agency to be a controlling person of an entity for which the license, including a renewal license or a license that does not expire, the listing, or the registration is sought; and
>
> (2) the agency's action that resulted in the person being listed in a record maintained under Section 531.952 is based on:
>
> (A) an act or omission that resulted in physical or mental harm to an individual in the care of the applicant or person;
>
> (B) a threat to the health, safety, or well-being of an individual in the care of the applicant or person;
>
> (C) the physical, mental, or financial exploitation of an individual in the care of the applicant or person; or
>
> (D) a determination by the agency that the applicant or person has committed an act or omission that renders the applicant unqualified or unfit to fulfill the obligations of the license, listing, or registration.

Revised Law

Sec. 526.0454. RECORD OF FINAL DECISION. (a) Each health and human services agency that regulates a person to whom this

subchapter applies shall, in accordance with this section and rules the executive commissioner adopts, maintain a record of:

(1) each application for a license, including a renewal license or a license that does not expire, a listing, or a registration that the agency denies under the law authorizing the agency to regulate the person; and

(2) each license, listing, or registration that the agency revokes, suspends, or terminates under the applicable law.

(b) The record of an application required by Subsection (a)(1) must be maintained until the 10th anniversary of the date the application is denied. The record of the license, listing, or registration required by Subsection (a)(2) must be maintained until the 10th anniversary of the date of the revocation, suspension, or termination.

(c) The record required under Subsection (a) must include:

(1) the name and address of the applicant for a license, listing, or registration that is denied as described by Subsection (a)(1);

(2) the name and address of each person listed in the application for a license, listing, or registration that is denied as described by Subsection (a)(1);

(3) the name of each person the applicable regulatory agency determines to be a controlling person of an entity for which an application, license, listing, or registration is denied, revoked, suspended, or terminated as described by Subsection (a);

(4) the specific type of license, listing, or registration the agency denied, revoked, suspended, or terminated;

(5) a summary of the terms of the denial, revocation, suspension, or termination; and

(6) the effective period of the denial, revocation, suspension, or termination.

(d) Each health and human services agency that regulates a person to whom this subchapter applies each month shall provide a copy of the records maintained under this section to any other

health and human services agency that regulates the person. (Gov. Code, Sec. 531.952.)

Source Law

Sec. 531.952. RECORD OF FINAL DECISION. (a) Each health and human services agency that regulates a person described by Section 531.951 shall in accordance with this section and executive commissioner rule maintain a record of:

(1) each application for a license, including a renewal license or a license that does not expire, a listing, or a registration that is denied by the agency under the law authorizing the agency to regulate the person; and

(2) each license, listing, or registration that is revoked, suspended, or terminated by the agency under the applicable law.

(b) The record of an application required by Subsection (a)(1) must be maintained until the 10th anniversary of the date the application is denied. The record of the license, listing, or registration required by Subsection (a)(2) must be maintained until the 10th anniversary of the date of the revocation, suspension, or termination.

(c) The record required under Subsection (a) must include:

(1) the name and address of the applicant for a license, listing, or registration that is denied as described by Subsection (a)(1);

(2) the name and address of each person listed in the application for a license, listing, or registration that is denied as described by Subsection (a)(1);

(3) the name of each person determined by the applicable regulatory agency to be a controlling person of an entity for which an application, license, listing, or registration is denied, revoked, suspended, or terminated as described by Subsection (a);

(4) the specific type of license, listing, or registration that was denied, revoked, suspended, or terminated by the agency;

(5) a summary of the terms of the denial, revocation, suspension, or termination; and

(6) the period the denial, revocation, suspension, or termination was effective.

(d) Each health and human services agency that regulates a person described by Section 531.951 each month shall provide a copy of the records maintained under this section to each other health and human services agency that regulates a person described by Section 531.951.

SUBCHAPTER K. CHILDREN AND FAMILIES

Revised Law

Sec. 526.0501. SUBSTITUTE CARE PROVIDER OUTCOME STANDARDS. (a) The executive commissioner, after consulting with representatives from the commission, the Department of Family and Protective Services, and the Texas Juvenile Justice Department,

shall by rule adopt result-oriented standards that a provider of substitute care services for children under the care of this state must achieve.

(b) A health and human services agency that purchases substitute care services shall include the result-oriented standards as requirements in each substitute care service provider contract.

(c) A health and human services agency may provide information about a substitute care provider, including rates, contracts, outcomes, and client information, to another agency that purchases substitute care services. (Gov. Code, Sec. 531.047.)

Source Law

> Sec. 531.047. SUBSTITUTE CARE PROVIDER OUTCOME STANDARDS. (a) The executive commissioner, after consulting with representatives from the Department of Family and Protective Services, the Texas Juvenile Justice Department, the Department of Aging and Disability Services, and the Department of State Health Services, shall by rule adopt result-oriented standards that a provider of substitute care services for children under the care of the state must achieve.
>
> (b) A health and human services agency that purchases substitute care services must include the result-oriented standards as requirements in each substitute care service provider contract.
>
> (c) A health and human services agency may provide information about a substitute care provider, including rates, contracts, outcomes, and client information, to another agency that purchases substitute care services.

Revisor's Note

Section 531.047(a), Government Code, requires the Health and Human Services Commission to consult with representatives from the "Department of Aging and Disability Services" and the "Department of State Health Services." The revised law omits the reference to the "Department of Aging and Disability Services" for the reason stated in Revisor's Note (1) to Section 526.0003 of this chapter. The revised law also substitutes "commission" for "Department of State Health Services" for the reason stated in Revisor's Note (3) to Section 526.0007 of this chapter.

Revised Law

Sec. 526.0502. REPORT ON DELIVERY OF HEALTH AND HUMAN SERVICES TO YOUNG TEXANS. (a) The commission shall publish on the commission's Internet website a biennial report that addresses the efforts of the health and human services agencies to provide health and human services to children younger than six years of age.

(b) The report may:

(1) contain the commission's recommendations to better coordinate state agency programs relating to the delivery of health and human services to children younger than six years of age; and

(2) propose joint agency collaborative programs.

(c) On or before the date the report is due, the commission shall notify the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, and the appropriate legislative committees that the report is available on the commission's Internet website. (Gov. Code, Sec. 531.02492.)

Source Law

> Sec. 531.02492. DELIVERY OF HEALTH AND HUMAN SERVICES TO YOUNG TEXANS. (b) The commission shall electronically publish on the commission's Internet website a biennial report and, on or before the date the report is due, shall notify the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, and the appropriate legislative committees that the report is available on the commission's Internet website. The report must address the efforts of the health and human services agencies to provide health and human services to children younger than six years of age. The report may contain recommendations by the commission to better coordinate state agency programs relating to the delivery of health and human services to children younger than six years of age and may propose joint agency collaborative programs.

Revised Law

Sec. 526.0503. POOLED FUNDING FOR FOSTER CARE PREVENTIVE SERVICES. (a) The commission and the Department of Family and Protective Services shall develop and implement a plan to combine, to the extent and in the manner allowed by Section 51, Article III, Texas Constitution, and other applicable law, funds held by those agencies with funds held by other appropriate state agencies and local governmental entities to provide services designed to prevent

children from being placed in foster care. The preventive services may include:

(1) child and family counseling;

(2) instruction in parenting and homemaking skills;

(3) parental support services;

(4) temporary respite care; and

(5) crisis services.

(b) The plan must provide for:

(1) state funding to be distributed to other state agencies, local governmental entities, or private entities only as specifically directed by the terms of a grant or contract to provide preventive services;

(2) procedures to ensure that funds the commission receives by gift, grant, or interagency or interlocal contract from another state agency, a local governmental entity, the federal government, or any other public or private source for purposes of this section are disbursed in accordance with the terms under which the commission received the funds; and

(3) a reporting mechanism to ensure appropriate use of funds.

(c) For the purposes of this section, the commission may request and accept gifts and grants under the terms of a gift, grant, or contract from a local governmental entity, a private entity, or any other public or private source for use in providing services designed to prevent children from being placed in foster care. If required by the terms of a gift, grant, or contract or by applicable law, the commission shall use the amounts received:

(1) from a local governmental entity to provide the services in the geographic area of this state in which the entity is located; and

(2) from the federal government or a private entity to provide the services statewide or in a particular geographic area of this state. (Gov. Code, Sec. 531.088.)

Source Law

Sec. 531.088. POOLED FUNDING FOR FOSTER CARE PREVENTIVE SERVICES. (a) The commission and the Department of Family and Protective Services shall develop and implement a plan to combine, to the extent and in the manner allowed by Section 51, Article III, Texas Constitution, and other applicable law, funds of those agencies with funds of other appropriate state agencies and local governmental entities to provide services designed to prevent children from being placed in foster care. The preventive services may include:

(1) child and family counseling;

(2) instruction in parenting and homemaking skills;

(3) parental support services;

(4) temporary respite care; and

(5) crisis services.

(b) The plan must provide for:

(1) state funding to be distributed to other state agencies, local governmental entities, or private entities only as specifically directed by the terms of a grant or contract to provide preventive services;

(2) procedures to ensure that funds received by the commission by gift, grant, or interagency or interlocal contract from another state agency, a local governmental entity, the federal government, or any other public or private source for purposes of this section are disbursed in accordance with the terms under which the commission received the funds; and

(3) a reporting mechanism to ensure appropriate use of funds.

(c) For the purposes of this section, the commission may request and accept gifts and grants under the terms of a gift, grant, or contract from a local governmental entity, a private entity, or any other public or private source for use in providing services designed to prevent children from being placed in foster care. If required by the terms of a gift, grant, or contract or by applicable law, the commission shall use the amounts received:

(1) from a local governmental entity to provide the services in the geographic area of this state in which the entity is located; and

(2) from the federal government or a private entity to provide the services statewide or in a particular geographic area of this state.

Revised Law

Sec. 526.0504. PARTICIPATION BY FATHERS. (a) The commission and each health and human services agency shall periodically examine commission or agency policies and procedures to determine if the policies and procedures deter or encourage participation of fathers in commission or agency programs and services relating to children.

(b) Based on the examination required under Subsection (a),

the commission and each health and human services agency shall modify policies and procedures as necessary to permit full participation of fathers in commission or agency programs and services relating to children in all appropriate circumstances. (Gov. Code, Sec. 531.061.)

Source Law

> Sec. 531.061. PARTICIPATION BY FATHERS. (a) The commission and each health and human services agency shall periodically examine commission or agency policies and procedures to determine if the policies and procedures deter or encourage participation of fathers in commission or agency programs and services relating to children.
>
> (b) Based on the examination required under Subsection (a), the commission and each health and human services agency shall modify policies and procedures as necessary to permit full participation of fathers in commission or agency programs and services relating to children in all appropriate circumstances.

Revised Law

Sec. 526.0505. PROHIBITED PUNITIVE ACTION FOR FAILURE TO IMMUNIZE. (a) In this section:

(1) "Person responsible for a child's care, custody, or welfare" has the meaning assigned by Section 261.001, Family Code.

(2) "Punitive action" includes initiating an investigation of a person responsible for a child's care, custody, or welfare for alleged or suspected abuse or neglect of a child.

(b) The executive commissioner by rule shall prohibit a health and human services agency from taking a punitive action against a person responsible for a child's care, custody, or welfare for the person's failure to ensure that the child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

(c) This section does not affect a law, including Chapter 31, Human Resources Code, that specifically provides a punitive action for failure to ensure that a child receives the immunization series prescribed by Section 161.004, Health and Safety Code. (Gov. Code, Sec. 531.0335.)

Source Law

Sec. 531.0335. PROHIBITION ON PUNITIVE ACTION FOR FAILURE TO IMMUNIZE. (a) In this section:

(1) "Person responsible for a child's care, custody, or welfare" has the meaning assigned by Section 261.001, Family Code.

(2) "Punitive action" includes the initiation of an investigation of a person responsible for a child's care, custody, or welfare for alleged or suspected abuse or neglect of a child.

(b) The executive commissioner by rule shall prohibit a health and human services agency from taking a punitive action against a person responsible for a child's care, custody, or welfare for failure of the person to ensure that the child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

(c) This section does not affect a law, including Chapter 31, Human Resources Code, that specifically provides a punitive action for failure to ensure that a child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

Revised Law

Sec. 526.0506. INVESTIGATION UNIT FOR CHILD-CARE FACILITIES OPERATING ILLEGALLY. The executive commissioner shall maintain a unit within the commission's child-care licensing division consisting of investigators whose primary responsibility is to:

(1) identify child-care facilities that are operating without a license, certification, registration, or listing required by Chapter 42, Human Resources Code; and

(2) initiate appropriate enforcement actions against those facilities. (Gov. Code, Sec. 531.0084.)

Source Law

Sec. 531.0084. INVESTIGATION UNIT FOR ILLEGALLY OPERATING CHILD-CARE FACILITIES. The executive commissioner shall maintain a unit within the child-care licensing division of the commission consisting of investigators whose primary responsibility is to:

(1) identify child-care facilities that are operating without a license, certification, registration, or listing required by Chapter 42, Human Resources Code; and

(2) initiate appropriate enforcement actions against those facilities.

SUBCHAPTER L. TEXAS HOME VISITING PROGRAM

Revised Law

Sec. 526.0551. DEFINITIONS. In this subchapter:

(1) "Home visiting program" means a voluntary-enrollment program in which early childhood and health professionals such as nurses, social workers, or trained and supervised paraprofessionals repeatedly visit over a period of at least six months the homes of pregnant women or families with children younger than six years of age who are born with or exposed to one or more risk factors.

(2) "Risk factors" means factors that make a child more likely to experience adverse experiences leading to negative consequences, including preterm birth, poverty, low parental education, having a teenaged mother or father, poor maternal health, and parental underemployment or unemployment. (Gov. Code, Sec. 531.981.)

Source Law

> Sec. 531.981. DEFINITIONS. In this subchapter:
>
> (1) "Home visiting program" means a voluntary-enrollment program in which early childhood and health professionals such as nurses, social workers, or trained and supervised paraprofessionals repeatedly visit over a period of at least six months the homes of pregnant women or families with children under the age of six who are born with or exposed to one or more risk factors.
>
> (2) "Risk factors" means factors that make a child more likely to experience adverse experiences leading to negative consequences, including preterm birth, poverty, low parental education, having a teenaged mother or father, poor maternal health, and parental underemployment or unemployment.

Revised Law

Sec. 526.0552. RULES. The executive commissioner may adopt rules as necessary to implement this subchapter. (Gov. Code, Sec. 531.988.)

Source Law

> Sec. 531.988. RULES. The executive commissioner may adopt rules as necessary to implement this subchapter.

Revised Law

Sec. 526.0553. STRATEGIC PLAN; ELIGIBILITY. (a) The commission shall maintain a strategic plan to serve at-risk pregnant women and families with children younger than six years of age through home visiting programs that improve outcomes for

parents and families.

(b) A pregnant woman or family is considered at-risk for purposes of this section and may be eligible for voluntary enrollment in a home visiting program if the woman or family is exposed to one or more risk factors.

(c) The commission may determine if a risk factor or combination of risk factors an at-risk pregnant woman or family experiences qualifies the woman or family for enrollment in a home visiting program. (Gov. Code, Sec. 531.982.)

Source Law

> Sec. 531.982. IMPLEMENTATION OF TEXAS HOME VISITING PROGRAM. (a) The commission shall maintain a strategic plan to serve at-risk pregnant women and families with children under the age of six through home visiting programs that improve outcomes for parents and families.
>
> (b) A pregnant woman or family is considered at-risk for purposes of this section and may be eligible for voluntary enrollment in a home visiting program if the woman or family is exposed to one or more risk factors.
>
> (c) The commission may determine if a risk factor or combination of risk factors experienced by an at-risk pregnant woman or family qualifies the woman or family for enrollment in a home visiting program.

Revised Law

Sec. 526.0554. TYPES OF HOME VISITING PROGRAMS. (a) A home visiting program is classified as either an evidence-based program or a promising practice program.

(b) An evidence-based program is a home visiting program that:

(1) is research-based and grounded in relevant, empirically based knowledge and program-determined outcomes;

(2) is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive standards that ensure high-quality service delivery and continuously improving quality;

(4) has demonstrated significant positive short-term and long-term outcomes;

(5) has been evaluated by at least one rigorous randomized controlled research trial across heterogeneous populations or communities, the results of at least one of which have been published in a peer-reviewed journal;

(6) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(7) employs well-trained and competent staff and provides continual relevant professional development opportunities;

(8) demonstrates strong links to other community-based services; and

(9) ensures compliance with home visiting standards.

(c) A promising practice program is a home visiting program that:

(1) has an active impact evaluation program or can demonstrate a timeline for implementing an active impact evaluation program;

(2) has been evaluated by at least one outcome-based study demonstrating effectiveness or a randomized controlled trial in a homogeneous sample;

(3) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(4) employs well-trained and competent staff and provides continual relevant professional development opportunities;

(5) demonstrates strong links to other community-based services; and

(6) ensures compliance with home visiting standards.

(Gov. Code, Sec. 531.983.)

Source Law

Sec. 531.983. TYPES OF HOME VISITING PROGRAMS. (a) A home visiting program is classified as either an evidence-based program or a promising practice

program.

(b) An evidence-based program is a home visiting program that:

(1) is research-based and grounded in relevant, empirically based knowledge and program-determined outcomes;

(2) is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive standards that ensure high-quality service delivery and continuously improving quality;

(4) has demonstrated significant positive short-term and long-term outcomes;

(5) has been evaluated by at least one rigorous randomized controlled research trial across heterogeneous populations or communities, the results of at least one of which has been published in a peer-reviewed journal;

(6) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(7) employs well-trained and competent staff and provides continual relevant professional development opportunities;

(8) demonstrates strong links to other community-based services; and

(9) ensures compliance with home visiting standards.

(c) A promising practice program is a home visiting program that:

(1) has an active impact evaluation program or can demonstrate a timeline for implementing an active impact evaluation program;

(2) has been evaluated by at least one outcome-based study demonstrating effectiveness or a randomized controlled trial in a homogeneous sample;

(3) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(4) employs well-trained and competent staff and provides continual relevant professional development opportunities;

(5) demonstrates strong links to other community-based services; and

(6) ensures compliance with home visiting standards.

Revised Law

Sec. 526.0555. OUTCOMES. The commission shall ensure that a home visiting program achieves favorable outcomes in at least two of the following areas:

(1) improved maternal or child health outcomes;

(2) improved cognitive development of children;

(3) increased school readiness of children;

(4) reduced child abuse, neglect, and injury;

(5) improved child safety;

(6) improved social-emotional development of children;

(7) improved parenting skills, including nurturing and bonding;

(8) improved family economic self-sufficiency;

(9) reduced parental involvement with the criminal justice system; and

(10) increased father involvement and support. (Gov. Code, Sec. 531.985.)

Source Law

Sec. 531.985. OUTCOMES. The commission shall ensure that a home visiting program achieves favorable outcomes in at least two of the following areas:

(1) improved maternal or child health outcomes;

(2) improved cognitive development of children;

(3) increased school readiness of children;

(4) reduced child abuse, neglect, and injury;

(5) improved child safety;

(6) improved social-emotional development of children;

(7) improved parenting skills, including nurturing and bonding;

(8) improved family economic self-sufficiency;

(9) reduced parental involvement with the criminal justice system; and

(10) increased father involvement and support.

Revised Law

Sec. 526.0556. EVALUATION OF HOME VISITING PROGRAM. (a) The commission shall adopt outcome indicators to measure the effectiveness of a home visiting program in achieving desired outcomes.

(b) The commission may work directly with the model developer of a home visiting program to identify appropriate outcome indicators for the program and to ensure that the program demonstrates fidelity to its research model.

(c) The commission shall develop internal processes to work with home visiting programs in sharing data and information to aid in relevant analysis of a home visiting program's performance.

(d) The commission shall use data gathered under this section to monitor, conduct ongoing quality improvement on, and evaluate the effectiveness of home visiting programs. (Gov. Code, Sec. 531.986.)

Source Law

> Sec. 531.986. EVALUATION OF HOME VISITING PROGRAM. (a) The commission shall adopt outcome indicators to measure the effectiveness of a home visiting program in achieving desired outcomes.
>
> (b) The commission may work directly with the model developer of a home visiting program to identify appropriate outcome indicators for the program and to ensure that the program demonstrates fidelity to its research model.
>
> (c) The commission shall develop internal processes to work with home visiting programs to share data and information to aid in making relevant analysis of the performance of a home visiting program.
>
> (d) The commission shall use data gathered under this section to monitor, conduct ongoing quality improvement on, and evaluate the effectiveness of home visiting programs.

Revised Law

Sec. 526.0557. FUNDING. (a) The commission shall ensure that at least 75 percent of the funds appropriated for home visiting programs is used in evidence-based programs described by Section 526.0554(b), with any remaining funds dedicated to promising practice programs described by Section 526.0554(c).

(b) The commission shall actively seek and apply for any available federal funds to support home visiting programs, including federal funds from the Temporary Assistance for Needy Families program.

(c) The commission may accept gifts, donations, and grants to support home visiting programs. (Gov. Code, Sec. 531.984; New.)

Source Law

> Sec. 531.984. FUNDING. (a) The commission shall ensure that at least 75 percent of funds appropriated for home visiting programs are used in evidence-based programs, with any remaining funds dedicated to promising practice programs.
>
> (b) The commission shall actively seek and apply for any available federal funds to support home visiting programs, including federal funds from the Temporary Assistance for Needy Families program.
>
> (c) The commission may accept gifts, donations, and grants to support home visiting programs.

Revisor's Note

Section 531.984(a), Government Code, requires the Health and Human Services Commission to ensure that certain amounts of funds are appropriated to evidence-based programs and promising practice programs. Sections 526.0554(b) and (c) of this chapter describe the requirements for evidence-based programs and promising practice programs, respectively. Accordingly, the revised law adds a reference to those subsections for clarity and the convenience of the reader.

Revised Law

Sec. 526.0558. REPORTS TO LEGISLATURE. (a) Not later than December 1 of each even-numbered year, the commission shall prepare and submit a report on state-funded home visiting programs to the Senate Committee on Health and Human Services and the House Human Services Committee or their successors.

(b) A report submitted under this section must include:

(1) a description of home visiting programs being implemented and the associated models;

(2) data on the number of families being served and their demographic information;

(3) the goals and achieved outcomes of home visiting programs;

(4) data on cost per family served, including third-party return-on-investment analysis, if available; and

(5) data explaining the percentage of funding that has been used on evidence-based programs and the percentage of funding that has been used on promising practice programs. (Gov. Code, Sec. 531.9871.)

Source Law

Sec. 531.9871. REPORTS TO LEGISLATURE. (a) Not later than December 1 of each even-numbered year, the commission shall prepare and submit a report on state-funded home visiting programs to the Senate Committee on Health and Human Services and the House

Human Services Committee or their successors.

(b) A report submitted under this section must include:

(1) a description of home visiting programs being implemented and the associated models;

(2) data on the number of families being served and their demographic information;

(3) the goals and achieved outcomes of home visiting programs;

(4) data on cost per family served, including third-party return-on-investment analysis, if available; and

(5) data explaining what percentage of funding has been used on evidence-based programs and what percentage of funding has been used on promising practice programs.

SUBCHAPTER M. SERVICE MEMBERS, DEPENDENTS, AND VETERANS

Revised Law

Sec. 526.0601. SERVICES FOR SERVICE MEMBERS. (a) In this section, "service member" means a member or former member of the state military forces or a component of the United States armed forces, including a reserve component.

(b) The executive commissioner shall ensure that each health and human services agency adopts policies and procedures that require the agency to:

(1) identify service members who are seeking services from the agency during the agency's intake and eligibility determination process; and

(2) direct service members seeking services to appropriate service providers, including:

(A) the United States Veterans Health Administration;

(B) National Guard Bureau facilities; and

(C) other federal, state, and local service providers.

(c) The executive commissioner shall make the directory of resources established under Section 161.552, Health and Safety Code, accessible to each health and human services agency. (Gov. Code, Sec. 531.093.)

Source Law

Sec. 531.093. SERVICES FOR MILITARY PERSONNEL. (a) In this section, "servicemember" has the meaning assigned by Section 161.551, Health and Safety Code.

(b) The executive commissioner shall ensure that each health and human services agency adopts policies and procedures that require the agency to:

(1) identify servicemembers who are seeking services from the agency during the agency's intake and eligibility determination process; and

(2) direct servicemembers seeking services to appropriate service providers, including the United States Veterans Health Administration, National Guard Bureau facilities, and other federal, state, and local service providers.

(c) The executive commissioner shall make the directory of resources established under Section 161.552, Health and Safety Code, accessible to each health and human services agency.

Revisor's Note

Section 531.093(a), Government Code, defines "servicemember" for that section by referencing the meaning assigned to the term by Section 161.551, Health and Safety Code. For consistency in terminology used throughout the revised chapter and for the convenience of the reader, the revised law substitutes "service member" for "servicemember" and adds the substance of the definition from Section 161.551.

Revised Law

Sec. 526.0602. INTEREST OR OTHER WAITING LIST FOR CERTAIN SERVICE MEMBERS AND DEPENDENTS. (a) In this section, "service member" means a member of the United States military serving in the army, navy, air force, marine corps, or coast guard on active duty.

(b) This section applies only to:

(1) a service member who has declared and maintains this state as the member's state of legal residence in the manner provided by the applicable military branch;

(2) a spouse or dependent child of a member described by Subdivision (1); or

(3) the spouse or dependent child of a former service member who had declared and maintained this state as the member's state of legal residence in the manner provided by the applicable military branch and who:

(A) was killed in action; or

(B) died while in service.

(c) The executive commissioner by rule shall require the commission or another health and human services agency to:

(1) maintain the position of an individual to whom this section applies in the queue of an interest list or other waiting list for any assistance program the commission or other health and human services agency provides, including a Section 1915(c) waiver program, if the individual cannot receive benefits under the assistance program because the individual temporarily resides out of state as the result of military service; and

(2) subject to Subsection (e), offer benefits to the individual according to the individual's position on the interest list or other waiting list that was attained while the individual resided out of state if the individual returns to reside in this state.

(d) If an individual to whom this section applies reaches a position on an interest list or other waiting list that would allow the individual to receive benefits under an assistance program but the individual cannot receive the benefits because the individual temporarily resides out of state as the result of military service, the commission or agency providing the benefits shall maintain the individual's position on the list relative to other individuals on the list but continue to offer benefits to other individuals on the interest list or other waiting list in accordance with those individuals' respective positions on the list.

(e) In adopting rules under Subsection (c), the executive commissioner must limit the amount of time an individual to whom this section applies may maintain the individual's position on an interest list or other waiting list under Subsection (c) to not more than one year after the date on which, as applicable:

(1) the service member's active duty ends;

(2) the member was killed if the member was killed in action; or

(3) the member died if the member died while in service. (Gov. Code, Sec. 531.0931.)

Source Law

Sec. 531.0931. INTEREST LIST OR OTHER WAITING LIST RULES FOR CERTAIN MILITARY MEMBERS AND THEIR DEPENDENTS. (a) In this section, "military member" means a member of the United States military serving in the army, navy, air force, marine corps, or coast guard on active duty.

(b) This section applies only to:

(1) a military member who has declared and maintains this state as the member's state of legal residence in the manner provided by the applicable military branch, or a spouse or dependent child of the member; or

(2) the spouse or dependent child of a former military member who had declared and maintained this state as the member's state of legal residence in the manner provided by the applicable military branch and who:

(A) was killed in action; or

(B) died while in service.

(c) The executive commissioner by rule shall require the commission or another health and human services agency to:

(1) maintain the position of a person subject to this section in the queue of an interest list or other waiting list for any assistance program, including a Section 1915(c) waiver program, provided by the commission or other health and human services agency, if the person cannot receive benefits under the assistance program because the person temporarily resides out of state as the result of military service; and

(2) subject to Subsection (e), offer benefits to the person according to the person's position on the interest list or other waiting list that was attained while the person resided out of state if the person returns to reside in this state.

(d) If a person subject to this section reaches a position on an interest list or other waiting list that would allow the person to receive benefits under an assistance program but the person cannot receive the benefits because the person temporarily resides out of state as the result of military service, the commission or agency providing the benefits shall maintain the person's position on the list relative to other persons on the list but continue to offer benefits to other persons on the interest list or other waiting list in accordance with those persons' respective positions on the list.

(e) In adopting rules under Subsection (c), the executive commissioner must limit the amount of time a person may maintain the person's position on an interest list or other waiting list under Subsection (c) to not more than one year after the date on which, as applicable:

(1) the member's active duty ends;

(2) the member was killed if the member was killed in action; or

(3) the member died if the member died while in service.

Revisor's Note

Section 531.0931(a), Government Code, refers to a "military member." The revised law substitutes

"service member" for clarity and consistency in the terminology used within the Government Code.

Revised Law

Sec. 526.0603. MEMORANDUM OF UNDERSTANDING REGARDING PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM; MAXIMIZATION OF BENEFITS. (a) In this section, "system" means the Public Assistance Reporting Information System (PARIS) operated by the Administration for Children and Families of the United States Department of Health and Human Services.

(b) The commission, the Texas Veterans Commission, and the Veterans' Land Board shall enter into a memorandum of understanding for the purposes of:

(1) coordinating and collecting information about state agencies' use and analysis of data received from the system; and

(2) developing new strategies for state agencies to use system data in ways that:

(A) generate fiscal savings for this state; and

(B) maximize the availability of and access to benefits for veterans.

(c) The commission and the Texas Veterans Commission:

(1) shall coordinate to assist veterans in maximizing the benefits available to each veteran by using the system; and

(2) together may determine the geographic scope of the efforts described by Subdivision (1).

(d) Not later than October 1 of each year, the commission, the Texas Veterans Commission, and the Veterans' Land Board collectively shall submit to the legislature, the governor, and the Legislative Budget Board a report describing:

(1) interagency progress in identifying and obtaining United States Department of Veterans Affairs benefits for veterans receiving Medicaid and other public benefits;

(2) the number of veterans benefits claims awarded, the total dollar amount of veterans benefits claims awarded, and

the costs to this state that were avoided as a result of state agencies' use of the system;

(3) efforts to expand the use of the system and improve the effectiveness of shifting veterans from Medicaid and other public benefits to United States Department of Veterans Affairs benefits, including any barriers and the manner in which state agencies have addressed those barriers; and

(4) the extent to which the Texas Veterans Commission has targeted specific veteran populations, including populations in rural counties and in specific age and service-connected disability categories, in order to maximize benefits for veterans and savings to this state.

(e) The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law. (Gov. Code, Sec. 531.0998.)

Source Law

Sec. 531.0998. MEMORANDUM OF UNDERSTANDING REGARDING PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM; MAXIMIZATION OF BENEFITS. (a) In this section, "system" means the Public Assistance Reporting Information System (PARIS) operated by the Administration for Children and Families of the United States Department of Health and Human Services.

(b) The commission, the Texas Veterans Commission, the Veterans' Land Board, and the Department of Aging and Disability Services shall enter into a memorandum of understanding for the purposes of:

(1) coordinating and collecting information about the use and analysis among state agencies of data received from the system; and

(2) developing new strategies for state agencies to use system data in ways that:

(A) generate fiscal savings for the state; and

(B) maximize the availability of and access to benefits for veterans.

(c) The commission, the Texas Veterans Commission, and the Department of Aging and Disability Services shall coordinate to assist veterans in maximizing the benefits available to each veteran by using the system.

(d) The commission and the Texas Veterans Commission together may determine the geographic scope of the efforts described by Subsection (c).

(e) Not later than October 1 of each year, the commission, the Texas Veterans Commission, the Veterans' Land Board, and the Department of Aging and Disability Services collectively shall submit to the legislature, the governor, and the Legislative Budget Board a report describing:

(1) interagency progress in identifying and obtaining United States Department of Veterans Affairs benefits for veterans receiving Medicaid and other public benefit programs;

(2) the number of veterans benefits claims awarded, the total dollar amount of veterans benefits claims awarded, and the costs to the state that were avoided as a result of state agencies' use of the system;

(3) efforts to expand the use of the system and improve the effectiveness of shifting veterans from Medicaid and other public benefits to United States Department of Veterans Affairs benefits, including any barriers and how state agencies have addressed those barriers; and

(4) the extent to which the Texas Veterans Commission has targeted specific populations of veterans, including populations in rural counties and in specific age and service-connected disability categories, in order to maximize benefits for veterans and savings to the state.

(g) The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.

SUBCHAPTER N. PLAN TO SUPPORT GUARDIANSHIPS

Revised Law

Sec. 526.0651. DEFINITIONS. In this subchapter:

(1) "Guardian" has the meaning assigned by Section 1002.012, Estates Code.

(2) "Guardianship program" has the meaning assigned by Section 155.001.

(3) "Incapacitated individual" means an incapacitated person as defined by Section 1002.017, Estates Code. (Gov. Code, Sec. 531.121.)

Source Law

Sec. 531.121. DEFINITIONS. In this subchapter:

(2) "Guardian" has the meaning assigned by Section 1002.012, Estates Code.

(3) "Guardianship program" has the meaning assigned by Section 111.001.

(4) "Incapacitated individual" means an incapacitated person as defined by Section 1002.017, Estates Code.

Revisor's Note

Section 531.121(3), Government Code, refers to Section 111.001, Government Code. Section 111.001 was redesignated as Section 155.001, Government Code, by Chapter 42 (S.B. 966), Acts of the 83rd Legislature, Regular Session, 2013. The revised law is drafted to

reflect that redesignation.

Revised Law

Sec. 526.0652. PLAN ESTABLISHMENT. The commission shall develop and, subject to appropriations, implement a plan to:

(1) ensure that each incapacitated individual in this state who needs a guardianship or another less restrictive type of assistance to make decisions concerning the incapacitated individual's own welfare and financial affairs receives that assistance; and

(2) foster the establishment and growth of local volunteer guardianship programs. (Gov. Code, Sec. 531.124.)

Source Law

> Sec. 531.124. COMMISSION DUTIES. The commission shall develop and, subject to appropriations, implement a plan to:
>
> (1) ensure that each incapacitated individual in this state who needs a guardianship or another less restrictive type of assistance to make decisions concerning the incapacitated individual's own welfare and financial affairs receives that assistance; and
>
> (2) foster the establishment and growth of local volunteer guardianship programs.

Revised Law

Sec. 526.0653. GUARDIANSHIP PROGRAM GRANT REQUIREMENTS. (a) The commission in accordance with commission rules may award grants to:

(1) a local guardianship program; and

(2) a local legal guardianship program to enable the family members and friends with low incomes of a proposed ward who is indigent to have legal representation in court if the individuals are willing and able to be appointed guardians of the proposed ward.

(b) To receive a grant under Subsection (a)(1), a local guardianship program operating in a county with a population of at least 150,000 must offer or submit a plan acceptable to the commission to offer, among the program's services, a money management service for appropriate clients, as determined by the program. The program may provide the money management service

directly or by referring a client to a money management service that satisfies the requirements under Subsection (c).

(c) A money management service to which a local guardianship program may refer a client must:

(1) use employees or volunteers to provide bill payment or representative payee services;

(2) provide the service's employees and volunteers with training, technical support, monitoring, and supervision;

(3) match employees or volunteers with clients in a manner that ensures that the match is agreeable to both the employee or volunteer and the client;

(4) insure each employee and volunteer and hold the employee or volunteer harmless from liability for damages proximately caused by acts or omissions of the employee or volunteer while acting in the course and scope of the employee's or volunteer's duties or functions within the organization;

(5) have an advisory council that meets regularly and is composed of individuals who are knowledgeable with respect to issues related to guardianship, alternatives to guardianship, and related social services programs;

(6) be administered by a nonprofit corporation:

(A) formed under the Texas Nonprofit Corporation Law, as described by Section 1.008, Business Organizations Code; and

(B) exempt from taxation under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt entity under Section 501(c)(3) of that code; and

(7) refer clients who are in need of other services from an area agency on aging to the appropriate area agency on aging.

(d) A local guardianship program operating in a county with a population of less than 150,000 may, at the program's option, offer, either directly or by referral, a money management service among the program's services. If the program elects to offer a money

management service by referral, the service must satisfy the requirements under Subsection (c), except as provided by Subsection (e).

(e) On request by a local guardianship program, the commission may waive a requirement under Subsection (c) if the commission determines the waiver is appropriate to strengthen the continuum of local guardianship programs in a geographic area. (Gov. Code, Sec. 531.125.)

Source Law

Sec. 531.125. GRANTS. (a) The commission in accordance with commission rules may award grants to:

(1) a local guardianship program, subject to the requirements of this section; and

(2) a local legal guardianship program to enable low-income family members and friends to have legal representation in court if they are willing and able to be appointed guardians of proposed wards who are indigent.

(b) To receive a grant under Subsection (a)(1), a local guardianship program operating in a county that has a population of at least 150,000 must offer or submit a plan acceptable to the commission to offer, among the program's services, a money management service for appropriate clients, as determined by the program. The local guardianship program may provide the money management service directly or by referring a client to a money management service that satisfies the requirements under Subsection (c).

(c) A money management service to which a local guardianship program may refer a client must:

(1) use employees or volunteers to provide bill payment or representative payee services;

(2) provide the service's employees and volunteers with training, technical support, monitoring, and supervision;

(3) match employees or volunteers with clients in a manner that ensures that the match is agreeable to both the employee or volunteer and the client;

(4) insure each employee and volunteer, and hold the employee or volunteer harmless from liability, for damages proximately caused by acts or omissions of the employee or volunteer while acting in the course and scope of the employee's or volunteer's duties or functions within the organization;

(5) have an advisory council that meets regularly and is composed of persons who are knowledgeable with respect to issues related to guardianship, alternatives to guardianship, and related social services programs;

(6) be administered by a nonprofit corporation:

(A) formed under the Texas Nonprofit Corporation Law, as described by Section 1.008, Business Organizations Code; and

(B) exempt from federal taxation under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt entity under Section

501(c)(3) of that code; and

(7) refer clients who are in need of other services from an area agency on aging to the appropriate area agency on aging.

(d) A local guardianship program operating in a county that has a population of less than 150,000 may, at the program's option, offer, either directly or by referral, a money management service among the program's services. If the program elects to offer a money management service by referral, the service must satisfy the requirements under Subsection (c), except as provided by Subsection (e).

(e) On request by a local guardianship program, the commission may waive a requirement under Subsection (c) if the commission determines that the waiver is appropriate to strengthen the continuum of local guardianship programs in a geographic area.

Revisor's Note

Section 531.125(a)(1), Government Code, allows the Health and Human Services Commission to award a grant to a local guardianship program "subject to the requirements of this section." The revised law omits the quoted language as unnecessary because the requirements of Section 531.125, Government Code, revised in this code as Section 526.0653, apply on their own terms.

SUBCHAPTER O. ASSISTANCE PROGRAM FOR DOMESTIC VICTIMS OF TRAFFICKING

Revised Law

Sec. 526.0701. DEFINITIONS. In this subchapter:

(1) "Domestic victim" means a victim of trafficking who is a permanent legal resident or citizen of the United States.

(2) "Victim of trafficking" has the meaning assigned by 22 U.S.C. Section 7102. (Gov. Code, Sec. 531.381.)

Source Law

Sec. 531.381. DEFINITIONS. In this subchapter:

(1) "Domestic victim" means a victim of trafficking who is a permanent legal resident or citizen of the United States.

(2) "Victim of trafficking" has the meaning assigned by 22 U.S.C. Section 7102.

Revised Law

Sec. 526.0702. VICTIM ASSISTANCE PROGRAM. The commission shall develop and implement a program designed to assist domestic victims, including victims who are children, in accessing necessary

services. The program must include:

(1) a searchable database of assistance programs for domestic victims that may be used to match victims with appropriate resources, including:

(A) programs that provide mental health services;

(B) other health services;

(C) services to meet victims' basic needs;

(D) case management services; and

(E) any other services the commission considers appropriate;

(2) the grant program described by Section 526.0703;

(3) recommended training programs for judges, prosecutors, and law enforcement personnel; and

(4) an outreach initiative to ensure that victims, judges, prosecutors, and law enforcement personnel are aware of the availability of services through the program. (Gov. Code, Sec. 531.382.)

Source Law

Sec. 531.382. VICTIM ASSISTANCE PROGRAM ESTABLISHED. The commission shall develop and implement a program designed to assist domestic victims, including victims who are children, in accessing necessary services. The program must consist of at least the following components:

(1) a searchable database of assistance programs for domestic victims, including programs that provide mental health services, other health services, services to meet victims' basic needs, case management services, and any other services the commission considers appropriate, that may be used to match victims with appropriate resources;

(2) the grant program described by Section 531.383;

(3) recommended training programs for judges, prosecutors, and law enforcement personnel; and

(4) an outreach initiative to ensure that victims, judges, prosecutors, and law enforcement personnel are aware of the availability of services through the program.

Revisor's Note

Section 531.382, Government Code, establishes a program consisting of "at least the following

components." The revised law substitutes "include" for the quoted language because Section 311.005(13), Government Code (Code Construction Act), provides that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 526.0703. GRANT PROGRAM. (a) Subject to available funds, the commission shall establish a grant program to award grants to public and nonprofit organizations that provide assistance to domestic victims, including organizations that provide public awareness activities, community outreach and training, victim identification services, and legal services.

(b) To apply for a grant under this section, an applicant must submit an application in the form and manner the commission prescribes. An applicant must describe in the application the services the applicant intends to provide to domestic victims if the grant is awarded.

(c) In awarding grants under this section, the commission shall give preference to organizations that have experience in successfully providing the types of services for which the grants are awarded.

(d) A grant recipient shall provide the reports the commission requires regarding the use of grant funds.

(e) Not later than December 1 of each even-numbered year, the commission shall submit a report to the legislature:

(1) summarizing the activities, funding, and outcomes of programs awarded a grant under this section; and

(2) providing recommendations regarding the grant program.

(f) For purposes of Subchapter I, Chapter 659:

(1) the commission, for the sole purpose of administering the grant program under this section, is considered an eligible charitable organization entitled to participate in the

state employee charitable campaign; and

(2) a state employee is entitled to authorize a deduction for contributions to the commission for the purposes of administering the grant program under this section as a charitable contribution under Section 659.132, and the commission may use the contributions as provided by Subsection (a). (Gov. Code, Sec. 531.383.)

Source Law

Sec. 531.383. GRANT PROGRAM. (a) Subject to available funds, the commission shall establish a grant program to award grants to public and nonprofit organizations that provide assistance to domestic victims, including organizations that provide public awareness activities, community outreach and training, victim identification services, and legal services.

(b) To apply for a grant under this section, an applicant must submit an application in the form and manner prescribed by the commission. An applicant must describe in the application the services the applicant intends to provide to domestic victims if the grant is awarded.

(c) In awarding grants under this section, the commission shall give preference to organizations that have experience in successfully providing the types of services for which the grants are awarded.

(d) A grant recipient shall provide reports as required by the commission regarding the use of grant funds.

(e) Not later than December 1 of each even-numbered year, the commission shall submit a report to the legislature summarizing the activities, funding, and outcomes of programs awarded a grant under this section and providing recommendations regarding the grant program.

(f) For purposes of Subchapter I, Chapter 659:

(1) the commission, for the sole purpose of administering the grant program under this section, is considered an eligible charitable organization entitled to participate in the state employee charitable campaign; and

(2) a state employee is entitled to authorize a deduction for contributions to the commission for the purposes of administering the grant program under this section as a charitable contribution under Section 659.132, and the commission may use the contributions as provided by Subsection (a).

Revised Law

Sec. 526.0704. TRAINING PROGRAMS. The commission, with assistance from the Office of Court Administration of the Texas Judicial System, the Department of Public Safety, and local law enforcement agencies, shall create training programs designed to

increase the awareness of judges, prosecutors, and law enforcement personnel on:

(1) the needs of domestic victims;

(2) the availability of services under this subchapter;

(3) the database of services described by Section 526.0702; and

(4) potential funding sources for those services. (Gov. Code, Sec. 531.384.)

Source Law

> Sec. 531.384. TRAINING PROGRAMS. The commission, with assistance from the Office of Court Administration of the Texas Judicial System, the Department of Public Safety, and local law enforcement agencies, shall create training programs designed to increase the awareness of judges, prosecutors, and law enforcement personnel of the needs of domestic victims, the availability of services under this subchapter, the database of services described by Section 531.382, and potential funding sources for those services.

Revised Law

Sec. 526.0705. FUNDING. The commission may use appropriated funds and may accept gifts, grants, and donations from any sources for purposes of the victim assistance program established under this subchapter. (Gov. Code, Sec. 531.385.)

Source Law

> Sec. 531.385. FUNDING. (a) The commission may use appropriated funds and may accept gifts, grants, and donations from any sources for purposes of the victim assistance program established under this subchapter.

SUBCHAPTER P. AGING ADULTS WITH VISUAL IMPAIRMENTS

Revised Law

Sec. 526.0751. OUTREACH CAMPAIGNS FOR AGING ADULTS WITH VISUAL IMPAIRMENTS. (a) The commission, in collaboration with the Texas State Library and Archives Commission and other appropriate state agencies, shall conduct public awareness and education outreach campaigns designed to provide information relating to the programs and resources available to aging adults who are blind or visually impaired in this state.

(b) The campaigns must be:

(1) tailored to targeted populations, including:

(A) aging adults with or at risk of blindness or visual impairment and the families and caregivers of those adults;

(B) health care providers, including home and community-based services providers, health care facilities, and emergency medical services providers;

(C) community and faith-based organizations; and

(D) the public; and

(2) disseminated through methods appropriate for each targeted population, including by:

(A) attending health fairs; and

(B) working with organizations or groups that serve aging adults, including community clinics, libraries, support groups for aging adults, veterans organizations, for-profit providers of vision services, and the state and local chapters of the National Federation of the Blind. (Gov. Code, Sec. 531.0319(a).)

Source Law

Sec. 531.0319. OUTREACH CAMPAIGNS FOR AGING ADULTS WITH VISUAL IMPAIRMENTS. (a) The commission, in collaboration with the Texas State Library and Archives Commission and other appropriate state agencies, shall conduct public awareness and education outreach campaigns designed to provide information relating to the programs and resources available to aging adults who are blind or visually impaired in this state. The campaigns must be:

(1) tailored to targeted populations, including:

(A) aging adults with or at risk of blindness or visual impairment and the families and caregivers of those adults;

(B) health care providers, including home and community-based services providers, health care facilities, and emergency medical services providers;

(C) community and faith-based organizations; and

(D) the general public; and

(2) disseminated through methods appropriate for each targeted population, including by:

(A) attending health fairs; and

(B) working with organizations or groups that serve aging adults, including community clinics, libraries, support groups for aging adults, veterans organizations, for-profit providers of

vision services, and the state and local chapters of the National Federation of the Blind.

Revised Law

Sec. 526.0752. RULES. The executive commissioner may adopt rules necessary to implement this subchapter. (Gov. Code, Sec. 531.0319(c).)

Source Law

(c) The executive commissioner may adopt rules necessary to implement this section.

Revised Law

Sec. 526.0753. COMMISSION SUPPORT. To support campaigns conducted under this subchapter, the commission shall:

(1) establish a toll-free telephone number for providing counseling and referrals to appropriate services for aging adults who are blind or visually impaired;

(2) post on the commission's Internet website information and training resources for aging adults, community stakeholders, and health care and other service providers that generally serve aging adults, including:

(A) links to Internet websites that contain resources for individuals who are blind or visually impaired;

(B) existing videos that provide awareness of blindness and visual impairments among aging adults and the importance of early intervention;

(C) best practices for referring aging adults at risk of blindness or visual impairment for appropriate services; and

(D) training about resources available for aging adults who are blind or visually impaired for the staff of aging and disability resource centers established under the Aging and Disability Resource Center initiative funded partly by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(3) designate a commission contact to assist aging adults who are diagnosed with a visual impairment and are losing

vision and the families of those adults with locating and obtaining appropriate services; and

(4) encourage awareness of the reading services the Texas State Library and Archives Commission offers for individuals who are blind or visually impaired. (Gov. Code, Sec. 531.0319(b).)

Source Law

(b) To support campaigns conducted under this section, the commission shall:

(1) establish a toll-free telephone number for providing counseling and referrals to appropriate services for aging adults who are blind or visually impaired;

(2) post on the commission's Internet website information and training resources for aging adults, community stakeholders, and health care and other service providers that generally serve aging adults, including:

(A) links to Internet websites that contain resources for persons who are blind or visually impaired;

(B) existing videos that provide awareness of blindness and visual impairments among aging adults and the importance of early intervention;

(C) best practices for referring aging adults at risk of blindness or visual impairment for appropriate services; and

(D) training about resources available for aging adults who are blind or visually impaired for the staff of aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(3) designate a contact in the commission to assist aging adults who are diagnosed with a visual impairment and are losing vision and the families of those adults with locating and obtaining appropriate services; and

(4) encourage awareness of the reading services for persons who are blind or visually impaired that are offered by the Texas State Library and Archives Commission.

CHAPTER 532. MEDICAID ADMINISTRATION AND OPERATION IN GENERAL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 532.0001. DEFINITION . . . . . 275

SUBCHAPTER B. ADMINISTRATION

Sec. 532.0051. COMMISSION ADMINISTRATION OF MEDICAID . . . . 276
Sec. 532.0052. STREAMLINING ADMINISTRATIVE PROCESSES . . . . 276
Sec. 532.0053. GRIEVANCES . . . . . 279
Sec. 532.0054. OFFICE OF COMMUNITY ACCESS AND SERVICES . . . 280
Sec. 532.0055. SERVICE DELIVERY AUDIT MECHANISMS . . . . . 281

Sec. 532.0056. FEDERAL AUTHORIZATION FOR REFORM . . . . . 281
Sec. 532.0057. FEES, CHARGES, AND RATES . . . . . 284
Sec. 532.0058. ACUTE CARE BILLING COORDINATION SYSTEM; PENALTIES . . . . . 286
Sec. 532.0059. RECOVERY OF CERTAIN THIRD-PARTY REIMBURSEMENTS . . . . . 289
Sec. 532.0060. DENTAL DIRECTOR . . . . . 290
Sec. 532.0061. ALIGNMENT OF MEDICAID AND MEDICARE DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES . . . . . 290
SUBCHAPTER C. FINANCING
Sec. 532.0101. FINANCING OPTIMIZATION . . . . . 291
Sec. 532.0102. RETENTION OF CERTAIN MONEY TO ADMINISTER CERTAIN PROGRAMS; ANNUAL REPORT REQUIRED . . . . . 292
Sec. 532.0103. BIENNIAL FINANCIAL REPORT . . . . . 294
SUBCHAPTER D. PROVIDERS
Sec. 532.0151. STREAMLINING PROVIDER ENROLLMENT AND CREDENTIALING PROCESSES . . . . . 296
Sec. 532.0152. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER . . . . . 298
Sec. 532.0153. ENROLLMENT OF CERTAIN EYE HEALTH CARE PROVIDERS . . . . . 299
Sec. 532.0154. RURAL HEALTH CLINIC REIMBURSEMENT . . . . . 302
Sec. 532.0155. RURAL HOSPITAL REIMBURSEMENT . . . . . 303
Sec. 532.0156. REIMBURSEMENT SYSTEM FOR ELECTRONIC HEALTH INFORMATION REVIEW AND TRANSMISSION . . . . . 306
SUBCHAPTER E. DATA AND TECHNOLOGY
Sec. 532.0201. DATA COLLECTION SYSTEM . . . . . 307
Sec. 532.0202. INFORMATION COLLECTION AND ANALYSIS . . . . . 309
Sec. 532.0203. PUBLIC ACCESS TO CERTAIN DATA . . . . . 313

Sec. 532.0204. DATA REGARDING TREATMENT FOR PRENATAL ALCOHOL OR CONTROLLED SUBSTANCE EXPOSURE . . . . . 314
Sec. 532.0205. MEDICAL TECHNOLOGY . . . . . 314
Sec. 532.0206. PILOT PROJECTS RELATING TO TECHNOLOGY APPLICATIONS . . . . . 315
SUBCHAPTER F. ELECTRONIC VISIT VERIFICATION SYSTEM
Sec. 532.0251. DEFINITION . . . . . 316
Sec. 532.0252. IMPLEMENTATION OF CERTAIN PROVISIONS . . . . 316
Sec. 532.0253. ELECTRONIC VISIT VERIFICATION SYSTEM IMPLEMENTATION . . . . . 317
Sec. 532.0254. INFORMATION TO BE VERIFIED . . . . . 317
Sec. 532.0255. COMPLIANCE STANDARDS AND STANDARDIZED PROCESSES . . . . . 318
Sec. 532.0256. RECIPIENT COMPLIANCE . . . . . 320
Sec. 532.0257. HEALTH CARE PROVIDER COMPLIANCE . . . . . 320
Sec. 532.0258. HEALTH CARE PROVIDER: USE OF PROPRIETARY SYSTEM . . . . . 322
Sec. 532.0259. STAKEHOLDER INPUT . . . . . 323
Sec. 532.0260. RULES . . . . . 324
SUBCHAPTER G. APPLICANTS AND RECIPIENTS
Sec. 532.0301. BILL OF RIGHTS AND BILL OF RESPONSIBILITIES . . . . . 324
Sec. 532.0302. UNIFORM FAIR HEARING RULES . . . . . 326
Sec. 532.0303. SUPPORT AND INFORMATION SERVICES FOR RECIPIENTS . . . . . 328
Sec. 532.0304. NURSING SERVICES ASSESSMENTS . . . . . 333
Sec. 532.0305. THERAPY SERVICES ASSESSMENTS . . . . . 336
Sec. 532.0306. WELLNESS SCREENING PROGRAM . . . . . 337
Sec. 532.0307. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES . . . . . 337

SUBCHAPTER H. PROGRAMS AND SERVICES FOR CERTAIN CATEGORIES OF MEDICAID POPULATION
Sec. 532.0351. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF MEDICAID POPULATION . . . . . 339
Sec. 532.0352. WAIVER PROGRAM FOR CERTAIN INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS . . . . . 343
Sec. 532.0353. BUY-IN PROGRAMS FOR CERTAIN INDIVIDUALS WITH DISABILITIES . . . . . 344
SUBCHAPTER I. UTILIZATION REVIEW, PRIOR AUTHORIZATION, AND COVERAGE PROCESSES AND DETERMINATIONS
Sec. 532.0401. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES . . . . . 345
Sec. 532.0402. ACCESSIBILITY OF INFORMATION REGARDING PRIOR AUTHORIZATION REQUIREMENTS . . . . . 346
Sec. 532.0403. NOTICE REQUIREMENTS REGARDING COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS . . . . . 348
Sec. 532.0404. EXTERNAL MEDICAL REVIEW . . . . . 351
SUBCHAPTER J. COST-SAVING INITIATIVES
Sec. 532.0451. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES . . . . . 354
Sec. 532.0452. PHYSICIAN INCENTIVE PROGRAM TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS . . . . . 357
Sec. 532.0453. CONTINUED IMPLEMENTATION OF CERTAIN INTERVENTIONS AND BEST PRACTICES BY PROVIDERS; SEMIANNUAL REPORT . . . . . 358
Sec. 532.0454. HEALTH SAVINGS ACCOUNT PILOT PROGRAM . . . . . 359
Sec. 532.0455. DURABLE MEDICAL EQUIPMENT REUSE PROGRAM . . . 360

## CHAPTER 532. MEDICAID ADMINISTRATION AND OPERATION IN GENERAL

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 532.0001. DEFINITION. In this chapter, "recipient" means a Medicaid recipient. (New.)

Revisor's Note

The definition of "recipient" is added to the revised law for drafting convenience and to eliminate the frequent, unnecessary repetition of the substance of the definition.

SUBCHAPTER B. ADMINISTRATION

Revised Law

Sec. 532.0051. COMMISSION ADMINISTRATION OF MEDICAID. (a) The commission is the state agency designated to administer federal Medicaid funds.

(b) The commission shall:

(1) in each agency that operates a portion of Medicaid, plan and direct Medicaid, including the management of the Medicaid managed care system and the development, procurement, management, and monitoring of contracts necessary to implement that system; and

(2) establish requirements for and define the scope of the ongoing evaluation of the Medicaid managed care system conducted in conjunction with the Department of State Health Services under Section 108.0065, Health and Safety Code. (Gov. Code, Secs. 531.021(a), (b).)

Source Law

Sec. 531.021. ADMINISTRATION OF MEDICAID. (a) The commission is the state agency designated to administer federal Medicaid funds.

(b) The commission shall:

(1) plan and direct Medicaid in each agency that operates a portion of Medicaid, including the management of the Medicaid managed care system and the development, procurement, management, and monitoring of contracts necessary to implement the Medicaid managed care system; and

(2) establish requirements for and define the scope of the ongoing evaluation of the Medicaid managed care system conducted in conjunction with the Department of State Health Services under Section 108.0065, Health and Safety Code.

Revised Law

Sec. 532.0052. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort:

(1) using the commission's existing resources, to

reduce the paperwork and other administrative burdens placed on recipients, Medicaid providers, and other Medicaid participants, and shall use technology and efficient business practices to reduce those burdens; and

(2) to improve the business practices associated with Medicaid administration by any method the commission determines is cost-effective, including:

(A) expanding electronic claims payment system use;

(B) developing an Internet portal system for prior authorization requests;

(C) encouraging Medicaid providers to submit program participation applications electronically;

(D) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers can conveniently apply to the program;

(E) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in Medicaid; and

(F) encouraging providers' increased use of medical technology, including increasing providers' use of:

(i) electronic communications between patients and their physicians or other health care providers;

(ii) electronic prescribing tools that provide current payer formulary information at the time the physician or other health care provider writes a prescription and that support the electronic transmission of a prescription;

(iii) ambulatory computerized order entry systems that facilitate at the point of care physician and other health care provider orders for medications and laboratory and radiological tests;

(iv) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting;

(v) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and

(vi) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely. (Gov. Code, Sec. 531.02411.)

Source Law

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in Medicaid and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of Medicaid by any method the commission determines is cost-effective, including:

(1) expanding the utilization of the electronic claims payment system;

(2) developing an Internet portal system for prior authorization requests;

(3) encouraging Medicaid providers to submit their program participation applications electronically;

(4) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently apply to the program;

(5) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in Medicaid; and

(6) encouraging the increased use of medical technology by providers, including increasing their use of:

(A) electronic communications between patients and their physicians or other health care providers;

(B) electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health care practitioner writes a prescription and that support the electronic transmission of a prescription;

(C) ambulatory computerized order entry systems that facilitate physician and other health care practitioner orders at the point of care for medications and laboratory and radiological tests;

(D) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting;

(E) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and

(F) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely.

Revisor's Note

Sections 531.02411(6)(B) and (C), Government

Code, refer to a health care "practitioner," while other provisions of Section 531.02411 refer to a health care "provider." The revised law substitutes "provider" for "practitioner" for consistency of terminology and because the terms are synonymous and the former is more commonly used in Subtitle I, Title 4, Government Code, which includes this chapter.

Revised Law

Sec. 532.0053. GRIEVANCES. (a) The commission shall:

(1) adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within the commission to ensure all grievances are managed consistently;

(2) standardize Medicaid grievance data reporting and tracking among divisions within the commission;

(3) implement a no-wrong-door system for Medicaid grievances reported to the commission; and

(4) verify grievance data a Medicaid managed care organization reports.

(b) The commission shall establish a procedure for expedited resolution of a grievance related to Medicaid that allows the commission to:

(1) identify a grievance related to a Medicaid access-to-care issue that is urgent and requires an expedited resolution; and

(2) resolve the grievance within a specified period.

(c) The commission shall:

(1) aggregate recipient and Medicaid provider grievance data to provide a comprehensive data set of grievances; and

(2) make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider. (Gov. Code, Sec. 531.02131.)

Source Law

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) The commission shall adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within the commission to ensure all grievances are managed consistently.

(b) The commission shall standardize Medicaid grievance data reporting and tracking among divisions within the commission.

(c) The commission shall implement a no-wrong-door system for Medicaid grievances reported to the commission.

(d) The commission shall establish a procedure for expedited resolution of a grievance related to Medicaid that allows the commission to:

(1) identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution; and

(2) resolve the grievance within a specified period.

(e) The commission shall verify grievance data reported by a Medicaid managed care organization.

(f) The commission shall:

(1) aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances; and

(2) make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

Revised Law

Sec. 532.0054. OFFICE OF COMMUNITY ACCESS AND SERVICES. The executive commissioner shall establish within the commission an office of community access and services. The office is responsible for:

(1) collaborating with community, state, and federal stakeholders to improve the elements of the health care system that are involved in delivering Medicaid services; and

(2) sharing with Medicaid providers, including hospitals, any best practices, resources, or other information regarding improvements to the health care system. (Gov. Code, Sec. 531.020.)

Source Law

Sec. 531.020. OFFICE OF COMMUNITY ACCESS AND SERVICES. The executive commissioner shall establish within the commission an office of community access and services. The office is responsible for:

(1) collaborating with community, state, and federal stakeholders to improve the elements of the health care system that are involved in the delivery of Medicaid services; and

(2) sharing with Medicaid providers, including hospitals, any best practices, resources, or other information regarding improvements to the health care system.

Revised Law

Sec. 532.0055. SERVICE DELIVERY AUDIT MECHANISMS. The commission shall make every effort to ensure the integrity of Medicaid. To ensure that integrity, the commission shall:

(1) perform risk assessments of every element of the program and audit the program elements determined to present the greatest risks;

(2) ensure that sufficient oversight is in place for the Medicaid medical transportation program and that a quality review assessment of that program occurs; and

(3) evaluate Medicaid with respect to use of the metrics developed through the Texas Health Steps performance improvement plan to guide changes and improvements to the program. (Gov. Code, Sec. 531.02412.)

Source Law

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. (a) The commission shall make every effort to ensure the integrity of Medicaid. To ensure that integrity, the commission shall:

(1) perform risk assessments of every element of the program and audit those elements of the program that are determined to present the greatest risks;

(2) ensure that sufficient oversight is in place for the Medicaid medical transportation program;

(3) ensure that a quality review assessment of the Medicaid medical transportation program occurs; and

(4) evaluate Medicaid with respect to use of the metrics developed through the Texas Health Steps performance improvement plan to guide changes and improvements to the program.

Revised Law

Sec. 532.0056. FEDERAL AUTHORIZATION FOR REFORM. The executive commissioner shall seek a waiver under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan that is designed to achieve the following objectives regarding Medicaid and alternatives to Medicaid:

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

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

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

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

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

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

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

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

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

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

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

(9) allow for the redesign of long-term care services

and supports to increase access to patient-centered care in the most cost-effective manner. (Gov. Code, Sec. 537.002.)

Source Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Revisor's Note

Section 537.002(b)(4), Government Code, refers to "people" who have access to private employer-based

health benefits. Throughout this chapter, the revised law substitutes "individuals" or "individual" for "people" or "person," respectively, for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), applicable to this code.

Revised Law

Sec. 532.0057. FEES, CHARGES, AND RATES. (a) The executive commissioner shall adopt reasonable rules and standards governing the determination of fees, charges, and rates for Medicaid payments.

(b) In adopting rules and standards required by Subsection (a), the executive commissioner:

(1) may provide for payment of fees, charges, and rates in accordance with:

(A) formulas, procedures, or methodologies commission rules prescribe;

(B) state or federal law, policies, rules, regulations, or guidelines;

(C) economic conditions that substantially and materially affect provider participation in Medicaid, as the executive commissioner determines; or

(D) available levels of appropriated state and federal funds; and

(2) shall include financial performance standards that, in the event of a proposed rate reduction, provide private ICF-IID facilities and home and community-based services providers with flexibility in determining how to use Medicaid payments to provide services in the most cost-effective manner while continuing to meet state and federal Medicaid requirements.

(c) Notwithstanding any other provision of Chapter 32, Human Resources Code, Chapter 531 or revised provisions of Chapter

531, as that chapter existed on March 31, 2025, or Chapter 540 or 540A, the commission may adjust the fees, charges, and rates paid to Medicaid providers as necessary to achieve the objectives of Medicaid in a manner consistent with the considerations described by Subsection (b)(1).

(d) In adopting rates for Medicaid payments under Subsection (a), the executive commissioner may adopt reimbursement rates for appropriate nursing services provided to recipients with certain health conditions if those services are determined to provide a cost-effective alternative to hospitalization. A physician must certify that the nursing services are medically appropriate for the recipient for those services to qualify for reimbursement under this subsection.

(e) In adopting rates for Medicaid payments under Subsection (a), the executive commissioner may adopt cost-effective reimbursement rates for group appointments with Medicaid providers for certain diseases and medical conditions commission rules specify. (Gov. Code, Secs. 531.021(b-1), (c), (d), (e), (f), (g).)

Source Law

> (b-1) The executive commissioner shall adopt reasonable rules and standards governing the determination of fees, charges, and rates for Medicaid payments.
>
> (c) The executive commissioner in the adoption of reasonable rules and standards under Subsection (b-1) shall include financial performance standards that, in the event of a proposed rate reduction, provide private ICF-IID facilities and home and community-based services providers with flexibility in determining how to use Medicaid payments to provide services in the most cost-effective manner while continuing to meet the state and federal requirements of Medicaid.
>
> (d) In adopting rules and standards required by Subsection (b-1), the executive commissioner may provide for payment of fees, charges, and rates in accordance with:
>
> (1) formulas, procedures, or methodologies prescribed by the commission's rules;
>
> (2) applicable state or federal law, policies, rules, regulations, or guidelines;
>
> (3) economic conditions that substantially and materially affect provider participation in Medicaid, as determined by the executive commissioner; or
>
> (4) available levels of appropriated state

and federal funds.

(e) Notwithstanding any other provision of Chapter 32, Human Resources Code, Chapter 533, or this chapter, the commission may adjust the fees, charges, and rates paid to Medicaid providers as necessary to achieve the objectives of Medicaid in a manner consistent with the considerations described by Subsection (d).

(f) In adopting rates for Medicaid payments under Subsection (b-1), the executive commissioner may adopt reimbursement rates for appropriate nursing services provided to recipients with certain health conditions if those services are determined to provide a cost-effective alternative to hospitalization. A physician must certify that the nursing services are medically appropriate for the recipient for those services to qualify for reimbursement under this subsection.

(g) In adopting rates for Medicaid payments under Subsection (b-1), the executive commissioner may adopt cost-effective reimbursement rates for group appointments with Medicaid providers for certain diseases and medical conditions specified by rules of the executive commissioner.

Revisor's Note

(1) Section 531.021(e), Government Code, provides that, notwithstanding certain provisions, including Chapter 533, Government Code, the Health and Human Services Commission may adjust fees paid to Medicaid providers. The provisions of Chapter 533 are revised in this subtitle as Chapters 540 and 540A, and the revised law is drafted accordingly.

(2) Section 531.021(g), Government Code, refers to "rules of the executive commissioner." The revised law substitutes "commission rules" for the quoted language for clarity and consistency in the terminology used within Subtitle I, Title 4, Government Code, which includes this chapter, and because under Section 531.033, Government Code, revised as Section 524.0151, the executive commissioner of the Health and Human Services Commission adopts rules for the commission.

Revised Law

Sec. 532.0058. ACUTE CARE BILLING COORDINATION SYSTEM; PENALTIES. (a) The acute care Medicaid billing coordination system for the fee-for-service and primary care case management

delivery models for which the commission contracts must, on entry of a claim in the claims system:

(1) identify within 24 hours whether another entity has primary responsibility for paying the claim; and

(2) submit the claim to the entity the system determines is the primary payor.

(b) The billing coordination system may not increase Medicaid claims payment error rates.

(c) If cost-effective and feasible, the commission shall contract to expand the acute care Medicaid billing coordination system to process claims for all other Medicaid health care services in the manner the system processes claims for acute care services. This subsection does not apply to claims for Medicaid health care services if, before September 1, 2009, those claims were being processed by an alternative billing coordination system.

(d) If cost-effective, the executive commissioner shall adopt rules to enable the acute care Medicaid billing coordination system to identify an entity with primary responsibility for paying a claim that is processed by the system and establish reporting requirements for an entity that may have a contractual responsibility to pay for the types of services that are provided under Medicaid and the claims for which are processed by the system.

(e) An entity that holds a permit, license, or certificate of authority issued by a regulatory agency of this state:

(1) must allow a contractor under this section access to databases to allow the contractor to carry out the purposes of this section, subject to the contractor's contract with the commission and rules the executive commissioner adopts under this section; and

(2) is subject to an administrative penalty or other sanction as provided by the law applicable to the permit, license, or certificate of authority for the entity's violation of a rule the executive commissioner adopts under this section.

(f) Public funds may not be spent on an entity that is not in

compliance with this section unless the executive commissioner and the entity enter into a memorandum of understanding.

(g) Information obtained under this section is confidential. The contractor may use the information only for the purposes authorized under this section. A person commits an offense if the person knowingly uses information obtained under this section for any purpose not authorized under this section. An offense under this subsection is a Class B misdemeanor and all other penalties may apply. (Gov. Code, Secs. 531.02413(a) (part), (a-1), (b), (c), (d), (e).)

Source Law

Sec. 531.02413. BILLING COORDINATION SYSTEM. (a) [If cost-effective and feasible, the commission shall, on or before March 1, 2008, contract through an existing procurement process for the implementation of] an acute care Medicaid billing coordination system for the fee-for-service and primary care case management delivery models that will, upon entry in the claims system, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the entity the system determines is the primary payor. The system may not increase Medicaid claims payment error rates.

(a-1) If cost-effective and feasible, the commission shall contract to expand the Medicaid billing coordination system described by Subsection (a) to process claims for all other health care services provided through Medicaid in the manner claims for acute care services are processed by the system under Subsection (a). This subsection does not apply to claims for health care services provided through Medicaid if, before September 1, 2009, those claims were being processed by an alternative billing coordination system.

(b) If cost-effective, the executive commissioner shall adopt rules for the purpose of enabling the system described by Subsection (a) to identify an entity with primary responsibility for paying a claim that is processed by the system under Subsection (a) and establish reporting requirements for any entity that may have a contractual responsibility to pay for the types of services that are provided under Medicaid and the claims for which are processed by the system under Subsection (a).

(c) An entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state must allow a contractor under this section access to databases to allow the contractor to carry out the purposes of this section, subject to the contractor's contract with the commission and rules adopted under this section, and is subject to an administrative penalty or other sanction as provided by the law applicable to the permit, license, or certificate of authority for a violation by the entity of a rule adopted under this section.

(d) After September 1, 2008, no public funds

shall be expended on entities not in compliance with this section unless a memorandum of understanding is entered into between the entity and the executive commissioner.

(e) Information obtained under this section is confidential. The contractor may use the information only for the purposes authorized under this section. A person commits an offense if the person knowingly uses information obtained under this section for any purpose not authorized under this section. An offense under this subsection is a Class B misdemeanor and all other penalties may apply.

Revisor's Note

(1) Section 531.02413(a), Government Code, requires the Health and Human Services Commission to contract for the implementation of an acute care Medicaid billing coordination system on or before March 1, 2008, if cost-effective and feasible. Because the commission has implemented the described system, the revised law omits this provision as executed. The omitted law reads:

> (a) If cost-effective and feasible, the commission shall, on or before March 1, 2008, contract through an existing procurement process for the implementation of [an acute care Medicaid billing coordination system] . . . .

(2) Section 531.02413(d), Government Code, restricts certain spending of public funds "[a]fter September 1, 2008." The revised law omits the quoted language as unnecessary because the specified date has passed, and any future expenditure of public funds would necessarily occur after that date.

Revised Law

Sec. 532.0059. RECOVERY OF CERTAIN THIRD-PARTY REIMBURSEMENTS. The commission shall obtain Medicaid reimbursement from each fiscal intermediary who makes a payment to a service provider on behalf of the Medicare program, including a reimbursement for a payment made to a home health services provider or nursing facility for services provided to an individual who is eligible to receive health care benefits under both Medicaid and the Medicare program. (Gov. Code, Sec. 531.0392.)

Source Law

> Sec. 531.0392. RECOVERY OF CERTAIN THIRD-PARTY REIMBURSEMENTS UNDER MEDICAID. (a) In this section, "dually eligible individual" means an individual who is eligible to receive health care benefits under both Medicaid and the Medicare program.
>
> (b) The commission shall obtain Medicaid reimbursement from each fiscal intermediary who makes a payment to a service provider on behalf of the Medicare program, including a reimbursement for a payment made to a home health services provider or nursing facility for services rendered to a dually eligible individual.

Revised Law

Sec. 532.0060. DENTAL DIRECTOR. The executive commissioner shall appoint a Medicaid dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and rules the State Board of Dental Examiners adopts under that subtitle. (Gov. Code, Sec. 531.02114.)

Source Law

> Sec. 531.02114. DENTAL DIRECTOR. The executive commissioner shall appoint for Medicaid a dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and rules adopted under that subtitle by the State Board of Dental Examiners.

Revised Law

Sec. 532.0061. ALIGNMENT OF MEDICAID AND MEDICARE DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES. (a) The commission shall review Medicaid forms and requirements regarding written orders for diabetic equipment and supplies to identify variations between permissible Medicaid ordering procedures and ordering procedures available to Medicare providers.

(b) To the extent practicable and in conformity with Chapter 157, Occupations Code, and Chapter 483, Health and Safety Code, after the commission conducts a review under Subsection (a), the commission or executive commissioner, as appropriate, shall modify only Medicaid forms, rules, and procedures applicable to orders for diabetic equipment and supplies to provide for an ordering system that is comparable to the Medicare ordering system for diabetic equipment and supplies. The ordering system must permit a diabetic equipment or supplies supplier to complete forms by hand or enter

medical information or supply orders electronically into a form as necessary to provide the information required to dispense diabetic equipment or supplies.

(c) A diabetic equipment and supplies provider may bill and collect payment for the provider's services if the provider has a copy of the form that meets the requirements of Subsection (b) and is signed by a medical provider licensed in this state to treat diabetic patients. Additional documentation may not be required. (Gov. Code, Sec. 531.099.)

Source Law

> Sec. 531.099. ALIGNMENT OF MEDICAID DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES WITH MEDICARE DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES. (a) The commission shall review forms and requirements under Medicaid regarding written orders for diabetic equipment and supplies to identify variations between permissible ordering procedures under that program and ordering procedures available to providers under the Medicare program.
>
> (b) To the extent practicable, and in conformity with Chapter 157, Occupations Code, and Chapter 483, Health and Safety Code, after conducting a review under Subsection (a) the commission or executive commissioner, as appropriate, shall modify only forms, rules, and procedures applicable to orders for diabetic equipment and supplies under Medicaid to provide for an ordering system that is comparable to the ordering system for diabetic equipment and supplies under the Medicare program. The ordering system must permit a diabetic equipment or supplies supplier to complete the forms by hand or to enter by electronic format medical information or supply orders into any form as necessary to provide the information required to dispense diabetic equipment or supplies.
>
> (c) A provider of diabetic equipment and supplies may bill and collect payment for the provider's services if the provider has a copy of the form that meets the requirements of Subsection (b) and that is signed by a medical practitioner licensed in this state to treat diabetic patients. Additional documentation may not be required.

Revisor's Note

Section 531.099(c), Government Code, refers to a "medical practitioner." The revised law substitutes "provider" for "practitioner" for the reason stated in the revisor's note to Section 532.0052 of this chapter.

SUBCHAPTER C. FINANCING

Revised Law

Sec. 532.0101. FINANCING OPTIMIZATION. The commission

shall ensure that the Medicaid finance system is optimized to:

(1) maximize this state's receipt of federal funds;

(2) create incentives for providers to use preventive care;

(3) increase and retain providers in the system to maintain an adequate provider network;

(4) more accurately reflect the costs borne by providers; and

(5) encourage improvement of the quality of care. (Gov. Code, Sec. 531.02113.)

Source Law

Sec. 531.02113. OPTIMIZATION OF MEDICAID FINANCING. The commission shall ensure that the Medicaid finance system is optimized to:

(1) maximize the state's receipt of federal funds;

(2) create incentives for providers to use preventive care;

(3) increase and retain providers in the system to maintain an adequate provider network;

(4) more accurately reflect the costs borne by providers; and

(5) encourage the improvement of the quality of care.

Revised Law

Sec. 532.0102. RETENTION OF CERTAIN MONEY TO ADMINISTER CERTAIN PROGRAMS; ANNUAL REPORT REQUIRED. (a) In this section, "directed payment program" means a delivery system and provider patient initiative implemented by this state under 42 C.F.R. Section 438.6(c).

(b) This section applies only to money the commission receives from a source other than the general revenue fund to operate a waiver program established under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) or a directed payment program or successor program as the commission determines.

(c) Subject to Subsection (d), the commission may retain from money to which this section applies an amount equal to the estimated costs necessary to administer the program for which the commission receives the money, but not to exceed $8 million for a state fiscal year.

(d) If the commission determines that the commission needs additional money to administer a program described by Subsection (b), the commission may retain an additional amount with the governor's and the Legislative Budget Board's approval, but not to exceed a total retained amount equal to 0.25 percent of the total estimated amount the commission receives for the program.

(e) The commission shall spend the retained money to assist in paying the costs necessary to administer the program for which the commission receives the money, except that the commission may not use the money to pay any type of administrative cost that, before June 1, 2019, was funded with general revenue.

(f) The commission shall submit an annual report to the governor and the Legislative Budget Board that:

(1) details the amount of money the commission retained and spent under this section during the preceding state fiscal year, including a separate detail of any increase in the amount of money the commission retained for a program under Subsection (d);

(2) contains a transparent description of how the commission used the money described by Subdivision (1); and

(3) assesses the extent to which the retained money covered the estimated costs to administer the applicable program and states whether, based on that assessment, the commission adjusted or considered adjustments to the amount retained.

(g) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 531.021135.)

Source Law

Sec. 531.021135. COMMISSION'S AUTHORITY TO RETAIN CERTAIN MONEY TO ADMINISTER CERTAIN MEDICAID PROGRAMS; REPORT REQUIRED. (a) In this section, "directed payment program" means a delivery system and provider patient initiative implemented by this state under 42 C.F.R. Section 438.6(c).

(b) This section applies only to money the commission receives from a source other than the general revenue fund to operate a waiver program established under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) or a directed payment program or successor program as determined by the commission.

(c) Subject to Subsection (e), the commission may retain from money to which this section applies an amount equal to the estimated costs necessary to administer the program for which the money is received, but not to exceed $8 million for a state fiscal year.

(d) The commission shall spend money retained under this section to assist in paying the costs necessary to administer the program for which the money is received, except that the commission may not use the money to pay any type of administrative cost that, before June 1, 2019, was funded with general revenue.

(e) If the commission determines that the commission needs additional money to administer a program described by Subsection (b), the commission may retain an additional amount with the approval of the governor and the Legislative Budget Board, but not to exceed a total retained amount equal to 0.25 percent of the total amount estimated to be received for the program.

(f) The commission shall submit an annual report to the governor and the Legislative Budget Board that:

(1) details the amount of money retained and spent by the commission under this section during the preceding state fiscal year, including a separate detail of any increase in the amount of money retained for a program under Subsection (e);

(2) contains a transparent description of how the commission used the money described by Subdivision (1); and

(3) assesses the extent to which the money retained by the commission under this section covered the estimated costs to administer the applicable program and states whether, based on that assessment, the commission adjusted or considered adjustments to the amount retained.

(g) The executive commissioner shall adopt rules necessary to implement this section.

Revised Law

Sec. 532.0103. BIENNIAL FINANCIAL REPORT. (a) The commission shall prepare a biennial Medicaid financial report covering each state agency that operates a part of Medicaid and each component of Medicaid those agencies operate.

(b) The report must include:

(1) for each state agency that operates a part of Medicaid:

(A) a description of each of the Medicaid components the agency operates; and

(B) an accounting of all funds related to Medicaid the agency received and disbursed during the period the report covers, including:

(i) the amount of any federal Medicaid

funds allocated to the agency for the support of each of the Medicaid components the agency operates;

(ii) the amount of any funds the legislature appropriated to the agency for each of those components; and

(iii) the amount of Medicaid payments and related expenditures made by or in connection with each of those components; and

(2) for each Medicaid component identified in the report:

(A) the amount and source of funds or other revenue received by or made available to the agency for the component;

(B) the amount spent on each type of service or benefit provided by or under the component;

(C) the amount spent on component operations, including eligibility determination, claims processing, and case management; and

(D) the amount spent on any other administrative costs.

(c) The report must cover the three-year period ending on the last day of the previous fiscal year.

(d) The commission may request from any appropriate state agency information necessary to complete the report. Each agency shall cooperate with the commission in providing information for the report.

(e) Not later than December 1 of each even-numbered year, the commission shall submit the report to the governor, the lieutenant governor, the speaker of the house of representatives, the presiding officer of each standing committee of the senate and house of representatives having jurisdiction over health and human services issues, and the state auditor. (Gov. Code, Sec. 531.02111.)

Source Law

Sec. 531.02111. BIENNIAL MEDICAID FINANCIAL REPORT. (a) The commission shall prepare a biennial Medicaid financial report covering each state agency that operates any part of Medicaid and each component of Medicaid operated by those agencies.

(b) The report must include:

(1) for each state agency described by Subsection (a):

(A) a description of each of the components of Medicaid operated by the agency; and

(B) an accounting of all funds related to Medicaid received and disbursed by the agency during the period covered by the report, including:

(i) the amount of any federal Medicaid funds allocated to the agency for the support of each of the Medicaid components operated by the agency;

(ii) the amount of any funds appropriated by the legislature to the agency for each of those components; and

(iii) the amount of Medicaid payments and related expenditures made by or in connection with each of those components; and

(2) for each Medicaid component identified in the report:

(A) the amount and source of funds or other revenue received by or made available to the agency for the component;

(B) the amount spent on each type of service or benefit provided by or under the component;

(C) the amount spent on component operations, including eligibility determination, claims processing, and case management; and

(D) the amount spent on any other administrative costs.

(c) The report must cover the three-year period ending on the last day of the previous fiscal year.

(d) The commission may request from any appropriate state agency information necessary to complete the report. Each agency shall cooperate with the commission in providing information for the report.

(e) Not later than December 1 of each even-numbered year, the commission shall submit the report to the governor, the lieutenant governor, the speaker of the house of representatives, the presiding officer of each standing committee of the senate and house of representatives having jurisdiction over health and human services issues, and the state auditor.

SUBCHAPTER D. PROVIDERS

Revised Law

Sec. 532.0151. STREAMLINING PROVIDER ENROLLMENT AND CREDENTIALING PROCESSES. (a) The commission shall streamline Medicaid provider enrollment and credentialing processes.

(b) In streamlining the Medicaid provider enrollment process, the commission shall establish a centralized Internet

portal through which providers may enroll in Medicaid.

(c) In streamlining the Medicaid provider credentialing process, the commission may:

(1) designate a centralized credentialing entity;

(2) share information in the database established under Subchapter C, Chapter 32, Human Resources Code, with the centralized credentialing entity; and

(3) require all Medicaid managed care organizations to use the centralized credentialing entity as a hub for collecting and sharing information.

(d) The commission may:

(1) use the Internet portal created under Subsection (b) to create a single, consolidated Medicaid provider enrollment and credentialing process; and

(2) if cost-effective, contract with a third party to develop the single, consolidated process. (Gov. Code, Sec. 531.02118.)

Source Law

> Sec. 531.02118. STREAMLINING MEDICAID PROVIDER ENROLLMENT AND CREDENTIALING PROCESSES. (a) The commission shall streamline provider enrollment and credentialing processes under Medicaid.
>
> (b) In streamlining the Medicaid provider enrollment process, the commission shall establish a centralized Internet portal through which providers may enroll in Medicaid. The commission may use the Internet portal created under this subsection to create a single, consolidated Medicaid provider enrollment and credentialing process.
>
> (c) In streamlining the Medicaid provider credentialing process under this section, the commission may designate a centralized credentialing entity and may:
>
> (1) share information in the database established under Subchapter C, Chapter 32, Human Resources Code, with the centralized credentialing entity; and
>
> (2) require all managed care organizations contracting with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization to use the centralized credentialing entity as a hub for the collection and sharing of information.
>
> (d) If cost-effective, the commission may contract with a third party to develop the single, consolidated Medicaid provider enrollment and credentialing process authorized under Subsection (b).

Revisor's Note

Section 531.02118(c)(2), Government Code, refers to "managed care organizations contracting with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization." Section 531.001(4-c), Government Code, which is revised in this subtitle as Section 521.0001(9), defines "Medicaid managed care organization" as "a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients." That definition applies throughout the subtitle and is synonymous with the quoted phrase. The revised law therefore substitutes the defined term "Medicaid managed care organization" for the quoted phrase from Section 531.02118(c)(2). Furthermore, for consistency of terminology throughout this chapter, the revised law substitutes "Medicaid managed care organization" for substantively synonymous source law references to "managed care organization that contracts with the commission under Chapter 533," "managed care organization participating in Medicaid," "managed care organization under Chapter 533," "managed care organization that contracts with the commission to provide health care services to Medicaid recipients," and other similar references to managed care organizations.

Revised Law

Sec. 532.0152. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER. (a) In this section, "national provider identifier number" means the national provider identifier number required under Section 1128J(e) of the Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The commission shall transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.

(c) The commission shall implement a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid.

(d) The commission shall implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services. (Gov. Code, Sec. 531.021182.)

Source Law

> Sec. 531.021182. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER. (a) In this section, "national provider identifier number" means the national provider identifier number required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).
>
> (b) The commission shall transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.
>
> (c) The commission shall implement a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid.
>
> (d) The commission shall implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

Revised Law

Sec. 532.0153. ENROLLMENT OF CERTAIN EYE HEALTH CARE PROVIDERS. (a) This section applies only to:

(1) an optometrist who is licensed by the Texas Optometry Board;

(2) a therapeutic optometrist who is licensed by the Texas Optometry Board;

(3) an ophthalmologist who is licensed by the Texas Medical Board; and

(4) an institution of higher education that provides an accredited program for:

(A) training as a doctor of optometry or an optometrist residency; or

(B) training as an ophthalmologist or an ophthalmologist residency.

(b) The commission may not prevent a provider to whom this section applies from enrolling as a Medicaid provider if the provider:

(1) either:

(A) joins an established practice of a health care provider or provider group that has a contract with a Medicaid managed care organization to provide health care services to recipients under Chapter 540 or 540A; or

(B) is employed by or otherwise compensated for providing training at an institution of higher education described by Subsection (a)(4);

(2) applies to be an enrolled Medicaid provider;

(3) if applicable, complies with the requirements of the contract described by Subdivision (1)(A); and

(4) complies with all other applicable requirements related to being a Medicaid provider.

(c) The commission may not prevent an institution of higher education from enrolling as a Medicaid provider if the institution:

(1) has a contract with a managed care organization to provide health care services to recipients under Chapter 540 or 540A;

(2) applies to be an enrolled Medicaid provider;

(3) complies with the requirements of the contract described by Subdivision (1); and

(4) complies with all other applicable requirements related to being a Medicaid provider. (Gov. Code, Sec. 531.021191.)

Source Law

Sec. 531.021191. MEDICAID ENROLLMENT OF CERTAIN EYE HEALTH CARE PROVIDERS. (a) This section applies only to:

(1) an optometrist who is licensed by the Texas Optometry Board;

(2) a therapeutic optometrist who is licensed by the Texas Optometry Board;

(3) an ophthalmologist who is licensed by the Texas Medical Board; and

(4) an institution of higher education that provides an accredited program for:

(A) training as a Doctor of Optometry or an optometrist residency; or

(B) training as an ophthalmologist or an ophthalmologist residency.

(b) The commission may not prevent a provider to whom this section applies from enrolling as a Medicaid provider if the provider:

(1) either:

(A) joins an established practice of a health care provider or provider group that has a contract with a managed care organization to provide health care services to recipients under Chapter 533; or

(B) is employed by or otherwise compensated for providing training at an institution of higher education described by Subsection (a)(4);

(2) applies to be an enrolled provider under Medicaid;

(3) if applicable, complies with the requirements of the contract between the provider or the provider's group and the applicable managed care organization; and

(4) complies with all other applicable requirements related to being a Medicaid provider.

(c) The commission may not prevent an institution of higher education from enrolling as a Medicaid provider if the institution:

(1) has a contract with a managed care organization to provide health care services to recipients under Chapter 533;

(2) applies to be an enrolled provider under Medicaid;

(3) complies with the requirements of the contract between the provider and the applicable managed care organization; and

(4) complies with all other applicable requirements related to being a Medicaid provider.

Revisor's Note

(1) Section 531.021191(b)(1), Government Code, refers to a health care provider or provider group that has a contract with a "managed care organization" to provide health care services to Medicaid recipients, and Section 531.021191(c)(1), Government Code, refers to an institution of higher education having a contract with a "managed care organization" to provide health care services to those recipients. As explained in the revisor's note to Section 532.0151 of this chapter, a Medicaid managed care organization is a managed care organization that contracts with the

Health and Human Services Commission to provide health care services to Medicaid recipients, and the term is defined by Section 531.001(4-c), Government Code, which is revised as Section 521.0001(9) and applies to Subtitle I, Title 4, Government Code, which includes this chapter. For clarity, the revised law substitutes "Medicaid managed care organization" for the references to "managed care organization" because the only type of managed care organization that would contract with a health care provider, provider group, or institution of higher education for the provision of health care services to Medicaid recipients is a Medicaid managed care organization.

(2) Sections 531.021991(b)(1)(A) and (c)(1), Government Code, refer to a health care provider or provider group that has a contract with a managed care organization to provide health care services under Medicaid under Chapter 533, Government Code. The revised law substitutes "Chapter 540 or 540A" for the reason stated in Revisor's Note (1) to Section 532.0057.

Revised Law

Sec. 532.0154. RURAL HEALTH CLINIC REIMBURSEMENT. The commission may not impose any condition on the reimbursement of a rural health clinic under Medicaid if the condition is more stringent than the conditions imposed by:

(1) the Rural Health Clinic Services Act of 1977 (Pub. L. No. 95-210); or

(2) the laws of this state regulating the practice of medicine, pharmacy, or professional nursing. (Gov. Code, Sec. 531.02193.)

Source Law

Sec. 531.02193. CERTAIN CONDITIONS ON MEDICAID REIMBURSEMENT OF RURAL HEALTH CLINICS PROHIBITED. The commission may not impose any condition on the

reimbursement of a rural health clinic under the Medicaid program if the condition is more stringent than the conditions imposed by the Rural Health Clinic Services Act of 1977 (Pub. L. No. 95-210) or the laws of this state regulating the practice of medicine, pharmacy, or professional nursing.

Revisor's Note

Section 531.02193, Government Code, refers to "the Medicaid program." Section 531.001, Government Code, revised as Section 521.0001, defines "Medicaid" as the medical assistance program, which is synonymous with the Medicaid program. That definition applies to Subtitle I, Title 4, Government Code, which includes this chapter. For that reason, the revised law substitutes "Medicaid" for "the Medicaid program."

Revised Law

Sec. 532.0155. RURAL HOSPITAL REIMBURSEMENT. (a) In this section, "rural hospital" has the meaning assigned by commission rules for purposes of reimbursing hospitals for providing Medicaid inpatient or outpatient services.

(b) To the extent allowed by federal law and subject to limitations on appropriations, the executive commissioner by rule shall adopt a prospective reimbursement methodology for the payment of rural hospitals participating in Medicaid that ensures the rural hospitals are reimbursed on an individual basis for providing inpatient and general outpatient services to recipients by using the hospitals' most recent cost information concerning the costs incurred for providing the services. The commission shall calculate the prospective cost-based reimbursement rates once every two years.

(c) In adopting rules under Subsection (b), the executive commissioner may:

(1) adopt a methodology that requires:

(A) a Medicaid managed care organization to reimburse rural hospitals for services delivered through the Medicaid managed care program using a minimum fee schedule or other method for which federal matching money is available; or

(B) both the commission and a Medicaid managed care organization to share in the total amount of reimbursement paid to rural hospitals; and

(2) require that the reimbursement amount paid to a rural hospital is subject to any applicable adjustments the commission makes for payments to or penalties imposed on the rural hospital that are based on a quality-based or performance-based requirement under the Medicaid managed care program.

(d) Not later than September 1 of each even-numbered year, the commission shall, for purposes of Subsection (b), determine the allowable costs incurred by a rural hospital participating in the Medicaid managed care program based on the rural hospital's cost reports submitted to the Centers for Medicare and Medicaid Services and other available information that the commission considers relevant in determining the hospital's allowable costs.

(e) Notwithstanding Subsection (b) and subject to Subsection (f), the executive commissioner shall adopt and the commission shall implement, beginning with the state fiscal year ending August 31, 2022, a true cost-based reimbursement methodology for inpatient and general outpatient services provided to recipients at rural hospitals that provides:

(1) prospective payments during a state fiscal year to the hospitals using the reimbursement methodology adopted under Subsection (b); and

(2) to the extent allowed by federal law, in the subsequent state fiscal year a cost settlement to provide additional reimbursement as necessary to reimburse the hospitals for the true costs incurred in providing inpatient and general outpatient services to recipients during the previous state fiscal year.

(f) If federal law does not permit the use of a true cost-based reimbursement methodology described by Subsection (e), the commission shall continue to use the prospective cost-based reimbursement methodology the executive commissioner adopts under

Subsection (b) for the payment of rural hospitals for providing inpatient and general outpatient services to recipients. (Gov. Code, Sec. 531.02194.)

Source Law

Sec. 531.02194. REIMBURSEMENT METHODOLOGY FOR RURAL HOSPITALS. (a) In this section, "rural hospital" has the meaning assigned by commission rules for purposes of the reimbursement of hospitals for providing inpatient or outpatient services under Medicaid.

(b) To the extent allowed by federal law and subject to limitations on appropriations, the executive commissioner by rule shall adopt a prospective reimbursement methodology for the payment of rural hospitals participating in Medicaid that ensures the rural hospitals are reimbursed on an individual basis for providing inpatient and general outpatient services to Medicaid recipients by using the hospitals' most recent cost information concerning the costs incurred for providing the services. The commission shall calculate the prospective cost-based reimbursement rates once every two years.

(c) In adopting rules under Subsection (b), the executive commissioner may:

(1) adopt a methodology that requires:

(A) a managed care organization to reimburse rural hospitals for services delivered through the Medicaid managed care program using a minimum fee schedule or other method for which federal matching money is available; or

(B) both the commission and a managed care organization to share in the total amount of reimbursement paid to rural hospitals; and

(2) require that the amount of reimbursement paid to a rural hospital is subject to any applicable adjustments made by the commission for payments to or penalties imposed on the rural hospital that are based on a quality-based or performance-based requirement under the Medicaid managed care program.

(d) Not later than September 1 of each even-numbered year, the commission shall, for purposes of Subsection (b), determine the allowable costs incurred by a rural hospital participating in the Medicaid managed care program based on the rural hospital's cost reports submitted to the federal Centers for Medicare and Medicaid Services and other available information that the commission considers relevant in determining the hospital's allowable costs.

(e) Notwithstanding Subsection (b) and subject to Subsection (f), the executive commissioner shall adopt and the commission shall implement, beginning with the state fiscal year ending August 31, 2022, a true cost-based reimbursement methodology for inpatient and general outpatient services provided to Medicaid recipients at rural hospitals that provides:

(1) prospective payments during a state fiscal year to the hospitals using the reimbursement methodology adopted under Subsection (b); and

(2) to the extent allowed by federal law, in the subsequent state fiscal year a cost settlement to provide additional reimbursement as necessary to reimburse the hospitals for the true costs incurred in

providing inpatient and general outpatient services to Medicaid recipients during the previous state fiscal year.

(f) Notwithstanding Subsection (e), if federal law does not permit the use of a true cost-based reimbursement methodology described by that subsection, the commission shall continue to use the prospective cost-based reimbursement methodology adopted under Subsection (b) for the payment of rural hospitals for providing inpatient and general outpatient services to Medicaid recipients.

Revisor's Note

Sections 531.02194(c)(1)(A) and (B), Government Code, refer to reimbursement to rural hospitals by a "managed care organization" for services delivered through the Medicaid managed care program. The only type of managed care organization that would provide reimbursement under the Medicaid managed care program is a Medicaid managed care organization. For the reasons stated in Revisor's Note (1) to Section 532.0153 of this chapter, the revised law substitutes "Medicaid managed care organization" for the references to "managed care organization."

Revised Law

Sec. 532.0156. REIMBURSEMENT SYSTEM FOR ELECTRONIC HEALTH INFORMATION REVIEW AND TRANSMISSION. If feasible and cost-effective, the executive commissioner by rule may develop and the commission may implement a system to provide Medicaid reimbursement to a health care provider, including a physician, for reviewing and transmitting electronic health information. (Gov. Code, Secs. 531.0162(g), (h) (part).)

Source Law

(g) The executive commissioner by rule may develop and the commission may implement a system to reimburse providers of health care services under the state Medicaid program for review and transmission of electronic health information if feasible and cost-effective.

(h) In this section, . . . "provider of health care services" include a physician.

Revisor's Note

(1) Section 531.0162(g), Government Code, refers to "the state Medicaid program." Section

531.001, Government Code, revised as Section 521.0001, defines "Medicaid" as the medical assistance program, which is synonymous with the state Medicaid program. That definition applies to Subtitle I, Title 4, Government Code, which includes this chapter. For that reason, the revised law substitutes "Medicaid" for "the state Medicaid program."

(2) Sections 531.0162(g) and (h), Government Code, refer to "providers of health care services" and a "provider of health care services," respectively. The revised law substitutes "health care provider" for "provider of health care services" because the terms are synonymous and the former is more commonly used in Subtitle I, Title 4, Government Code, which includes this chapter.

SUBCHAPTER E. DATA AND TECHNOLOGY

Revised Law

Sec. 532.0201. DATA COLLECTION SYSTEM. (a) The commission and each health and human services agency that administers a part of Medicaid shall jointly develop a system to coordinate and integrate state Medicaid databases to:

(1) facilitate the comprehensive analysis of Medicaid data; and

(2) detect fraud a program provider or recipient perpetrates.

(b) To minimize cost and duplication of activities, the commission shall assist and coordinate:

(1) the efforts of the agencies that are participating in developing the system; and

(2) the efforts of those agencies with the efforts of other agencies involved in a statewide health care data collection system provided for by Section 108.006, Health and Safety Code, including avoiding duplication of expenditure of state funds for computer hardware, staff, or services.

(c) On the executive commissioner's request, a state agency that administers any part of Medicaid shall assist the commission in developing the system.

(d) The commission shall develop the system in a manner that will enable a complete analysis of the use of prescription medications, including information relating to:

(1) recipients for whom more than three medications have been prescribed; and

(2) the medical effect denial of Medicaid coverage for more than three medications has had on recipients.

(e) The commission shall ensure that the system is used each month to match vital statistics unit death records with a list of individuals eligible for Medicaid, and that each individual who is deceased is promptly removed from the list of individuals eligible for Medicaid. (Gov. Code, Sec. 531.0214.)

Source Law

Sec. 531.0214. MEDICAID DATA COLLECTION SYSTEM. (a) The commission and each health and human services agency that administers a part of Medicaid shall jointly develop a system to coordinate and integrate state Medicaid databases to:

(1) facilitate the comprehensive analysis of Medicaid data; and

(2) detect fraud perpetrated by a program provider or client.

(b) To minimize cost and duplication of activities, the commission shall assist and coordinate:

(1) the efforts of the agencies that are participating in the development of the system required by Subsection (a); and

(2) the efforts of those agencies with the efforts of other agencies involved in a statewide health care data collection system provided for by Section 108.006, Health and Safety Code, including avoiding duplication of expenditure of state funds for computer hardware, staff, or services.

(c) On the request of the executive commissioner, a state agency that administers any part of Medicaid shall assist the commission in developing the system required by this section.

(d) The commission shall develop the database system in a manner that will enable a complete analysis of the use of prescription medications, including information relating to:

(1) Medicaid clients for whom more than three medications have been prescribed; and

(2) the medical effect denial of Medicaid coverage for more than three medications has had on Medicaid clients.

(e) The commission shall ensure that the

database system is used each month to match vital statistics unit death records with a list of persons eligible for Medicaid, and that each person who is deceased is promptly removed from the list of persons eligible for Medicaid.

Revisor's Note

Section 531.0214(a), Government Code, refers to a Medicaid program "client" and Section 531.0214(d), Government Code, refers to "Medicaid clients." A "Medicaid client" is an individual who receives health care services through Medicaid. The term is synonymous with "Medicaid recipient." The revised law in Section 532.0001 of this chapter adds a definition of "recipient" for purposes of the chapter and provides that the term means "a Medicaid recipient." For consistency of terminology, the revised law throughout this chapter substitutes "recipient" for "client," "Medicaid client," and other similar references to individuals receiving health care services under Medicaid.

Revised Law

Sec. 532.0202. INFORMATION COLLECTION AND ANALYSIS. (a) The commission shall:

(1) make every effort to improve data analysis and integrate available information associated with Medicaid;

(2) use the decision support system in the commission's center for analytics and decision support for the purpose described by Subdivision (1);

(3) modify or redesign the decision support system to allow for the data collected by Medicaid to be used more systematically and effectively for Medicaid evaluation and policy development; and

(4) develop or redesign the decision support system as necessary to ensure that the system:

(A) incorporates currently collected Medicaid enrollment, utilization, and provider data;

(B) allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within Medicaid;

(C) is able to obtain consistent and accurate answers to questions;

(D) allows for analysis of multiple issues within Medicaid to determine whether any programmatic or policy issues overlap or are in conflict;

(E) includes predefined data reports on utilization of high-cost services that allow Medicaid management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate;

(F) includes any encounter data with respect to recipients that a Medicaid managed care organization receives from a health care provider in the organization's provider network; and

(G) links Medicaid and non-Medicaid data sets, including data sets related to:

(i) Medicaid;

(ii) the financial assistance program under Chapter 31, Human Resources Code;

(iii) the special supplemental nutrition program for women, infants, and children authorized by 42 U.S.C. Section 1786;

(iv) vital statistics; and

(v) other public health programs.

(b) The commission shall ensure that all Medicaid data sets the decision support system creates or identifies are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist or arise with respect to making the data sets available on the Internet, the system and the commission shall make every effort to make the data available on the Internet either by:

(1) removing individually identifiable information;

or

(2) aggregating the data in a manner to prevent the association of individual records with particular individuals.

(c) The commission shall regularly evaluate data submitted by Medicaid managed care organizations to determine whether:

(1) the data continues to serve a useful purpose; and

(2) additional data is needed to oversee contracts or evaluate the effectiveness of Medicaid.

(d) The commission shall collect Medicaid managed care data that effectively captures the quality of services recipients receive.

(e) The commission shall develop a dashboard for agency leadership that is designed to assist leadership with overseeing Medicaid and comparing the performance of Medicaid managed care organizations. The dashboard must identify a concise number of important Medicaid indicators, including key data, performance measures, trends, and problems. (Gov. Code, Sec. 531.02141.)

Source Law

Sec. 531.02141. MEDICAID INFORMATION COLLECTION AND ANALYSIS. (a) The commission shall make every effort to improve data analysis and integrate available information associated with Medicaid. The commission shall use the decision support system in the commission's center for strategic decision support for this purpose and shall modify or redesign the system to allow for the data collected by Medicaid to be used more systematically and effectively for Medicaid evaluation and policy development. The commission shall develop or redesign the system as necessary to ensure that the system:

(1) incorporates program enrollment, utilization, and provider data that are currently collected;

(2) allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within the program;

(3) is able to obtain consistent and accurate answers to questions;

(4) allows for analysis of multiple issues within the program to determine whether any programmatic or policy issues overlap or are in conflict;

(5) includes predefined data reports on utilization of high-cost services that allow program management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate;

(6) includes any encounter data with

respect to recipients that a managed care organization that contracts with the commission under Chapter 533 receives from a health care provider under the organization's provider network; and

(7) links Medicaid and non-Medicaid data sets, including data sets related to Medicaid, the Temporary Assistance for Needy Families program, the Special Supplemental Nutrition Program for Women, Infants, and Children, vital statistics, and other public health programs.

(b) The commission shall ensure that all Medicaid data sets created or identified by the decision support system are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist or arise with respect to making the data sets available on the Internet, the system and the commission shall make every effort to make the data available through that means either by removing information by which particular individuals may be identified or by aggregating the data in a manner so that individual records cannot be associated with particular individuals.

(c) The commission shall regularly evaluate data submitted by managed care organizations that contract with the commission under Chapter 533 to determine whether:

(1) the data continues to serve a useful purpose; and

(2) additional data is needed to oversee contracts or evaluate the effectiveness of Medicaid.

(d) The commission shall collect Medicaid managed care data that effectively captures the quality of services received by Medicaid recipients.

(e) The commission shall develop a dashboard for agency leadership that is designed to assist leadership with overseeing Medicaid and comparing the performance of managed care organizations participating in Medicaid. The dashboard must identify a concise number of important Medicaid indicators, including key data, performance measures, trends, and problems.

Revisor's Note

(1) Section 531.02141(a), Government Code, refers to the "center for strategic decision support" within the Health and Human Services Commission. According to the commission, the current name of the center is the "center for analytics and decision support." The revised law is drafted accordingly.

(2) Section 531.02141(a)(7), Government Code, refers to the "Temporary Assistance for Needy Families program," meaning the financial assistance program under Chapter 31, Human Resources Code. For clarity, the revised law substitutes "financial assistance program under Chapter 31, Human Resources Code" for

"Temporary Assistance for Needy Families program."

(3) Section 531.02141(a)(7), Government Code, refers to the "Special Supplemental Nutrition Program for Women, Infants, and Children," meaning the federal program authorized by 42 U.S.C. Section 1786. For clarity, the revised law adds a reference to the federal statute.

Revised Law

Sec. 532.0203. PUBLIC ACCESS TO CERTAIN DATA. (a) To the extent permitted by federal law, the commission, in collaboration with the appropriate advisory committees related to Medicaid, shall make available to the public on the commission's Internet website in an easy-to-read format data relating to the quality of health care recipients received and the health outcomes of those recipients. Data the commission makes available to the public must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing duties under this section, the commission may collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data. (Gov. Code, Sec. 531.02142.)

Source Law

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) To the extent permitted by federal law, the commission in consultation and collaboration with the appropriate advisory committees related to Medicaid shall make available to the public on the commission's Internet website in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients. Data made available to the public under this section must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing its duties under this section, the commission may collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

Revisor's Note

Section 531.02142(a), Government Code, provides that the Health and Human Services Commission shall

take certain action in "consultation and collaboration" with certain advisory committees. The revised law omits "consultation" in this context as redundant because "consultation" is included within the meaning of "collaboration."

Revised Law

Sec. 532.0204. DATA REGARDING TREATMENT FOR PRENATAL ALCOHOL OR CONTROLLED SUBSTANCE EXPOSURE. (a) The commission shall collect hospital discharge data for recipients regarding treatment of a newborn child for prenatal exposure to alcohol or a controlled substance.

(b) The commission shall provide the collected data to the Department of Family and Protective Services. (Gov. Code, Sec. 531.02143.)

Source Law

Sec. 531.02143. DATA REGARDING POSTNATAL ALCOHOL AND CONTROLLED SUBSTANCE TREATMENT. (a) The commission shall collect hospital discharge data for Medicaid recipients regarding treatment of a newborn child for prenatal exposure to alcohol or a controlled substance.

(b) The commission shall provide the data collected under Subsection (a) to the Department of Family and Protective Services.

Revised Law

Sec. 532.0205. MEDICAL TECHNOLOGY. The commission shall explore and evaluate new developments in medical technology and propose implementing the technology in Medicaid, if appropriate and cost-effective. Commission staff implementing this section must have skills and experience in research regarding health care technology. (Gov. Code, Sec. 531.0081.)

Source Law

Sec. 531.0081. MEDICAL TECHNOLOGY. (b) The commission shall explore and evaluate new developments in medical technology and propose implementing the technology in Medicaid, if appropriate and cost-effective.

(c) Commission staff implementing this section must have skills and experience in research regarding health care technology.

Revised Law

Sec. 532.0206. PILOT PROJECTS RELATING TO TECHNOLOGY APPLICATIONS. (a) Notwithstanding any other law, the commission may establish one or more pilot projects through which Medicaid reimbursement is made to demonstrate the applications of technology in providing Medicaid services.

(b) A pilot project under this section may relate to providing rehabilitation services, services for the aging or individuals with disabilities, or long-term care services, including community care services and supports.

(c) Notwithstanding an eligibility requirement prescribed by any other law or rule, the commission may establish requirements for an individual to receive services provided through a pilot project under this section.

(d) An individual's receipt of services provided through a pilot project under this section does not entitle the individual to other services under a government-funded health program.

(e) The commission may set a maximum enrollment limit for a pilot project under this section. (Gov. Code, Sec. 531.062.)

Source Law

Sec. 531.062. PILOT PROJECTS RELATING TO TECHNOLOGY APPLICATIONS. (a) Notwithstanding any other law, the commission may establish one or more pilot projects through which reimbursement under Medicaid is made to demonstrate the applications of technology in providing services under that program.

(b) A pilot project established under this section may relate to providing rehabilitation services, services for the aging or persons with disabilities, or long-term care services, including community care services and support.

(c) Notwithstanding an eligibility requirement prescribed by any other law or rule, the commission may establish requirements for a person to receive services provided through a pilot project under this section.

(d) Receipt of services provided through a pilot project under this section does not entitle the recipient to other services under a government-funded health program.

(e) The commission may set a maximum enrollment limit for a pilot project established under this section.

SUBCHAPTER F. ELECTRONIC VISIT VERIFICATION SYSTEM

Revised Law

Sec. 532.0251. DEFINITION. In this subchapter, "electronic visit verification system" means the electronic visit verification system implemented under Section 532.0253. (New.)

Revisor's Note

The definition of "electronic visit verification system" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 532.0252. IMPLEMENTATION OF CERTAIN PROVISIONS. Notwithstanding any other provision of this subchapter, the commission is required to implement a change in law made to former Section 531.024172 by Chapter 909 (S.B. 894), Acts of the 85th Legislature, Regular Session, 2017, only if the commission determines the implementation is appropriate based on the findings of the electronic visit verification system review conducted before April 1, 2018, under Section 531.024172(a) as that section existed before that date. (Gov. Code, Sec. 531.024172(a) (part).)

Source Law

> (a) . . . Notwithstanding any other provision of this section, the commission is required to implement a change in law made to this section by S.B. 894, Acts of the 85th Legislature, Regular Session, 2017, only if the commission determines the implementation is appropriate based on the findings of the review. . . .

Revisor's Note

Section 531.024172(a), Government Code, requires the Health and Human Services Commission to conduct a review of the electronic visit verification system not later than March 31, 2018, and states that the commission may combine the review with any similar review. The revised law omits these provisions as executed. The omitted law reads:

> Sec. 531.024172. ELECTRONIC VISIT

> VERIFICATION SYSTEM. (a) Not later than March 31, 2018, the commission shall conduct a review of the electronic visit verification system in use under this section on August 31, 2017. . . . The commission may combine the review required by this subsection with any similar review required to be conducted by the commission.

Revised Law

Sec. 532.0253. ELECTRONIC VISIT VERIFICATION SYSTEM IMPLEMENTATION. (a) Subject to Section 532.0258(a), the commission shall, in accordance with federal law, implement an electronic visit verification system to electronically verify that personal care services, attendant care services, or other services the commission identifies that are provided under Medicaid to recipients, including personal care services or attendant care services provided under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) or any other Medicaid waiver program, are provided to recipients in accordance with a prior authorization or plan of care.

(b) The verification must be made through a telephone, global positioning, or computer-based system. (Gov. Code, Sec. 531.024172(b) (part).)

Source Law

> (b) Subject to Subsection (g), the commission shall, in accordance with federal law, implement an electronic visit verification system to electronically verify through a telephone, global positioning, or computer-based system that personal care services, attendant care services, or other services identified by the commission that are provided to recipients under Medicaid, including personal care services or attendant care services provided under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) or any other Medicaid waiver program, are provided to recipients in accordance with a prior authorization or plan of care. . . .

Revised Law

Sec. 532.0254. INFORMATION TO BE VERIFIED. The electronic visit verification system must allow for verification of only the following information relating to the delivery of Medicaid services:

(1) the type of service provided;

(2) the name of the recipient to whom the service was provided;

(3) the date and times the provider began and ended the service delivery visit;

(4) the location, including the address, at which the service was provided;

(5) the name of the individual who provided the service; and

(6) other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims. (Gov. Code, Sec. 531.024172(b) (part).)

Source Law

> (b) . . . The electronic visit verification system implemented under this subsection must allow for verification of only the following information relating to the delivery of Medicaid services:
>
> (1) the type of service provided;
>
> (2) the name of the recipient to whom the service is provided;
>
> (3) the date and times the provider began and ended the service delivery visit;
>
> (4) the location, including the address, at which the service was provided;
>
> (5) the name of the individual who provided the service; and
>
> (6) other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims.

Revised Law

Sec. 532.0255. COMPLIANCE STANDARDS AND STANDARDIZED PROCESSES. (a) In implementing the electronic visit verification system:

(1) subject to Subsection (b), the executive commissioner shall adopt compliance standards for health care providers; and

(2) the commission shall ensure that:

(A) the information required to be reported by health care providers is standardized across Medicaid managed care organizations and commission programs;

(B) processes Medicaid managed care

organizations require to retrospectively correct data are standardized and publicly accessible to health care providers;

(C) standardized processes are established for addressing the failure of a Medicaid managed care organization to provide a timely authorization for delivering services necessary to ensure continuity of care; and

(D) a health care provider is allowed to enter a variable schedule into the system.

(b) In establishing compliance standards for health care providers under Subsection (a), the executive commissioner shall consider:

(1) the administrative burdens placed on health care providers required to comply with the standards; and

(2) the benefits of using emerging technologies for ensuring compliance, including Internet-based, mobile telephone-based, and global positioning-based technologies. (Gov. Code, Secs. 531.024172(d), (e).)

Source Law

(d) In implementing the electronic visit verification system:

(1) subject to Subsection (e), the executive commissioner shall adopt compliance standards for health care providers; and

(2) the commission shall ensure that:

(A) the information required to be reported by health care providers is standardized across managed care organizations that contract with the commission to provide health care services to Medicaid recipients and across commission programs;

(B) processes required by managed care organizations to retrospectively correct data are standardized and publicly accessible to health care providers;

(C) standardized processes are established for addressing the failure of a managed care organization to provide a timely authorization for delivering services necessary to ensure continuity of care; and

(D) a health care provider is allowed to enter a variable schedule into the electronic visit verification system.

(e) In establishing compliance standards for health care providers under Subsection (d), the executive commissioner shall consider:

(1) the administrative burdens placed on health care providers required to comply with the standards; and

(2) the benefits of using emerging technologies for ensuring compliance, including

Internet-based, mobile telephone-based, and global positioning-based technologies.

Revised Law

Sec. 532.0256. RECIPIENT COMPLIANCE. The commission shall inform each recipient who receives personal care services, attendant care services, or other services the commission identifies that the health care provider providing the services and the recipient are each required to comply with the electronic visit verification system. A Medicaid managed care organization shall also inform recipients described by this section who are enrolled in a managed care plan offered by the organization of those requirements. (Gov. Code, Sec. 531.024172(c).)

Source Law

(c) The commission shall inform each Medicaid recipient who receives personal care services, attendant care services, or other services identified by the commission that the health care provider providing the services and the recipient are each required to comply with the electronic visit verification system. A managed care organization that contracts with the commission to provide health care services to Medicaid recipients described by this subsection shall also inform recipients enrolled in a managed care plan offered by the organization of those requirements.

Revised Law

Sec. 532.0257. HEALTH CARE PROVIDER COMPLIANCE. A health care provider that provides to recipients personal care services, attendant care services, or other services the commission identifies shall:

(1) use the electronic visit verification system or a proprietary system the commission allows as provided by Section 532.0258 to document the provision of those services;

(2) comply with all documentation requirements the commission establishes;

(3) comply with federal and state laws regarding confidentiality of recipients' information;

(4) ensure that the commission or the Medicaid managed care organization with which a claim for reimbursement for a service is filed may review electronic visit verification system

documentation related to the claim or obtain a copy of that documentation at no charge to the commission or the organization; and

(5) at any time, allow the commission or a Medicaid managed care organization with which a health care provider contracts to provide health care services to recipients enrolled in the organization's managed care plan to have direct, on-site access to the electronic visit verification system in use by the health care provider. (Gov. Code, Sec. 531.024172(f).)

Source Law

(f) A health care provider that provides personal care services, attendant care services, or other services identified by the commission to Medicaid recipients shall:

(1) use an electronic visit verification system to document the provision of those services;

(2) comply with all documentation requirements established by the commission;

(3) comply with applicable federal and state laws regarding confidentiality of recipients' information;

(4) ensure that the commission or the managed care organization with which a claim for reimbursement for a service is filed may review electronic visit verification system documentation related to the claim or obtain a copy of that documentation at no charge to the commission or the organization; and

(5) at any time, allow the commission or a managed care organization with which a health care provider contracts to provide health care services to recipients enrolled in the organization's managed care plan to have direct, on-site access to the electronic visit verification system in use by the health care provider.

Revisor's Note

Section 531.024172(f)(1), Government Code, requires certain health care providers to use "an electronic visit verification system." Section 531.024172(g), Government Code, revised as Section 532.0258(a) of this chapter, authorizes a health care provider to use a proprietary electronic visit verification system if allowed by the Health and Human Services Commission. It is clear that "an electronic visit verification system" referenced in Section 531.024172(f)(1) could mean either the system

implemented under Section 531.024172, which is revised in relevant part as Section 532.0253 of this chapter, or the proprietary system authorized by Section 531.024172(g). For clarity, the revised law refers to "the electronic visit verification system," which is defined by Section 532.0251 of this chapter to mean the system implemented under Section 532.0253 of this chapter, and to "a proprietary system the commission allows as provided by Section 532.0258."

Revised Law

Sec. 532.0258. HEALTH CARE PROVIDER: USE OF PROPRIETARY SYSTEM. (a) The commission may recognize a health care provider's proprietary electronic visit verification system, whether purchased or developed by the provider, as complying with this subchapter and allow the health care provider to use that system for a period the commission determines if the commission determines that the system:

(1) complies with all necessary data submission, exchange, and reporting requirements established under this subchapter; and

(2) meets all other standards and requirements established under this subchapter.

(b) If feasible, the executive commissioner shall ensure a health care provider is reimbursed for the use of the provider's proprietary electronic visit verification system the commission recognizes.

(c) For purposes of facilitating the use of proprietary electronic visit verification systems by health care providers and in consultation with industry stakeholders and the work group established under Section 532.0259, the commission or the executive commissioner, as appropriate, shall:

(1) develop an open model system that mitigates the administrative burdens providers required to use electronic visit verification identify;

(2) allow providers to use emerging technologies, including Internet-based, mobile telephone-based, and global positioning-based technologies, in the providers' proprietary electronic visit verification systems; and

(3) adopt rules governing data submission and provider reimbursement. (Gov. Code, Secs. 531.024172(g), (g-1), (g-2).)

Source Law

> (g) The commission may recognize a health care provider's proprietary electronic visit verification system, whether purchased or developed by the provider, as complying with this section and allow the health care provider to use that system for a period determined by the commission if the commission determines that the system:
>
> (1) complies with all necessary data submission, exchange, and reporting requirements established under this section; and
>
> (2) meets all other standards and requirements established under this section.
>
> (g-1) If feasible, the executive commissioner shall ensure a health care provider that uses the provider's proprietary electronic visit verification system recognized under Subsection (g) is reimbursed for the use of that system.
>
> (g-2) For purposes of facilitating the use of proprietary electronic visit verification systems by health care providers under Subsection (g) and in consultation with industry stakeholders and the work group established under Subsection (h), the commission or the executive commissioner, as appropriate, shall:
>
> (1) develop an open model system that mitigates the administrative burdens identified by providers required to use electronic visit verification;
>
> (2) allow providers to use emerging technologies, including Internet-based, mobile telephone-based, and global positioning-based technologies, in the providers' proprietary electronic visit verification systems; and
>
> (3) adopt rules governing data submission and provider reimbursement.

Revised Law

Sec. 532.0259. STAKEHOLDER INPUT. The commission shall create a stakeholder work group composed of representatives of affected health care providers, Medicaid managed care organizations, and recipients. The commission shall periodically solicit from the work group input regarding the ongoing operation of the electronic visit verification system. (Gov. Code, Sec. 531.024172(h).)

Source Law

(h) The commission shall create a stakeholder work group comprised of representatives of affected health care providers, managed care organizations, and Medicaid recipients and periodically solicit from that work group input regarding the ongoing operation of the electronic visit verification system under this section.

Revisor's Note

Section 531.024172(h), Government Code, refers to "affected . . . managed care organizations," meaning managed care organizations affected by the electronic visit verification system described in Section 531.024172, which is revised as this subchapter. The only type of managed care organization that would be affected by the electronic visit verification system is a Medicaid managed care organization. For the reasons stated in the revisor's note to Section 532.0153 of this chapter, the revised law substitutes "Medicaid managed care organizations" for the reference to "managed care organizations."

Revised Law

Sec. 532.0260. RULES. The executive commissioner may adopt rules necessary to implement this subchapter. (Gov. Code, Sec. 531.024172(i).)

Source Law

(i) The executive commissioner may adopt rules necessary to implement this section.

SUBCHAPTER G. APPLICANTS AND RECIPIENTS

Revised Law

Sec. 532.0301. BILL OF RIGHTS AND BILL OF RESPONSIBILITIES. (a) The executive commissioner by rule shall adopt a bill of rights and a bill of responsibilities for each recipient.

(b) The bill of rights must address a recipient's right to:

(1) respect, dignity, privacy, confidentiality, and nondiscrimination;

(2) a reasonable opportunity to choose a health

benefits plan and primary care provider and to change to another plan or provider in a reasonable manner;

(3) consent to or refuse treatment and actively participate in treatment decisions;

(4) ask questions and receive complete information relating to the recipient's medical condition and treatment options, including specialty care;

(5) access each available complaint process, receive a timely response to a complaint, and receive a fair hearing; and

(6) timely access to care that does not have any communication or physical access barriers.

(c) The bill of responsibilities must address a recipient's responsibility to:

(1) learn and understand each right the recipient has under Medicaid;

(2) abide by the health plan and Medicaid policies and procedures;

(3) share information relating to the recipient's health status with the primary care provider and become fully informed about service and treatment options; and

(4) actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain the recipient's health. (Gov. Code, Sec. 531.0212.)

Source Law

Sec. 531.0212. MEDICAID BILL OF RIGHTS AND BILL OF RESPONSIBILITIES. (a) The executive commissioner by rule shall adopt a bill of rights and a bill of responsibilities for each person enrolled in Medicaid.

(b) The bill of rights must address a client's right to:

(1) respect, dignity, privacy, confidentiality, and nondiscrimination;

(2) a reasonable opportunity to choose a health care plan and primary care provider and to change to another plan or provider in a reasonable manner;

(3) consent to or refuse treatment and actively participate in treatment decisions;

(4) ask questions and receive complete information relating to the client's medical condition and treatment options, including specialty care;

(5) access each available complaint process, receive a timely response to a complaint, and receive a fair hearing; and

(6) timely access to care that does not have any communication or physical access barriers.

(c) The bill of responsibilities must address a client's responsibility to:

(1) learn and understand each right the client has under Medicaid;

(2) abide by the health plan and Medicaid policies and procedures;

(3) share information relating to the client's health status with the primary care provider and become fully informed about service and treatment options; and

(4) actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain the client's health.

Revisor's Note

Section 531.0212(b)(2), Government Code, refers to a Medicaid recipient's opportunity to choose a "health care plan," and Section 531.0212(c)(2), Government Code, refers to that recipient's responsibility to follow the "health plan" policies and procedures. The revised law substitutes "health benefits plan" for the quoted phrases because that is the term more commonly used to reference that type of plan offered by a managed care organization.

Revised Law

Sec. 532.0302. UNIFORM FAIR HEARING RULES. (a) The executive commissioner shall adopt uniform fair hearing rules for Medicaid-funded services. The rules must provide:

(1) due process to a Medicaid applicant and to a recipient who seeks a Medicaid service, including a service that requires prior authorization; and

(2) the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:

(A) the written notice to an individual of the individual's right to a hearing must:

(i) contain an explanation of the circumstances under which Medicaid is continued if a hearing is

requested; and

(ii) be delivered by mail, and postmarked at least 10 business days, before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by 42 C.F.R. Section 431.213 or 431.214; and

(B) if a hearing is requested before the date a recipient's service, including a service that requires prior authorization, is scheduled to be terminated, suspended, or reduced, the agency may not take that proposed action before a decision is rendered after the hearing unless:

(i) it is determined at the hearing that the sole issue is one of federal or state law or policy; and

(ii) the agency promptly informs the recipient in writing that services are to be terminated, suspended, or reduced pending the hearing decision.

(b) The commission shall develop a process to address a situation in which:

(1) an individual does not receive adequate notice as required by Subsection (a)(2)(A); or

(2) the notice required by Subsection (a)(2)(A) is delivered without a postmark. (Gov. Code, Secs. 531.024(a) (part), (b), (c).)

Source Law

Sec. 531.024. PLANNING AND DELIVERY OF HEALTH SERVICES; DATA SHARING. (a) The executive commissioner shall:

. . .

(7) promulgate uniform fair hearing rules for all Medicaid-funded services.

(b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services and to a Medicaid recipient who seeks a Medicaid service, including a service that requires prior authorization. The rules must provide the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:

(1) the written notice to an individual of the individual's right to a hearing must:

(A) contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and

(B) be delivered by mail, and postmarked at least 10 business days, before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by 42 C.F.R. Section 431.213 or 431.214; and

(2) if a hearing is requested before the date a Medicaid recipient's service, including a service that requires prior authorization, is scheduled to be terminated, suspended, or reduced, the agency may not take that proposed action before a decision is rendered after the hearing unless:

(A) it is determined at the hearing that the sole issue is one of federal or state law or policy; and

(B) the agency promptly informs the recipient in writing that services are to be terminated, suspended, or reduced pending the hearing decision.

(c) The commission shall develop a process to address a situation in which:

(1) an individual does not receive adequate notice as required by Subsection (b)(1); or

(2) the notice required by Subsection (b)(1) is delivered without a postmark.

Revised Law

Sec. 532.0303. SUPPORT AND INFORMATION SERVICES FOR RECIPIENTS. (a) The commission shall provide support and information services to a recipient or applicant for Medicaid who experiences barriers to receiving health care services. The commission shall give emphasis to assisting an individual with an urgent or immediate medical or support need.

(b) The commission shall provide the support and information services through a network of entities that are:

(1) coordinated by the commission's office of the ombudsman or other commission division the executive commissioner designates; and

(2) composed of:

(A) the commission's office of the ombudsman or other commission division the executive commissioner designates to coordinate the network;

(B) the office of the state long-term care ombudsman required under Subchapter F, Chapter 101A, Human Resources Code;

(C) the commission division responsible for oversight of Medicaid managed care contracts;

(D) area agencies on aging;

(E) aging and disability resource centers established under the aging and disability resource center initiative funded in part by the Administration on Aging and the Centers for Medicare and Medicaid Services; and

(F) any other entity the executive commissioner determines appropriate, including nonprofit organizations with which the commission contracts under Subsection (c).

(c) The commission may provide the support and information services by contracting with nonprofit organizations that are not involved in providing health care, health insurance, or health benefits.

(d) As a part of the support and information services, the commission shall:

(1) operate a statewide toll-free assistance telephone number that includes relay services for individuals with speech or hearing disabilities and assistance for individuals who speak Spanish;

(2) intervene promptly with the state Medicaid office, Medicaid managed care organizations and providers, and any other appropriate entity on behalf of an individual who has an urgent need for medical services;

(3) assist an individual who is experiencing barriers in the Medicaid application and enrollment process and refer the individual for further assistance if appropriate;

(4) educate individuals so that they:

(A) understand the concept of managed care;

(B) understand their rights under Medicaid, including grievance and appeal procedures; and

(C) are able to advocate for themselves;

(5) collect and maintain statistical information on a regional basis regarding calls the assistance lines receive and publish quarterly reports that:

(A) list the number of calls received by region;

(B) identify trends in delivery and access problems;

(C) identify recurring barriers in the Medicaid system; and

(D) indicate other identified problems with Medicaid managed care;

(6) assist the state Medicaid office and Medicaid managed care organizations and providers in identifying and correcting problems, including site visits to affected regions if necessary;

(7) meet the needs of all current and future managed care recipients, including children receiving dental benefits and other recipients receiving benefits, under:

(A) the STAR Medicaid managed care program;

(B) the STAR+PLUS Medicaid managed care program, including the Texas Dual Eligible Integrated Care Demonstration Project provided under that program;

(C) the STAR Kids managed care program established under Subchapter R, Chapter 540; and

(D) the STAR Health program;

(8) incorporate support services for children enrolled in the child health plan program established under Chapter 62, Health and Safety Code; and

(9) ensure that staff providing support and information services receive sufficient training, including training in the Medicare program for the purpose of assisting recipients who are dually eligible for Medicare and Medicaid, and have sufficient authority to resolve barriers experienced by recipients to health care and long-term services and supports.

(e) The commission's office of the ombudsman or other commission division the executive commissioner designates to coordinate the network of entities responsible for providing the support and information services must be sufficiently independent from other aspects of Medicaid managed care to represent the best

interests of recipients in problem resolution. (Gov. Code, Sec. 531.0213.)

Source Law

Sec. 531.0213. SUPPORT SERVICES FOR MEDICAID RECIPIENTS. (a) The commission shall provide support and information services to a person enrolled in or applying for Medicaid coverage who experiences barriers to receiving health care services.

(b) The commission shall give emphasis to assisting a person with an urgent or immediate medical or support need.

(b-1) The commission shall provide support and information services required by this section through a network of entities coordinated by the commission's office of the ombudsman or other division of the commission designated by the executive commissioner and composed of:

(1) the commission's office of the ombudsman or other division of the commission designated by the executive commissioner to coordinate the network;

(2) the office of the state long-term care ombudsman required under Subchapter F, Chapter 101A, Human Resources Code;

(3) the division within the commission responsible for oversight of Medicaid managed care contracts;

(4) area agencies on aging;

(5) aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services; and

(6) any other entity the executive commissioner determines appropriate, including nonprofit organizations with which the commission contracts under Subsection (c).

(c) The commission may provide support and information services by contracting with nonprofit organizations that are not involved in providing health care, health insurance, or health benefits.

(d) As a part of the support and information services required by this section, the commission shall:

(1) operate a statewide toll-free assistance telephone number that includes relay services for persons with speech or hearing disabilities and assistance for persons who speak Spanish;

(2) intervene promptly with the state Medicaid office, managed care organizations and providers, and any other appropriate entity on behalf of a person who has an urgent need for medical services;

(3) assist a person who is experiencing barriers in the Medicaid application and enrollment process and refer the person for further assistance if appropriate;

(4) educate persons so that they:

(A) understand the concept of managed care;

(B) understand their rights under Medicaid, including grievance and appeal procedures; and

(C) are able to advocate for themselves;

(5) collect and maintain statistical information on a regional basis regarding calls received by the assistance lines and publish quarterly reports that:

(A) list the number of calls received by region;

(B) identify trends in delivery and access problems;

(C) identify recurring barriers in the Medicaid system; and

(D) indicate other problems identified with Medicaid managed care;

(6) assist the state Medicaid office and managed care organizations and providers in identifying and correcting problems, including site visits to affected regions if necessary;

(7) meet the needs of all current and future Medicaid managed care recipients, including children receiving dental benefits and other recipients receiving benefits, under the:

(A) STAR Medicaid managed care program;

(B) STAR + PLUS Medicaid managed care program, including the Texas Dual Eligibles Integrated Care Demonstration Project provided under that program;

(C) STAR Kids managed care program established under Section 533.00253; and

(D) STAR Health program;

(8) incorporate support services for children enrolled in the child health plan established under Chapter 62, Health and Safety Code; and

(9) ensure that staff providing support and information services receives sufficient training, including training in the Medicare program for the purpose of assisting recipients who are dually eligible for Medicare and Medicaid, and has sufficient authority to resolve barriers experienced by recipients to health care and long-term services and supports.

(e) The commission's office of the ombudsman, or other division of the commission designated by the executive commissioner to coordinate the network of entities responsible for providing support and information services under this section, must be sufficiently independent from other aspects of Medicaid managed care to represent the best interests of recipients in problem resolution.

Revisor's Note

(1) Section 531.0213(d)(2), Government Code, requires the Health and Human Services Commission, as part of the information and services required to be provided to a Medicaid applicant or recipient under Section 531.0213, to intervene with "managed care organizations and providers" on behalf of an individual with urgent medical needs, and Section 531.0213(d)(6), Government Code, requires the

commission to assist "managed care organizations and providers" in identifying and correcting problems as part of the information and services. The revised law substitutes "Medicaid managed care organizations and providers" for the quoted phrases because it is clear from the context that the provisions apply only to managed care organizations and providers participating in Medicaid.

(2) Section 531.0213(d)(7)(C), Government Code, refers to the STAR Kids managed care program established under Section 533.00253, Government Code. The provisions of Section 533.00253 relating to the STAR Kids managed care program are revised in this subtitle as Subchapter R, Chapter 540, and the revised law is drafted accordingly.

Revised Law

Sec. 532.0304. NURSING SERVICES ASSESSMENTS. (a) In this section, "acute nursing services" means home health skilled nursing services, home health aide services, and private duty nursing services.

(b) If cost-effective, the commission shall develop an objective assessment process for use in assessing a recipient's need for acute nursing services. If the commission develops the objective assessment process, the commission shall require that:

(1) the assessment be conducted:

(A) by a state employee or contractor who is a registered nurse licensed to practice in this state, and who is not:

(i) the individual who will deliver any necessary services to the recipient; or

(ii) affiliated with the person who will deliver those services; and

(B) in a timely manner so as to protect the recipient's health and safety by avoiding unnecessary delays in service delivery; and

(2) the process include:

(A) an assessment of specified criteria and documentation of the assessment results on a standard form;

(B) an assessment of whether the recipient should be referred for additional assessments regarding the recipient's need for therapy services, as described by Section 532.0305, attendant care services, and durable medical equipment; and

(C) completion by the individual conducting the assessment of any documents related to obtaining prior authorization for necessary nursing services.

(c) If the commission develops the objective assessment process under Subsection (b), the commission shall:

(1) implement the process within the Medicaid fee-for-service model and the primary care case management Medicaid managed care model; and

(2) take necessary actions, including modifying contracts with Medicaid managed care organizations to the extent allowed by law, to implement the process within the STAR and STAR+PLUS Medicaid managed care programs.

(d) Unless the commission determines that the assessment is feasible and beneficial, an assessment under Subsection (b)(2)(B) of whether a recipient should be referred for additional therapy services assessments shall be waived if the recipient's need for therapy services has been established by a recommendation from a therapist providing care before the recipient is discharged from a licensed hospital or nursing facility. The assessment may not be waived if the recommendation is made by a therapist who:

(1) will deliver any services to the recipient; or

(2) is affiliated with a person who will deliver those services after the recipient is discharged from the licensed hospital or nursing facility.

(e) The executive commissioner shall adopt rules providing for a process by which a provider of acute nursing services who disagrees with the results of the assessment conducted under

Subsection (b) may request and obtain a review of those results.

(Gov. Code, Sec. 531.02417.)

Source Law

Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS. (a) In this section, "acute nursing services" means home health skilled nursing services, home health aide services, and private duty nursing services.

(b) If cost-effective, the commission shall develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services. If the commission develops an objective assessment process under this section, the commission shall require that:

(1) the assessment be conducted:

(A) by a state employee or contractor who is a registered nurse who is licensed to practice in this state and who is not the person who will deliver any necessary services to the recipient and is not affiliated with the person who will deliver those services; and

(B) in a timely manner so as to protect the health and safety of the recipient by avoiding unnecessary delays in service delivery; and

(2) the process include:

(A) an assessment of specified criteria and documentation of the assessment results on a standard form;

(B) an assessment of whether the recipient should be referred for additional assessments regarding the recipient's needs for therapy services, as defined by Section 531.024171, attendant care services, and durable medical equipment; and

(C) completion by the person conducting the assessment of any documents related to obtaining prior authorization for necessary nursing services.

(c) If the commission develops the objective assessment process under Subsection (b), the commission shall:

(1) implement the process within the Medicaid fee-for-service model and the primary care case management Medicaid managed care model; and

(2) take necessary actions, including modifying contracts with managed care organizations under Chapter 533 to the extent allowed by law, to implement the process within the STAR and STAR + PLUS Medicaid managed care programs.

(d) Unless the commission determines that the assessment is feasible and beneficial, an assessment under Subsection (b)(2)(B) of whether a recipient should be referred for additional therapy services shall be waived if the recipient's need for therapy services has been established by a recommendation from a therapist providing care prior to discharge of the recipient from a licensed hospital or nursing home. The assessment may not be waived if the recommendation is made by a therapist who will deliver any services to the recipient or is affiliated with a person who will deliver those services when the recipient is discharged from the licensed hospital or nursing home.

(e) The executive commissioner shall adopt rules providing for a process by which a provider of

acute nursing services who disagrees with the results of the assessment conducted under Subsection (b) may request and obtain a review of those results.

Revisor's Note

Section 531.02417(d), Government Code, refers to a "nursing home." The revised law substitutes "nursing facility" for "nursing home" because the terms are synonymous and for consistency of terminology throughout Subtitle I, Title 4, Government Code, which includes this chapter.

Revised Law

Sec. 532.0305. THERAPY SERVICES ASSESSMENTS. (a) In this section, "therapy services" includes occupational, physical, and speech therapy services.

(b) After implementing the objective assessment process for acute nursing services in accordance with Section 532.0304, the commission shall consider whether implementing age- and diagnosis-appropriate objective assessment processes for use in assessing a recipient's need for therapy services would be feasible and beneficial.

(c) If the commission determines that implementing age- and diagnosis-appropriate processes with respect to one or more types of therapy services is feasible and would be beneficial, the commission may implement the processes within:

(1) the Medicaid fee-for-service model;

(2) the primary care case management Medicaid managed care model; and

(3) the STAR and STAR+PLUS Medicaid managed care programs.

(d) An objective assessment process implemented under this section must include a process that allows a therapy services provider to request and obtain a review of the results of an assessment conducted as provided by this section. The review process must be comparable to the review process implemented under Section 532.0304(e). (Gov. Code, Sec. 531.024171.)

Source Law

Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) In this section, "therapy services" includes occupational, physical, and speech therapy services.

(b) After implementing the objective assessment process for acute nursing services in accordance with Section 531.02417, the commission shall consider whether implementing age- and diagnosis-appropriate objective assessment processes for assessing the needs of a Medicaid recipient for therapy services would be feasible and beneficial.

(c) If the commission determines that implementing age- and diagnosis-appropriate processes with respect to one or more types of therapy services is feasible and would be beneficial, the commission may implement the processes within:

(1) the Medicaid fee-for-service model;

(2) the primary care case management Medicaid managed care model; and

(3) the STAR and STAR + PLUS Medicaid managed care programs.

(d) An objective assessment process implemented under this section must include a process that allows a provider of therapy services to request and obtain a review of the results of an assessment conducted as provided by this section that is comparable to the process implemented under rules adopted under Section 531.02417(e).

Revised Law

Sec. 532.0306. WELLNESS SCREENING PROGRAM. If cost-effective, the commission may implement a wellness screening program for recipients that is designed to evaluate a recipient's risk for having certain diseases and medical conditions to establish:

(1) a health baseline for each recipient that may be used to tailor the recipient's treatment plan; or

(2) the recipient's health goals. (Gov. Code, Sec. 531.0981.)

Source Law

Sec. 531.0981. WELLNESS SCREENING PROGRAM. If cost-effective, the commission may implement a wellness screening program for Medicaid recipients designed to evaluate a recipient's risk for having certain diseases and medical conditions for purposes of establishing a health baseline for each recipient that may be used to tailor the recipient's treatment plan or for establishing the recipient's health goals.

Revised Law

Sec. 532.0307. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES. (a) In this section:

(1) "Federally qualified health center services" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(A).

(2) "Rural health clinic services" has the meaning assigned by 42 U.S.C. Section 1396d(l)(1).

(b) Notwithstanding any provision of this chapter, Chapter 32, Human Resources Code, or any other law, the commission shall:

(1) promote recipient access to federally qualified health center services or rural health clinic services; and

(2) ensure that payment for federally qualified health center services or rural health clinic services is in accordance with 42 U.S.C. Section 1396a(bb). (Gov. Code, Secs. 531.02192(a) (part), (b).)

Source Law

Sec. 531.02192. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES. (a) In this section:

. . .

(2) "Federally qualified health center services" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(A).

(3) . . . "rural health clinic services" have the meanings assigned by 42 U.S.C. Section 1396d(l)(1).

(b) Notwithstanding any provision of this chapter, Chapter 32, Human Resources Code, or any other law, the commission shall:

(1) promote Medicaid recipient access to federally qualified health center services or rural health clinic services; and

(2) ensure that payment for federally qualified health center services or rural health clinic services is in accordance with 42 U.S.C. Section 1396a(bb).

Revisor's Note

(1) Section 531.02192(a), Government Code, defines "federally qualified health center," "federally qualified health center services," "rural health clinic," and "rural health clinic services" for purposes of Section 531.02192, Government Code. However, "federally qualified health center" is not used in the section independently from "federally qualified health center services," and "rural health clinic" is not used in the section independently from

"rural health clinic services," and the revised law omits the definitions of those terms as unnecessary. The omitted law reads:

> [(a) In this section:]
>
> (1) "Federally qualified health center" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(B).
>
> . . .
>
> (3) "Rural health clinic" and . . . [have the meanings assigned by 42 U.S.C. Section 1396d(l)(1).]

(2) Section 531.02192(b), Government Code, refers to "any provision of this chapter," meaning Chapter 531, Government Code, "or any other law." Chapter 531 is revised throughout Subtitle I, Title 4, Government Code, including in this chapter. The revised law substitutes a reference to "any provision of this chapter . . . or any other law" for the quoted phrases because the provisions of Chapter 531 that are not revised in this chapter are included within the meaning of "any other law."

SUBCHAPTER H. PROGRAMS AND SERVICES FOR CERTAIN CATEGORIES OF MEDICAID POPULATION

Revised Law

Sec. 532.0351. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF MEDICAID POPULATION. (a) The executive commissioner may seek a waiver under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to develop and, subject to Subsection (c), implement tailored benefit packages designed to:

(1) provide Medicaid benefits that are customized to meet the health care needs of recipients within defined categories of the Medicaid population through a defined system of care;

(2) improve health outcomes and access to services for those recipients;

(3) achieve cost containment and efficiency; and

(4) reduce the administrative complexity of delivering Medicaid benefits.

(b) The commission:

(1) shall develop a tailored benefit package that is customized to meet the health care needs of recipients who are children with special health care needs, subject to approval of the waiver described by Subsection (a); and

(2) may develop tailored benefit packages that are customized to meet the health care needs of other categories of recipients.

(c) If the commission develops tailored benefit packages under Subsection (b)(2), the commission shall submit to the standing committees of the senate and house of representatives having primary jurisdiction over Medicaid a report that specifies in detail the categories of recipients to which each of those packages will apply and the services available under each package.

(d) Except as otherwise provided by this section and subject to the terms of the waiver authorized by this section, the commission has broad discretion to develop the tailored benefit packages and determine the respective categories of recipients to which the packages apply in a manner that preserves recipients' access to necessary services and is consistent with federal requirements. In developing the tailored benefit packages, the commission shall consider similar benefit packages established in other states as a guide.

(e) Each tailored benefit package must include:

(1) a basic set of benefits that are provided under all tailored benefit packages;

(2) to the extent applicable to the category of recipients to which the package applies:

(A) a set of benefits customized to meet the health care needs of recipients in that category; and

(B) services to integrate the management of a recipient's acute and long-term care needs, to the extent feasible; and

(3) if the package applies to recipients who are

children, at least the services required by federal law under the early and periodic screening, diagnosis, and treatment program.

(f) A tailored benefit package may include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventive health or wellness service.

(g) A tailored benefit package must increase this state's flexibility with respect to the state's use of Medicaid funding and may not reduce the benefits available under the Medicaid state plan to any recipient population.

(h) The executive commissioner by rule shall define each category of recipients to which a tailored benefit package applies and a mechanism for appropriately placing recipients in specific categories. Recipient categories must include children with special health care needs and may include:

(1) individuals with disabilities or special health care needs;

(2) elderly individuals;

(3) children without special health care needs; and

(4) working-age parents and caretaker relatives. (Gov. Code, Sec. 531.097.)

Source Law

Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to develop and, subject to Subsection (c), implement tailored benefit packages designed to:

(1) provide Medicaid benefits that are customized to meet the health care needs of recipients within defined categories of the Medicaid population through a defined system of care;

(2) improve health outcomes for those recipients;

(3) improve those recipients' access to services;

(4) achieve cost containment and efficiency; and

(5) reduce the administrative complexity of delivering Medicaid benefits.

(b) The commission:

(1) shall develop a tailored benefit package that is customized to meet the health care needs of Medicaid recipients who are children with

special health care needs, subject to approval of the waiver described by Subsection (a); and

(2) may develop tailored benefit packages that are customized to meet the health care needs of other categories of Medicaid recipients.

(c) If the commission develops tailored benefit packages under Subsection (b)(2), the commission shall submit a report to the standing committees of the senate and house of representatives having primary jurisdiction over Medicaid that specifies, in detail, the categories of Medicaid recipients to which each of those packages will apply and the services available under each package.

(d) Except as otherwise provided by this section and subject to the terms of the waiver authorized by this section, the commission has broad discretion to develop the tailored benefit packages under this section and determine the respective categories of Medicaid recipients to which the packages apply in a manner that preserves recipients' access to necessary services and is consistent with federal requirements.

(e) Each tailored benefit package developed under this section must include:

(1) a basic set of benefits that are provided under all tailored benefit packages; and

(2) to the extent applicable to the category of Medicaid recipients to which the package applies:

(A) a set of benefits customized to meet the health care needs of recipients in that category; and

(B) services to integrate the management of a recipient's acute and long-term care needs, to the extent feasible.

(f) In addition to the benefits required by Subsection (e), a tailored benefit package developed under this section that applies to Medicaid recipients who are children must provide at least the services required by federal law under the early and periodic screening, diagnosis, and treatment program.

(g) A tailored benefit package developed under this section may include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventive health or wellness service.

(g-1) A tailored benefit package developed under this section must increase the state's flexibility with respect to the state's use of Medicaid funding and may not reduce the benefits available under the Medicaid state plan to any Medicaid recipient population.

(h) In developing the tailored benefit packages, the commission shall consider similar benefit packages established in other states as a guide.

(i) The executive commissioner, by rule, shall define each category of recipients to which a tailored benefit package applies and a mechanism for appropriately placing recipients in specific categories. Recipient categories must include children with special health care needs and may include:

(1) persons with disabilities or special health needs;

(2) elderly persons;

(3) children without special health care needs; and

(4) working-age parents and caretaker

relatives.

Revised Law

Sec. 532.0352. WAIVER PROGRAM FOR CERTAIN INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS. (a) If feasible and cost-effective, the commission may apply for a waiver from the Centers for Medicare and Medicaid Services or another appropriate federal agency to more efficiently leverage the use of state and local funds to maximize the receipt of federal Medicaid matching funds by providing Medicaid benefits to individuals who:

(1) meet established income and other eligibility criteria; and

(2) are eligible to receive services through the county for chronic health conditions.

(b) In establishing the waiver program, the commission shall:

(1) ensure that this state is a prudent purchaser of the health care services that are needed for the individuals described by Subsection (a);

(2) solicit broad-based input from interested persons;

(3) ensure that the benefits an individual receives through the county are not reduced once the individual is enrolled in the waiver program; and

(4) employ the use of intergovernmental transfers and other procedures to maximize the receipt of federal Medicaid matching funds. (Gov. Code, Sec. 531.0226.)

Source Law

Sec. 531.0226. CHRONIC HEALTH CONDITIONS SERVICES MEDICAID WAIVER PROGRAM. (a) If feasible and cost-effective, the commission may apply for a waiver from the federal Centers for Medicare and Medicaid Services or another appropriate federal agency to more efficiently leverage the use of state and local funds in order to maximize the receipt of federal Medicaid matching funds by providing benefits under Medicaid to individuals who:

(1) meet established income and other eligibility criteria; and

(2) are eligible to receive services through the county for chronic health conditions.

(b) In establishing the waiver program under

this section, the commission shall:

(1) ensure that the state is a prudent purchaser of the health care services that are needed for the individuals described by Subsection (a);

(2) solicit broad-based input from interested persons;

(3) ensure that the benefits received by an individual through the county are not reduced once the individual is enrolled in the waiver program; and

(4) employ the use of intergovernmental transfers and other procedures to maximize the receipt of federal Medicaid matching funds.

Revised Law

Sec. 532.0353. BUY-IN PROGRAMS FOR CERTAIN INDIVIDUALS WITH DISABILITIES. (a) The executive commissioner shall develop and implement:

(1) a Medicaid buy-in program for individuals with disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (Pub. L. No. 105-33); and

(2) a Medicaid buy-in program for children with disabilities described by 42 U.S.C. Section 1396a(cc)(1) whose family incomes do not exceed 300 percent of the applicable federal poverty level, as authorized by the Deficit Reduction Act of 2005 (Pub. L. No. 109-171).

(b) The executive commissioner shall adopt rules in accordance with federal law that provide for:

(1) eligibility requirements for each program described by Subsection (a); and

(2) requirements for program participants to pay premiums or cost-sharing payments, subject to Subsection (c).

(c) Rules the executive commissioner adopts under Subsection (b) with respect to the program for children with disabilities described by Subsection (a)(2) must require a participant to pay monthly premiums according to a sliding scale that is based on family income, subject to the requirements of 42 U.S.C. Sections 1396o(i)(2) and (3). (Gov. Code, Sec. 531.02444.)

Source Law

Sec. 531.02444. MEDICAID BUY-IN PROGRAMS FOR CERTAIN PERSONS WITH DISABILITIES. (a) The executive commissioner shall develop and implement:

(1) a Medicaid buy-in program for persons with disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (Pub. L. No. 105-33); and

(2) as authorized by the Deficit Reduction Act of 2005 (Pub. L. No. 109-171), a Medicaid buy-in program for children with disabilities that is described by 42 U.S.C. Section 1396a(cc)(1) whose family incomes do not exceed 300 percent of the applicable federal poverty level.

(b) The executive commissioner shall adopt rules in accordance with federal law that provide for:

(1) eligibility requirements for each program described by Subsection (a); and

(2) requirements for participants in the program to pay premiums or cost-sharing payments, subject to Subsection (c).

(c) Rules adopted by the executive commissioner under Subsection (b) with respect to the program for children with disabilities described by Subsection (a)(2) must require a participant to pay monthly premiums according to a sliding scale that is based on family income, subject to the requirements of 42 U.S.C. Sections 1396o(i)(2) and (3).

Revisor's Note

Section 531.02444(a)(2), Government Code, refers to the Medicaid buy-in program for children with disabilities "that is described by 42 U.S.C. Section 1396a(cc)(1)." 42 U.S.C. Section 1396a(cc)(1) describes the children with disabilities who are eligible for the Medicaid buy-in program, not the program itself. The revised law is drafted accordingly.

SUBCHAPTER I. UTILIZATION REVIEW, PRIOR AUTHORIZATION, AND COVERAGE PROCESSES AND DETERMINATIONS

Revised Law

Sec. 532.0401. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. The commission shall:

(1) in accordance with an established schedule, periodically review the prior authorization and utilization review processes within the Medicaid fee-for-service delivery model to determine whether those processes need modification to reduce authorizations of unnecessary services and inappropriate use of services;

(2) monitor the prior authorization and utilization

review processes within the Medicaid fee-for-service delivery model for anomalies and, on identification of an anomaly in a process, review the process for modification earlier than scheduled; and

(3) monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services. (Gov. Code, Sec. 531.076.)

Source Law

> Sec. 531.076. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. (a) The commission shall periodically review in accordance with an established schedule the prior authorization and utilization review processes within the Medicaid fee-for-service delivery model to determine if those processes need modification to reduce authorizations of unnecessary services and inappropriate use of services. The commission shall also monitor the processes described in this subsection for anomalies and, on identification of an anomaly in a process, shall review the process for modification earlier than scheduled.
>
> (b) The commission shall monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services.

Revised Law

Sec. 532.0402. ACCESSIBILITY OF INFORMATION REGARDING PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's Internet website in an easily searchable and accessible format:

(1) the applicable timelines for prior authorization requirements, including:

(A) the time within which the organization or entity must make a determination on a prior authorization request;

(B) a description of the notice the organization or entity provides to a provider and recipient on whose behalf the

request was submitted regarding the documentation required to complete a determination on a prior authorization request; and

(C) the deadline by which the organization or entity is required to submit the notice described by Paragraph (B); and

(2) an accurate and current catalog of coverage criteria and prior authorization requirements, including:

(A) for a prior authorization requirement first imposed on or after September 1, 2019, the effective date of the requirement;

(B) a list or description of any supporting or other documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each review of a prior authorization requirement conducted under Section 540.0304, if applicable.

(b) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to:

(1) adopt and maintain a process for a provider or recipient to contact the organization or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request; and

(2) ensure that the process described by Subdivision (1) is not arduous or overly burdensome to a provider or recipient. (Gov. Code, Sec. 531.024163.)

Source Law

Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING MEDICAID PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's Internet website in an easily searchable and accessible format:

(1) the applicable timelines for prior authorization requirements, including:

(A) the time within which the organization or entity must make a determination on a

prior authorization request;

(B) a description of the notice the organization or entity provides to a provider and Medicaid recipient on whose behalf the request was submitted regarding the documentation required to complete a determination on a prior authorization request; and

(C) the deadline by which the organization or entity is required to submit the notice described by Paragraph (B); and

(2) an accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including:

(A) for a prior authorization requirement first imposed on or after September 1, 2019, the effective date of the requirement;

(B) a list or description of any supporting or other documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each review of the prior authorization requirement conducted under Section 533.00283, if applicable.

(b) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to:

(1) adopt and maintain a process for a provider or Medicaid recipient to contact the organization or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request; and

(2) ensure that the process described by Subdivision (1) is not arduous or overly burdensome to a provider or recipient.

Revised Law

Sec. 532.0403. NOTICE REQUIREMENTS REGARDING COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (a) The commission shall ensure that a notice the commission or a Medicaid managed care organization sends to a recipient or Medicaid provider regarding the denial, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

(1) information required by federal and state law and regulations;

(2) for the recipient:

(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;

(B) a copy of the information the commission or organization sent to the provider; and

(C) an educational component that includes:

(i) a description of the recipient's rights;

(ii) an explanation of the process related to appeals and Medicaid fair hearings; and

(iii) a description of the role of an external medical review; and

(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as applicable, information required under Subsection (b).

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the recipient on whose behalf the request was submitted. The notice must:

(1) include a section specifically for the provider that contains:

(A) a clear and specific list and description of the documentation necessary for the commission or organization to make a final determination on the request;

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process described by Section 540.0306, if applicable; and

(C) information on the manner through which a provider may contact a Medicaid managed care organization or other entity as required by Section 532.0402; and

(2) be sent:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the extent practicable using existing resources. (Gov. Code, Sec. 531.024162.)

Source Law

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (a) The commission shall ensure that notice sent by the commission or a Medicaid managed care organization to a Medicaid recipient or provider regarding the denial, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

(1) information required by federal and state law and applicable regulations;

(2) for the recipient:

(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;

(B) a copy of the information sent to the provider; and

(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and a description of the role of an external medical review; and

(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as applicable, information required under Subsection (b).

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the Medicaid recipient on whose behalf the request was submitted. The notice issued under this subsection must:

(1) include a section specifically for the provider that contains:

(A) a clear and specific list and description of the documentation necessary for the commission or organization to make a final determination on the request;

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process described by Section 533.00284, if applicable; and

(C) information on the manner through which a provider may contact a Medicaid managed care organization or other entity as required by Section 531.024163; and

(2) be sent:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the

extent practicable using existing resources.

Revised Law

Sec. 532.0404. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" means a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with state law and rules.

(b) The commission shall contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) the commission's denial of eligibility for a Medicaid program in which eligibility is based on a recipient's medical and functional needs.

(c) A Medicaid managed care organization may not have a financial relationship with or ownership interest in the external medical reviewer with which the commission contracts.

(d) The external medical reviewer with which the commission contracts must:

(1) be overseen by a medical director who is a physician licensed in this state; and

(2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.

(e) The commission shall establish:

(1) a common procedure for external medical reviews that:

(A) to the greatest extent possible, reduces:

(i) administrative burdens on providers; and

(ii) the submission of duplicative information or documents; and

(B) bases a medical necessity determination on clinical criteria that is:

(i) publicly available;

(ii) current;

(iii) evidence-based; and

(iv) peer-reviewed; and

(2) a procedure and time frame for expedited reviews that allow the external medical reviewer to:

(A) identify an appeal that requires an expedited resolution; and

(B) resolve the review of the appeal within a specified period.

(f) The external medical reviewer shall conduct an external medical review within a period the commission specifies.

(g) A recipient or Medicaid applicant, or the recipient's or applicant's parent or legally authorized representative, must affirmatively request an external medical review. If requested:

(1) an external medical review described by Subsection (b)(1):

(A) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing; and

(B) is granted when a recipient contests the internal appeal decision of the Medicaid managed care organization; and

(2) an external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing.

(h) The external medical reviewer's determination of medical necessity establishes the minimum level of services a recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

(i) The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

(j) To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations the external medical reviewer reviewed, including the rate of prior authorization denials the external medical reviewer overturned and additional information the commission and the external medical reviewer determine appropriate. (Gov. Code, Sec. 531.024164.)

Source Law

Sec. 531.024164. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" and "reviewer" mean a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with applicable state law and rules.

(b) The commission shall contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a Medicaid recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) a denial by the commission of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs.

(c) A Medicaid managed care organization may not have a financial relationship with or ownership interest in the external medical reviewer with which the commission contracts.

(d) The external medical reviewer with which the commission contracts must:

(1) be overseen by a medical director who is a physician licensed in this state; and

(2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.

(e) The commission shall establish a common procedure for reviews. To the greatest extent possible, the procedure must reduce administrative burdens on providers and the submission of duplicative information or documents. Medical necessity under the procedure must be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The reviewer shall conduct the review within a period specified by the commission. The commission shall also establish a procedure and time frame for expedited reviews that allows the reviewer to:

(1) identify an appeal that requires an

expedited resolution; and

(2) resolve the review of the appeal within a specified period.

(f) A Medicaid recipient or applicant, or the recipient's or applicant's parent or legally authorized representative, must affirmatively request an external medical review. If requested:

(1) an external medical review described by Subsection (b)(1) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing and is granted when a Medicaid recipient contests the internal appeal decision of the Medicaid managed care organization; and

(2) an external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing.

(g) The external medical reviewer's determination of medical necessity establishes the minimum level of services a Medicaid recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

(h) The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

(i) To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations reviewed by the external medical reviewer, including the rate of prior authorization denials overturned by the external medical reviewer and additional information the commission and the external medical reviewer determine appropriate.

SUBCHAPTER J. COST-SAVING INITIATIVES

Revised Law

Sec. 532.0451. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES. (a) The commission shall develop and implement a comprehensive plan to reduce recipients' use of hospital emergency room services. The plan may include:

(1) a pilot program that is designed to assist a program participant in accessing an appropriate level of health care and that may include as components:

(A) providing a program participant access to bilingual health services providers; and

(B) giving a program participant information on how to access primary care physicians, advanced practice registered nurses, and local health clinics;

(2) a pilot program under which a health care provider other than a hospital is given a financial incentive for treating a

recipient outside of normal business hours to divert the recipient from a hospital emergency room;

(3) payment of a nominal referral fee to a hospital emergency room that performs an initial medical evaluation of a recipient and subsequently refers the recipient, if medically stable, to an appropriate level of health care, such as care provided by a primary care physician, advanced practice registered nurse, or local clinic;

(4) a program under which the commission or a Medicaid managed care organization contacts, by telephone or mail, a recipient who accesses a hospital emergency room three times during a six-month period and provides the recipient with information on ways the recipient may secure a medical home to avoid unnecessary treatment at a hospital emergency room;

(5) a health care literacy program under which the commission develops partnerships with other state agencies and private entities to:

(A) assist the commission in developing materials that:

(i) contain basic health care information for parents of young children who are recipients and who are participating in public or private child-care or prekindergarten programs, including federal Head Start programs; and

(ii) are written in a language understandable to those parents and specifically tailored to be applicable to the needs of those parents;

(B) distribute the materials developed under Paragraph (A) to those parents; and

(C) otherwise teach those parents about their children's health care needs and ways to address those needs; and

(6) other initiatives developed and implemented in other states that have shown success in reducing the incidence of unnecessary treatment in a hospital emergency room.

(b) The commission shall coordinate with hospitals and

other providers that receive supplemental payments under the uncompensated care payment program operated under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to identify and implement initiatives based on best practices and models that are designed to reduce recipients' use of hospital emergency room services as a primary means of receiving health care benefits, including initiatives designed to improve recipients' access to and use of primary care providers. (Gov. Code, Sec. 531.085.)

Source Law

Sec. 531.085. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES. (a) The commission shall develop and implement a comprehensive plan to reduce the use of hospital emergency room services by recipients under Medicaid. The plan may include:

(1) a pilot program designed to facilitate program participants in accessing an appropriate level of health care, which may include as components:

(A) providing program participants access to bilingual health services providers; and

(B) giving program participants information on how to access primary care physicians, advanced practice registered nurses, and local health clinics;

(2) a pilot program under which health care providers, other than hospitals, are given financial incentives for treating recipients outside of normal business hours to divert those recipients from hospital emergency rooms;

(3) payment of a nominal referral fee to hospital emergency rooms that perform an initial medical evaluation of a recipient and subsequently refer the recipient, if medically stable, to an appropriate level of health care, such as care provided by a primary care physician, advanced practice registered nurse, or local clinic;

(4) a program under which the commission or a managed care organization that enters into a contract with the commission under Chapter 533 contacts, by telephone or mail, a recipient who accesses a hospital emergency room three times during a six-month period and provides the recipient with information on ways the recipient may secure a medical home to avoid unnecessary treatment at hospital emergency rooms;

(5) a health care literacy program under which the commission develops partnerships with other state agencies and private entities to:

(A) assist the commission in developing materials that:

(i) contain basic health care information for parents of young children who are recipients under Medicaid and who are participating in public or private child-care or prekindergarten programs, including federal Head Start programs; and

(ii) are written in a language understandable to those parents and specifically tailored to be applicable to the needs of those parents;

(B) distribute the materials developed under Paragraph (A) to those parents; and

(C) otherwise teach those parents about the health care needs of their children and ways to address those needs; and

(6) other initiatives developed and implemented in other states that have shown success in reducing the incidence of unnecessary treatment in hospital emergency rooms.

(b) The commission shall coordinate with hospitals and other providers that receive supplemental payments under the uncompensated care payment program operated under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to identify and implement initiatives based on best practices and models that are designed to reduce Medicaid recipients' use of hospital emergency room services as a primary means of receiving health care benefits, including initiatives designed to improve recipients' access to and use of primary care providers.

Revised Law

Sec. 532.0452. PHYSICIAN INCENTIVE PROGRAM TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) If cost-effective, the executive commissioner by rule shall establish a physician incentive program designed to reduce recipients' use of hospital emergency room services for non-emergent conditions.

(b) In establishing the physician incentive program, the executive commissioner may include only the program components identified as cost-effective in the study conducted under former Section 531.086 before that section expired September 1, 2014.

(c) If the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, the executive commissioner shall implement controls to ensure that the after-hours services billed are actually provided outside of normal business hours. (Gov. Code, Sec. 531.0861.)

Source Law

Sec. 531.0861. PHYSICIAN INCENTIVE PROGRAM TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) If cost-effective, the executive commissioner by rule shall establish a physician incentive program designed to reduce the use of hospital emergency room services for non-emergent conditions by recipients under Medicaid.

(b) In establishing the physician incentive program under Subsection (a), the executive commissioner may include only the program components identified as cost-effective in the study conducted under former Section 531.086.

(c) If the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, the executive commissioner shall implement controls to ensure that the after-hours services billed are actually being provided outside of normal business hours.

Revisor's Note

Section 531.0861(b), Government Code, refers to a study conducted under "former Section 531.086," Government Code. Section 531.086 required the Health and Human Services Commission to conduct a study to evaluate physician incentive programs that attempt to reduce Medicaid recipients' hospital emergency room use for non-emergent conditions. Section 531.086(d) provided that the section expired September 1, 2014. The revised law includes a reference to the expiration date for the convenience of the reader.

Revised Law

Sec. 532.0453. CONTINUED IMPLEMENTATION OF CERTAIN INTERVENTIONS AND BEST PRACTICES BY PROVIDERS; SEMIANNUAL REPORT. (a) The commission shall encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of recipients that were developed and achieved under the Delivery System Reform Incentive Payment (DSRIP) program previously operated under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315), through:

(1) existing provider incentive programs and the creation of new provider incentive programs;

(2) the terms included in contracts with Medicaid managed care organizations;

(3) implementation of alternative payment models; or

(4) adoption of other cost-effective measures.

(b) The commission shall semiannually prepare and submit to the legislature a report that contains a summary of the commission's efforts under this section and Section 532.0451(b). (Gov. Code, Sec. 531.0862.)

Source Law

> Sec. 531.0862. CONTINUED IMPLEMENTATION OF CERTAIN INTERVENTIONS AND BEST PRACTICES BY PROVIDERS; BIANNUAL REPORT. (a) The commission shall encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were developed and achieved under the Delivery System Reform Incentive Payment (DSRIP) program previously operated under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), through:
>
> (1) existing provider incentive programs and the creation of new provider incentive programs;
>
> (2) the terms included in contracts with Medicaid managed care organizations;
>
> (3) implementation of alternative payment models; or
>
> (4) adoption of other cost-effective measures.
>
> (b) The commission shall biannually prepare and submit a report to the legislature that contains a summary of the commission's efforts under this section and Section 531.085(b).

Revised Law

Sec. 532.0454. HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a) If the commission determines that it is cost-effective and feasible, the commission shall develop and implement a Medicaid health savings account pilot program that is consistent with federal law to:

(1) encourage adult recipients' health care cost awareness and sensitivity; and

(2) promote adult recipients' appropriate use of Medicaid services.

(b) If the commission implements the pilot program, the commission:

(1) may include only adult recipients as program participants; and

(2) shall ensure that:

(A) participation in the pilot program is

voluntary; and

(B) a recipient who participates in the pilot program may, at the recipient's option and subject to Subsection (c), discontinue participating and resume receiving benefits and services under the traditional Medicaid delivery model.

(c) A recipient who chooses to discontinue participating in the pilot program and resume receiving benefits and services under the traditional Medicaid delivery model before completion of the health savings account enrollment period forfeits any funds remaining in the recipient's health savings account. (Gov. Code, Sec. 531.0941.)

Source Law

> Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a) If the commission determines that it is cost-effective and feasible, the commission shall develop and implement a Medicaid health savings account pilot program that is consistent with federal law to:
>
> (1) encourage health care cost awareness and sensitivity by adult recipients; and
>
> (2) promote appropriate utilization of Medicaid services by adult recipients.
>
> (b) If the commission implements the pilot program, the commission may only include adult recipients as participants in the program.
>
> (c) If the commission implements the pilot program, the commission shall ensure that:
>
> (1) participation in the pilot program is voluntary; and
>
> (2) a recipient who participates in the pilot program may, at the recipient's option and subject to Subsection (d), discontinue participation in the program and resume receiving benefits and services under the traditional Medicaid delivery model.
>
> (d) A recipient who chooses to discontinue participation in the pilot program and resume receiving benefits and services under the traditional Medicaid delivery model before completion of the health savings account enrollment period forfeits any funds remaining in the recipient's health savings account.

Revised Law

Sec. 532.0455. DURABLE MEDICAL EQUIPMENT REUSE PROGRAM. (a) In this section:

(1) "Complex rehabilitation technology equipment":

(A) means equipment that is:

(i) classified as durable medical equipment

under the Medicare program on January 1, 2013;

(ii) configured specifically for an individual to meet the individual's unique medical, physical, and functional needs and capabilities for basic and instrumental daily living activities; and

(iii) medically necessary to prevent the individual's hospitalization or institutionalization; and

(B) includes a complex rehabilitation power wheelchair, highly configurable manual wheelchair, adaptive seating and positioning system, standing frame, and gait trainer.

(2) "Durable medical equipment" means equipment, including repair and replacement parts for the equipment, but excluding complex rehabilitation technology equipment, that:

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to an individual in the absence of illness or injury; and

(D) is appropriate and safe for use in the home.

(b) If the commission determines that it is cost-effective, the executive commissioner by rule shall establish a program to facilitate the reuse of durable medical equipment provided to recipients.

(c) The program must include provisions for ensuring that:

(1) reused equipment meets applicable standards of functionality and sanitation; and

(2) a recipient's participation in the reuse program is voluntary.

(d) The program does not:

(1) waive any immunity from liability of the commission or a commission employee; or

(2) create a cause of action against the commission or a commission employee arising from the provision of reused durable medical equipment under the program. (Gov. Code, Secs.

531.0843(a), (b), (c), (d).)

Source Law

Sec. 531.0843. DURABLE MEDICAL EQUIPMENT REUSE PROGRAM. (a) In this section:

(1) "Complex rehabilitation technology equipment" means equipment that is classified as durable medical equipment under the Medicare program on January 1, 2013, configured specifically for an individual to meet the individual's unique medical, physical, and functional needs and capabilities for basic and instrumental daily living activities, and medically necessary to prevent the individual's hospitalization or institutionalization. The term includes a complex rehabilitation power wheelchair, highly configurable manual wheelchair, adaptive seating and positioning system, standing frame, and gait trainer.

(2) "Durable medical equipment" means equipment, including repair and replacement parts for the equipment, but excluding complex rehabilitation technology equipment, that:

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to a person in the absence of illness or injury; and

(D) is appropriate and safe for use in the home.

(b) If the commission determines that it is cost-effective, the executive commissioner by rule shall establish a program to facilitate the reuse of durable medical equipment provided to recipients under the Medicaid program.

(c) The program must include provisions for ensuring that:

(1) reused equipment meets applicable standards of functionality and sanitation; and

(2) a Medicaid recipient's participation in the reuse program is voluntary.

(d) The program does not:

(1) waive any immunity from liability of the commission or an employee of the commission; or

(2) create a cause of action against the commission or an employee of the commission arising from the provision of reused durable medical equipment under the program.

Revisor's Note

Section 531.0843(e), Government Code, requires the executive commissioner of the Health and Human Services Commission to provide notice of each proposed rule, adopted rule, and hearing in accordance with Chapter 551 or 2001, Government Code, as applicable. Chapter 551, Government Code, requires a governmental body to give notice of each meeting held by the governmental body. See Section 551.041, Government

Code. Section 551.001 of that chapter defines "governmental body" for purposes of the chapter in a manner that includes the Health and Human Services Commission. Chapter 2001, Government Code, requires a state agency to give notice of proposed rules and to file adopted rules with the office of the secretary of state for publication in the Texas Register. See Sections 2001.023 and 2001.036(c), Government Code. Section 2001.003 of that chapter defines "state agency" for purposes of the chapter in a manner that includes the Health and Human Services Commission. The notice requirements of Chapters 551 and 2001 apply by their own terms. Therefore, the revised law omits the requirements of Section 531.0843(e) as unnecessary. The omitted law reads:

> (e) In accordance with Chapter 551 or 2001, as applicable, the executive commissioner shall provide notice of each proposed rule, adopted rule, and hearing that relates to establishing the program under this section.

CHAPTER 540. MEDICAID MANAGED CARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 540.0001. DEFINITIONS . . . . . 371

SUBCHAPTER B. ADMINISTRATION OF MEDICAID MANAGED CARE PROGRAM

Sec. 540.0051. PURPOSE AND IMPLEMENTATION . . . . . 374
Sec. 540.0052. RECIPIENT DIRECTORY . . . . . 375
Sec. 540.0053. STATEWIDE EFFORT TO PROMOTE MEDICAID ELIGIBILITY MAINTENANCE . . . . . 376
Sec. 540.0054. PROVIDER AND RECIPIENT EDUCATION PROGRAMS . . . . . 378
Sec. 540.0055. MARKETING GUIDELINES . . . . . 380
Sec. 540.0056. GUIDELINES FOR COMMUNICATIONS WITH RECIPIENTS . . . . . 381
Sec. 540.0057. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES . . . . . 382

Sec. 540.0058. INFORMATION FOR FRAUD CONTROL . . . . . 383
Sec. 540.0059. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM . . . . . 384
Sec. 540.0060. COMPLAINT SYSTEM GUIDELINES . . . . . 385
SUBCHAPTER C. FISCAL PROVISIONS
Sec. 540.0101. FISCAL SOLVENCY STANDARDS . . . . . 386
Sec. 540.0102. PROFIT SHARING . . . . . 386
Sec. 540.0103. TREATMENT OF STATE TAXES IN CALCULATING EXPERIENCE REBATE OR PROFIT SHARING . . . . 387
SUBCHAPTER D. STRATEGY FOR MANAGING AUDIT RESOURCES
Sec. 540.0151. DEFINITIONS . . . . . 387
Sec. 540.0152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER . . . . . 388
Sec. 540.0153. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES . . . . . 389
Sec. 540.0154. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP . . . . . 389
Sec. 540.0155. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS . . . . . 390
Sec. 540.0156. AUDITS OF PHARMACY BENEFIT MANAGERS . . . . . 391
Sec. 540.0157. COLLECTING COSTS FOR AUDIT-RELATED SERVICES . . . . . 392
Sec. 540.0158. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING . . . . . 392
Sec. 540.0159. USING INFORMATION FROM EXTERNAL QUALITY REVIEWS . . . . . 393
Sec. 540.0160. SECURITY OF AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS . . . . 394
SUBCHAPTER E. CONTRACT ADMINISTRATION
Sec. 540.0201. CONTRACT ADMINISTRATION IMPROVEMENT EFFORTS . . . . . 394
Sec. 540.0202. PUBLIC NOTICE OF REQUEST FOR CONTRACT APPLICATIONS . . . . . 397
Sec. 540.0203. CERTIFICATION BY COMMISSION . . . . . 398

Sec. 540.0204. CONTRACT CONSIDERATIONS RELATING TO MANAGED CARE ORGANIZATIONS . . . . . 399
Sec. 540.0205. CONTRACT CONSIDERATIONS RELATING TO PHARMACY BENEFIT MANAGERS . . . . . 400
Sec. 540.0206. MANDATORY CONTRACTS . . . . . 401
Sec. 540.0207. CONTRACTUAL OBLIGATIONS REVIEW . . . . . 405
Sec. 540.0208. CONTRACT IMPLEMENTATION PLAN . . . . . 405
Sec. 540.0209. COMPLIANCE AND READINESS REVIEW . . . . . 406
Sec. 540.0210. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS . . . . . 407
Sec. 540.0211. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS . . . . . 409
Sec. 540.0212. MONITORING COMPLIANCE WITH BEHAVIORAL HEALTH INTEGRATION . . . . . 412
SUBCHAPTER F. REQUIRED CONTRACT PROVISIONS
Sec. 540.0251. APPLICABILITY . . . . . 413
Sec. 540.0252. ACCOUNTABILITY TO STATE . . . . . 413
Sec. 540.0253. CAPITATION RATES . . . . . 414
Sec. 540.0254. COST INFORMATION . . . . . 415
Sec. 540.0255. FRAUD CONTROL . . . . . 415
Sec. 540.0256. RECIPIENT OUTREACH AND EDUCATION . . . . . 416
Sec. 540.0257. NOTICE OF MEDICAID CERTIFICATION DATE . . . . 416
Sec. 540.0258. PRIMARY CARE PROVIDER ASSIGNMENT . . . . . 417
Sec. 540.0259. COMPLIANCE WITH PROVIDER NETWORK REQUIREMENTS . . . . . 417
Sec. 540.0260. COMPLIANCE WITH PROVIDER ACCESS STANDARDS; REPORT . . . . . 418
Sec. 540.0261. PROVIDER NETWORK SUFFICIENCY . . . . . 419
Sec. 540.0262. QUALITY MONITORING PROGRAM FOR HEALTH CARE SERVICES . . . . . 421
Sec. 540.0263. OUT-OF-NETWORK PROVIDER USAGE AND REIMBURSEMENT . . . . . 422
Sec. 540.0264. PROVIDER REIMBURSEMENT RATE REDUCTION . . . . 423
Sec. 540.0265. PROMPT PAYMENT OF CLAIMS . . . . . 424

Sec. 540.0266. REIMBURSEMENT FOR CERTAIN SERVICES PROVIDED OUTSIDE REGULAR BUSINESS HOURS . . . . . 425
Sec. 540.0267. PROVIDER APPEALS PROCESS . . . . . 426
Sec. 540.0268. ASSISTANCE RESOLVING RECIPIENT AND PROVIDER ISSUES . . . . . 427
Sec. 540.0269. USE OF ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS . . . . . 428
Sec. 540.0270. MEDICAL DIRECTOR AVAILABILITY . . . . . 429
Sec. 540.0271. PERSONNEL REQUIRED IN CERTAIN SERVICE REGIONS . . . . . 430
Sec. 540.0272. CERTAIN SERVICES PERMITTED IN LIEU OF OTHER MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES; ANNUAL REPORT . . . . . 430
Sec. 540.0273. OUTPATIENT PHARMACY BENEFIT PLAN . . . . . 432
Sec. 540.0274. PHARMACY BENEFIT PLAN: REBATES AND RECEIPT OF CONFIDENTIAL INFORMATION PROHIBITED . . . . . 433
Sec. 540.0275. PHARMACY BENEFIT PLAN: CERTAIN PHARMACY BENEFITS FOR SEX OFFENDERS PROHIBITED . . . 434
Sec. 540.0276. PHARMACY BENEFIT PLAN: RECIPIENT SELECTION OF PHARMACEUTICAL SERVICES PROVIDER . . . . . 435
Sec. 540.0277. PHARMACY BENEFIT PLAN: PHARMACY BENEFIT PROVIDERS . . . . . 435
Sec. 540.0278. PHARMACY BENEFIT PLAN: PROMPT PAYMENT OF PHARMACY BENEFIT CLAIMS . . . . . 437
Sec. 540.0279. PHARMACY BENEFIT PLAN: MAXIMUM ALLOWABLE COST PRICE AND LIST FOR PHARMACY BENEFITS . . . . . 438
Sec. 540.0280. PHARMACY BENEFIT PLAN: PHARMACY BENEFITS FOR CHILD ENROLLED IN STAR KIDS MANAGED CARE PROGRAM . . . . . 441

SUBCHAPTER G. PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCEDURES
Sec. 540.0301. INAPPLICABILITY OF CERTAIN OTHER LAW TO MEDICAID MANAGED CARE UTILIZATION REVIEWS . . . . . 443
Sec. 540.0302. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT . . . . . 443
Sec. 540.0303. PRIOR AUTHORIZATION PROCEDURES FOR NONHOSPITALIZED RECIPIENT . . . . . 444
Sec. 540.0304. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS . . . . . 446
Sec. 540.0305. PHYSICIAN CONSULTATION BEFORE ADVERSE PRIOR AUTHORIZATION DETERMINATION . . . . . 447
Sec. 540.0306. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS . . . . . 448
Sec. 540.0307. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE . . . . . 450
SUBCHAPTER H. PREMIUM PAYMENT RATES
Sec. 540.0351. PREMIUM PAYMENT RATE DETERMINATION . . . . . 450
Sec. 540.0352. MAXIMUM PREMIUM PAYMENT RATES FOR CERTAIN PROGRAMS . . . . . 453
Sec. 540.0353. USE OF ENCOUNTER DATA IN DETERMINING PREMIUM PAYMENT RATES AND OTHER PAYMENT AMOUNTS . . . . . 455
SUBCHAPTER I. ENCOUNTER DATA
Sec. 540.0401. PROVIDER REPORTING OF ENCOUNTER DATA . . . . . 456
Sec. 540.0402. CERTIFIER OF ENCOUNTER DATA QUALIFICATIONS . . . . . 456
Sec. 540.0403. ENCOUNTER DATA CERTIFICATION . . . . . 457
SUBCHAPTER J. MANAGED CARE PLAN REQUIREMENTS
Sec. 540.0451. MEDICAID MANAGED CARE PLAN ACCREDITATION . . . . . 458
Sec. 540.0452. MEDICAL DIRECTOR QUALIFICATIONS . . . . . 458

SUBCHAPTER K. MEDICAID MANAGED CARE PLAN ENROLLMENT AND DISENROLLMENT
Sec. 540.0501. RECIPIENT ENROLLMENT IN AND DISENROLLMENT FROM MEDICAID MANAGED CARE PLAN . . . . . 459
Sec. 540.0502. AUTOMATIC ENROLLMENT IN MEDICAID MANAGED CARE PLAN . . . . . 461
Sec. 540.0503. ENROLLMENT OF CERTAIN RECIPIENTS IN SAME MEDICAID MANAGED CARE PLAN . . . . . 462
Sec. 540.0504. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MEDICAID MANAGED CARE ORGANIZATIONS . . . . . 462
Sec. 540.0505. LIMITATIONS ON RECIPIENT DISENROLLMENT FROM MEDICAID MANAGED CARE PLAN . . . . . 463
SUBCHAPTER L. CONTINUITY OF CARE AND COORDINATION OF BENEFITS
Sec. 540.0551. GUIDANCE REGARDING CONTINUATION OF SERVICES UNDER CERTAIN CIRCUMSTANCES . . . 464
Sec. 540.0552. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS . . . 464
SUBCHAPTER M. PROVIDER NETWORK ADEQUACY
Sec. 540.0601. MONITORING OF PROVIDER NETWORKS . . . . . 470
Sec. 540.0602. REPORT ON OUT-OF-NETWORK PROVIDER SERVICES . . . . . 470
Sec. 540.0603. REPORT ON COMMISSION INVESTIGATION OF PROVIDER COMPLAINT . . . . . 471
Sec. 540.0604. ADDITIONAL REIMBURSEMENT FOLLOWING PROVIDER COMPLAINT . . . . . 472
Sec. 540.0605. CORRECTIVE ACTION PLAN FOR INADEQUATE NETWORK AND PROVIDER REIMBURSEMENT . . . . 473
Sec. 540.0606. REMEDIES FOR NONCOMPLIANCE WITH CORRECTIVE ACTION PLAN . . . . . 474

SUBCHAPTER N. PROVIDERS
Sec. 540.0651. INCLUSION OF CERTAIN PROVIDERS IN MEDICAID MANAGED CARE ORGANIZATION PROVIDER NETWORK . . . . . 475
Sec. 540.0652. PROVIDER ACCESS STANDARDS; BIENNIAL REPORT . . . . . 478
Sec. 540.0653. PENALTIES AND OTHER REMEDIES FOR FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS . . . . . 480
Sec. 540.0654. PROVIDER NETWORK DIRECTORIES . . . . . 481
Sec. 540.0655. PROVIDER PROTECTION PLAN . . . . . 482
Sec. 540.0656. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS . . . . . 485
Sec. 540.0657. FREQUENCY OF PROVIDER RECREDENTIALING . . . . 488
Sec. 540.0658. PROVIDER INCENTIVES FOR PROMOTING PREVENTIVE SERVICES . . . . . 488
Sec. 540.0659. REIMBURSEMENT RATE FOR CERTAIN SERVICES PROVIDED BY CERTAIN HEALTH CENTERS AND CLINICS OUTSIDE REGULAR BUSINESS HOURS . . . . . 489
SUBCHAPTER O. DELIVERY OF SERVICES: GENERAL PROVISIONS
Sec. 540.0701. ACUTE CARE SERVICE DELIVERY THROUGH MOST COST-EFFECTIVE MODEL; MANAGED CARE SERVICE DELIVERY AREAS . . . . . 489
Sec. 540.0702. TRANSITION OF CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MEDICAID MANAGED CARE PROGRAM . . . . . 492
Sec. 540.0703. BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES . . . . . 493
Sec. 540.0704. TARGETED CASE MANAGEMENT AND PSYCHIATRIC REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES . . . . . 495

Sec. 540.0705. BEHAVIORAL HEALTH SERVICES PROVIDED THROUGH THIRD PARTY OR SUBSIDIARY . . . . . 497
Sec. 540.0706. PSYCHOTROPIC MEDICATION MONITORING SYSTEM FOR CERTAIN CHILDREN . . . . . 499
Sec. 540.0707. MEDICATION THERAPY MANAGEMENT . . . . . 500
Sec. 540.0708. SPECIAL DISEASE MANAGEMENT . . . . . 500
Sec. 540.0709. SPECIAL PROTOCOLS FOR INDIGENT POPULATIONS . . . . . 503
Sec. 540.0710. DIRECT ACCESS TO EYE HEALTH CARE SERVICES . . . . . 503
Sec. 540.0711. DELIVERY OF BENEFITS USING TELECOMMUNICATIONS OR INFORMATION TECHNOLOGY . . . . . 504
Sec. 540.0712. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOME . . . . . 508
Sec. 540.0713. VALUE-ADDED SERVICES . . . . . 509
SUBCHAPTER P. DELIVERY OF SERVICES: STAR+PLUS MEDICAID MANAGED CARE PROGRAM
Sec. 540.0751. DELIVERY OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS . . . . . 510
Sec. 540.0752. DELIVERY OF MEDICAID BENEFITS TO NURSING FACILITY RESIDENTS . . . . . 511
Sec. 540.0753. DELIVERY OF BASIC ATTENDANT AND HABILITATION SERVICES . . . . . 516
Sec. 540.0754. EVALUATION OF CERTAIN PROGRAM SERVICES . . . 517
Sec. 540.0755. UTILIZATION REVIEW; ANNUAL REPORT . . . . . 517
SUBCHAPTER Q. DELIVERY OF SERVICES: STAR HEALTH PROGRAM
Sec. 540.0801. TRAUMA-INFORMED CARE TRAINING . . . . . 520
Sec. 540.0802. MENTAL HEALTH PROVIDERS . . . . . 520
Sec. 540.0803. HEALTH SCREENING REQUIREMENTS AND COMPLIANCE WITH TEXAS HEALTH STEPS . . . . . 521
Sec. 540.0804. HEALTH CARE AND OTHER SERVICES FOR CHILDREN IN SUBSTITUTE CARE . . . . . 522

Sec. 540.0805. PLACEMENT CHANGE NOTICE AND CARE COORDINATION . . . . . 524
Sec. 540.0806. MEDICAID BENEFITS FOR CERTAIN CHILDREN FORMERLY IN FOSTER CARE . . . . . 524
SUBCHAPTER R. DELIVERY OF SERVICES: STAR KIDS MANAGED CARE PROGRAM
Sec. 540.0851. STAR KIDS MANAGED CARE PROGRAM . . . . . 526
Sec. 540.0852. CARE MANAGEMENT AND CARE NEEDS ASSESSMENT . . . . . 528
Sec. 540.0853. BENEFITS FOR CHILDREN IN MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM . . . . . 531
Sec. 540.0854. BENEFITS TRANSITION FROM STAR KIDS TO STAR+PLUS MEDICAID MANAGED CARE PROGRAM . . . . . 531
Sec. 540.0855. UTILIZATION REVIEW OF PRIOR AUTHORIZATIONS . . . . . 532

## CHAPTER 540. MEDICAID MANAGED CARE PROGRAM

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 540.0001. DEFINITIONS. In this chapter:

(1) Notwithstanding Section 521.0001(2), "commission" means the Health and Human Services Commission or an agency operating part of the Medicaid managed care program, as appropriate.

(2) "Health care service region" or "region" means a Medicaid managed care service area the commission delineates.

(3) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

(4) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those

services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(5) "Potentially preventable event" has the meaning assigned by Section 543A.0001.

(6) "Recipient" means a Medicaid recipient. (Gov. Code, Secs. 533.001(1), (4), (5), (6), (7), 533.00251(a)(4), 533.00253(a)(3), 533.00256(a)(1) (part), 533.00511(a).)

Source Law

Sec. 533.001. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program, as appropriate.

(4) "Managed care organization" means a person who is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

(5) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(6) "Recipient" means a recipient of Medicaid.

(7) "Health care service region" or "region" means a Medicaid managed care service area as delineated by the commission.

Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS, INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this section and Sections 533.002515 and 533.00252:

(4) "Potentially preventable event" has the meaning assigned by Section 536.001.

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(3) "Potentially preventable event" has the meaning assigned by Section 536.001.

[Sec. 533.00256]

(a) . . . [the commission shall:

(1) establish a clinical improvement program to . . . reduce] potentially preventable events, as defined by Section 536.001; and

. . .

Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MANAGED CARE ORGANIZATIONS. (a) In this section, "potentially preventable event" has the meaning assigned by Section 536.001.

Revisor's Note

(1) Section 533.001(1), Government Code, defines "[c]ommission" for purposes of Chapter 533, Government Code, as meaning the Health and Human Services Commission and certain other state agencies. That definition applies to the law revised in this chapter, which is substantially derived from Chapter 533. Section 531.001(2), Government Code, which is revised as Section 521.0001(2) of this subtitle, defines "[c]ommission" for purposes of Subtitle I, Title 4, Government Code, to mean only the Health and Human Services Commission. The law revised in this chapter is derived from Subtitle I, and the definition provided by Section 531.001(2) would apply to this chapter in the absence of the definition provided by Section 533.001(1) that more specifically applies to the law revised in this chapter that is derived from Chapter 533. The provisions of this chapter that are not derived from Chapter 533 do not use the term "commission." The revised law defines "commission" to have the more expansive meaning assigned by Section 533.001(1) for purposes of the law revised in this chapter and, for clarity and the convenience of the reader, adds that this definition is "[n]otwithstanding Section 521.0001(2)."

(2) Sections 533.001(2) and (3), Government Code, define "[e]xecutive commissioner" and "[h]ealth and human services agencies" for purposes of Chapter 533, Government Code. The law revised in this chapter is substantially derived from Chapter 533, and the cited definitions apply to the terms as used in this chapter that are derived from Chapter 533. However,

the revised law omits the definitions because the definitions duplicate the definitions for those terms in Section 531.001, Government Code, which is revised in this subtitle as Section 521.0001 and applies to this subtitle, including to the law revised in this chapter. The omitted law reads:

> (2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.
>
> (3) "Health and human services agencies" has the meaning assigned by Section 531.001.

(3) Sections 533.001(4) and (6), Government Code, define "[m]anaged care organization" and "[r]ecipient" for purposes of Chapter 533, Government Code. The law revised in this chapter is substantially derived from Chapter 533. This chapter also includes the revision of Section 531.0211, Government Code. That section is revised in this chapter as Section 540.0054, and the defined terms are made applicable to that revised law. Because it is clear from the context that the defined terms have the same meaning in Section 531.0211, applying the defined terms to the revision of that section in this chapter does not result in a substantive change.

SUBCHAPTER B. ADMINISTRATION OF MEDICAID MANAGED CARE PROGRAM

Revised Law

Sec. 540.0051. PURPOSE AND IMPLEMENTATION. The commission shall implement the Medicaid managed care program by contracting with managed care organizations in a manner that, to the extent possible:

(1) improves the health of Texans by:

(A) emphasizing prevention;

(B) promoting continuity of care; and

(C) providing a medical home for recipients;

(2) ensures each recipient receives high quality,

comprehensive health care services in the recipient's local community;

(3) encourages training of and access to primary care physicians and providers;

(4) maximizes cooperation with existing public health entities, including local health departments;

(5) provides incentives to managed care organizations to improve the quality of health care services for recipients by providing value-added services; and

(6) reduces administrative and other nonfinancial barriers for recipients in obtaining health care services. (Gov. Code, Sec. 533.002.)

Source Law

> Sec. 533.002. PURPOSE. The commission shall implement the Medicaid managed care program by contracting with managed care organizations in a manner that, to the extent possible:
>
> (1) improves the health of Texans by:
>
> (A) emphasizing prevention;
>
> (B) promoting continuity of care; and
>
> (C) providing a medical home for recipients;
>
> (2) ensures that each recipient receives high quality, comprehensive health care services in the recipient's local community;
>
> (3) encourages the training of and access to primary care physicians and providers;
>
> (4) maximizes cooperation with existing public health entities, including local departments of health;
>
> (5) provides incentives to managed care organizations to improve the quality of health care services for recipients by providing value-added services; and
>
> (6) reduces administrative and other nonfinancial barriers for recipients in obtaining health care services.

Revised Law

Sec. 540.0052. RECIPIENT DIRECTORY. The commission shall, in accordance with a single source of truth design:

(1) maintain an accurate electronic directory of contact information for each recipient enrolled in a Medicaid managed care plan offered by a managed care organization, including, to the extent feasible, each recipient's:

(A) home, work, and mobile telephone numbers;

(B) e-mail address; and

(C) home and work addresses; and

(2) ensure that each Medicaid managed care organization and enrollment broker participating in the Medicaid managed care program update the electronic directory in real time. (Gov. Code, Sec. 533.00751.)

Source Law

Sec. 533.00751. RECIPIENT DIRECTORY. The commission shall in accordance with a single source of truth design:

(1) maintain an accurate electronic directory of contact information for each recipient enrolled in a managed care plan offered by a Medicaid managed care organization under this chapter, including, to the extent feasible, each recipient's:

(A) home, work, and mobile telephone numbers;

(B) e-mail address; and

(C) home and work addresses; and

(2) ensure that each Medicaid managed care organization and enrollment broker participating in the Medicaid managed care program update the electronic directory required under Subdivision (1) in real time.

Revisor's Note

Section 533.00751(1), Government Code, refers to "a managed care plan" offered by a Medicaid managed care organization. Throughout this chapter, the revised law substitutes "Medicaid managed care plan" for "managed care plan" for clarity and consistency when the context is clear that the source law is referring to a managed care plan offered under the Medicaid managed care program.

Revised Law

Sec. 540.0053. STATEWIDE EFFORT TO PROMOTE MEDICAID ELIGIBILITY MAINTENANCE. (a) The commission shall develop and implement a statewide effort to assist recipients who satisfy Medicaid eligibility requirements and who receive Medicaid services through a Medicaid managed care organization with:

(1) maintaining eligibility; and

(2) avoiding lapses in Medicaid coverage.

(b) As part of the commission's effort under Subsection (a),

the commission shall:

(1) require each Medicaid managed care organization to assist the organization's recipients with maintaining eligibility;

(2) if the commission determines it is cost-effective, develop specific strategies for assisting recipients who receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq. with maintaining eligibility; and

(3) ensure information relevant to a recipient's eligibility status is provided to the recipient's Medicaid managed care organization. (Gov. Code, Sec. 533.0077.)

Source Law

Sec. 533.0077. STATEWIDE EFFORT TO PROMOTE MAINTENANCE OF ELIGIBILITY. (a) The commission shall develop and implement a statewide effort to assist recipients who satisfy Medicaid eligibility requirements and who receive Medicaid services through a managed care organization with maintaining eligibility and avoiding lapses in coverage under Medicaid.

(b) As part of its effort under Subsection (a), the commission shall:

(1) require each managed care organization providing health care services to recipients to assist those recipients with maintaining eligibility;

(2) if the commission determines it is cost-effective, develop specific strategies for assisting recipients who receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq. with maintaining eligibility; and

(3) ensure information that is relevant to a recipient's eligibility status is provided to the managed care organization through which the recipient receives Medicaid services.

Revisor's Note

Section 533.0077(a), Government Code, refers to Medicaid recipients who receive "Medicaid services through a managed care organization," and Section 533.0077(b)(1), Government Code, refers to a "managed care organization providing health care services to recipients." A managed care organization that provides those services to recipients is a Medicaid managed care organization, which is defined by Section 521.0001 as a managed care organization that contracts with the Health and Human Services Commission under

Chapter 533, Government Code, the relevant portions of which are revised in this chapter, to provide health care services to Medicaid recipients. That definition applies subtitle-wide, including to the law revised in this chapter. For consistency of terminology, the revised law substitutes "Medicaid managed care organization" for "managed care organization." Similar changes are made throughout the revised law in this chapter where the context of the law from which the revised law is derived indicates that the reference is specifically to a Medicaid managed care organization rather than to a managed care organization generally.

Revised Law

Sec. 540.0054. PROVIDER AND RECIPIENT EDUCATION PROGRAMS. (a) In adopting rules to implement a Medicaid managed care program, the executive commissioner shall establish guidelines for, and require Medicaid managed care organizations to provide, education programs for providers and recipients using a variety of techniques and media.

(b) A provider education program must include information on:

(1) Medicaid policies, procedures, eligibility standards, and benefits;

(2) recipients' specific problems and needs; and

(3) recipients' rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section 532.0301.

(c) A recipient education program must present information in a manner that is easy to understand. A program must include information on:

(1) a recipient's rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section 532.0301;

(2) how to access health care services;

(3) how to access complaint procedures and the recipient's right to bypass the Medicaid managed care organization's internal complaint system and use the notice and appeal procedures otherwise required by Medicaid;

(4) Medicaid policies, procedures, eligibility standards, and benefits;

(5) the Medicaid managed care organization's policies and procedures; and

(6) the importance of prevention, early intervention, and appropriate use of services. (Gov. Code, Sec. 531.0211.)

Source Law

Sec. 531.0211. MANAGED CARE MEDICAID PROGRAM: RULES; EDUCATION PROGRAMS. (a) In adopting rules to implement a managed care Medicaid program, the executive commissioner shall establish guidelines for, and require managed care organizations to provide, education programs for providers and clients using a variety of techniques and mediums.

(b) A provider education program must include information on:

(1) Medicaid policies, procedures, eligibility standards, and benefits;

(2) the specific problems and needs of Medicaid clients; and

(3) the rights and responsibilities of Medicaid clients under the bill of rights and the bill of responsibilities prescribed by Section 531.0212.

(c) A client education program must present information in a manner that is easy to understand. A program must include information on:

(1) a client's rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section 531.0212;

(2) how to access health care services;

(3) how to access complaint procedures and the client's right to bypass the managed care organization's internal complaint system and use the notice and appeal procedures otherwise required by Medicaid;

(4) Medicaid policies, procedures, eligibility standards, and benefits;

(5) the policies and procedures of the managed care organization; and

(6) the importance of prevention, early intervention, and appropriate use of services.

Revisor's Note

(1) Section 531.0211(a), Government Code, refers to a "managed care Medicaid program." The revised law substitutes the term "Medicaid managed

care program" for "managed care Medicaid program" because the terms are synonymous and "Medicaid managed care program" is more commonly used.

(2) Section 531.0211, Government Code, refers to a Medicaid client. The revised law substitutes "recipient" for references to a Medicaid client for clarity and consistency in the terminology used within the chapter and because "recipient," as defined by Section 540.0001 of this chapter, is applicable to the revised law and is more commonly used.

Revised Law

Sec. 540.0055. MARKETING GUIDELINES. (a) The commission shall establish marketing guidelines for Medicaid managed care organizations, including guidelines that prohibit:

(1) door-to-door marketing to a recipient by a Medicaid managed care organization or the organization's agent;

(2) using marketing materials with inaccurate or misleading information;

(3) making a misrepresentation to a recipient or provider;

(4) offering a recipient a material or financial incentive to choose a Medicaid managed care plan, other than a nominal gift or free health screening the commission approves that the Medicaid managed care organization offers to all recipients regardless of whether the recipients enroll in the plan;

(5) using a marketing agent who is paid solely by commission; and

(6) face-to-face marketing at a public assistance office by a Medicaid managed care organization or the organization's agent.

(b) This section does not prohibit:

(1) distributing approved marketing materials at a public assistance office; or

(2) providing information directly to a recipient

under marketing guidelines the commission establishes. (Gov. Code, Secs. 533.008(a), (b).)

Source Law

> Sec. 533.008. MARKETING GUIDELINES. (a) The commission shall establish marketing guidelines for managed care organizations that contract with the commission to provide health care services to recipients, including guidelines that prohibit:
>
> (1) door-to-door marketing to recipients by managed care organizations or agents of those organizations;
>
> (2) the use of marketing materials with inaccurate or misleading information;
>
> (3) misrepresentations to recipients or providers;
>
> (4) offering recipients material or financial incentives to choose a managed care plan other than nominal gifts or free health screenings approved by the commission that the managed care organization offers to all recipients regardless of whether the recipients enroll in the managed care plan;
>
> (5) the use of marketing agents who are paid solely by commission; and
>
> (6) face-to-face marketing at public assistance offices by managed care organizations or agents of those organizations.
>
> (b) This section does not prohibit:
>
> (1) the distribution of approved marketing materials at public assistance offices; or
>
> (2) the provision of information directly to recipients under marketing guidelines established by the commission.

Revised Law

Sec. 540.0056. GUIDELINES FOR COMMUNICATIONS WITH RECIPIENTS. The executive commissioner shall adopt and publish guidelines for Medicaid managed care organizations regarding how an organization may communicate by text message or e-mail with a recipient enrolled in the organization's Medicaid managed care plan using the contact information provided in the recipient's application for Medicaid benefits under Section 32.025(g)(2), Human Resources Code, including updated information provided to the organization in accordance with Section 32.025(h), Human Resources Code. (Gov. Code, Sec. 533.008(c).)

Source Law

> (c) The executive commissioner shall adopt and publish guidelines for Medicaid managed care organizations regarding how organizations may communicate by text message or e-mail with recipients enrolled in the organization's managed care plan using the contact information provided in a recipient's

application for Medicaid benefits under Section 32.025(g)(2), Human Resources Code, including updated information provided to the organization in accordance with Section 32.025(h), Human Resources Code.

Revised Law

Sec. 540.0057. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. (a) To the extent possible, the commission shall coordinate all external oversight activities to minimize duplicating oversight of Medicaid managed care plans and disrupting operations under those plans.

(b) The executive commissioner, after consulting with the commission's office of inspector general, shall by rule define the commission's and office's roles in, jurisdiction over, and frequency of audits of Medicaid managed care organizations that are conducted by the commission and the office.

(c) In accordance with Section 544.0109, the commission shall share with the commission's office of inspector general, at the office's request, the results of any informal audit or on-site visit that could inform the office's risk assessment when determining:

(1) whether to conduct an audit of a Medicaid managed care organization; or

(2) the scope of the audit. (Gov. Code, Sec. 533.015.)

Source Law

Sec. 533.015. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. (a) To the extent possible, the commission shall coordinate all external oversight activities to minimize duplication of oversight of managed care plans under Medicaid and disruption of operations under those plans.

(b) The executive commissioner, after consulting with the commission's office of inspector general, shall by rule define the commission's and office's roles in and jurisdiction over, and frequency of, audits of managed care organizations participating in Medicaid that are conducted by the commission and the commission's office of inspector general.

(c) [as added Acts 84th Leg., R.S., Ch. 837] In accordance with Section 531.102(q), the commission shall share with the commission's office of inspector general, at the request of the office, the results of any informal audit or onsite visit that could inform that office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

(c) [as added Acts 84th Leg., R.S., Ch. 945] In accordance with Section 531.102(w), the commission

shall share with the commission's office of inspector general, at the request of the office, the results of any informal audit or on-site visit that could inform that office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

Revised Law

Sec. 540.0058. INFORMATION FOR FRAUD CONTROL. (a) Each Medicaid managed care organization shall submit at no cost to the commission and, on request, the office of the attorney general:

(1) a description of any financial or other business relationship between the organization and any subcontractor providing health care services under the contract between the organization and the commission;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control program any subcontractor that delivers health care services uses; and

(4) a description and breakdown of all funds paid to or by the organization, including a health maintenance organization, primary care case management provider, pharmacy benefit manager, and exclusive provider organization, necessary for the commission to determine the actual cost of administering the Medicaid managed care plan.

(b) The information under this section must be:

(1) submitted in the form the commission or the office of the attorney general, as applicable, requires; and

(2) updated as the commission or the office of the attorney general, as applicable, requires.

(c) The commission's office of inspector general or the office of the attorney general, as applicable, shall review the information a Medicaid managed care organization submits under this section as appropriate in investigating fraud in the Medicaid managed care program.

(d) Information a Medicaid managed care organization submits to the commission or the office of the attorney general

under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552. (Gov. Code, Sec. 533.012.)

Source Law

Sec. 533.012. INFORMATION FOR FRAUD CONTROL. (a) Each managed care organization contracting with the commission under this chapter shall submit the following, at no cost, to the commission and, on request, the office of the attorney general:

(1) a description of any financial or other business relationship between the organization and any subcontractor providing health care services under the contract;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control program used by any subcontractor that delivers health care services; and

(4) a description and breakdown of all funds paid to or by the managed care organization, including a health maintenance organization, primary care case management provider, pharmacy benefit manager, and exclusive provider organization, necessary for the commission to determine the actual cost of administering the managed care plan.

(b) The information submitted under this section must be submitted in the form required by the commission or the office of the attorney general, as applicable, and be updated as required by the commission or the office of the attorney general, as applicable.

(c) The commission's office of inspector general or the office of the attorney general, as applicable, shall review the information submitted under this section as appropriate in the investigation of fraud in the Medicaid managed care program.

(e) Information submitted to the commission or the office of the attorney general, as applicable, under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552, Government Code.

Revised Law

Sec. 540.0059. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:

(1) establish a clinical improvement program to identify goals designed to:

(A) improve quality of care and care management; and

(B) reduce potentially preventable events; and

(2) require Medicaid managed care organizations to develop and implement collaborative program improvement strategies to address the goals.

(b) Goals established under this section may be set by geographic region and program type. (Gov. Code, Secs. 533.00256(a) (part), (b).)

Source Law

> Sec. 533.00256. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:
>
> (1) establish a clinical improvement program to identify goals designed to improve quality of care and care management and to reduce potentially preventable events . . . ; and
>
> (2) require managed care organizations to develop and implement collaborative program improvement strategies to address the goals.
>
> (b) Goals established under this section may be set by geographic region and program type.

Revised Law

Sec. 540.0060. COMPLAINT SYSTEM GUIDELINES. (a) The Texas Department of Insurance, in conjunction with the commission, shall establish complaint system guidelines for Medicaid managed care organizations.

(b) The guidelines must require that information regarding a Medicaid managed care organization's complaint process be made available to a recipient in an appropriate communication format when the recipient enrolls in the Medicaid managed care program. (Gov. Code, Secs. 533.020(a) (part), (b).)

Source Law

> Sec. 533.020. MANAGED CARE ORGANIZATIONS: FISCAL SOLVENCY AND COMPLAINT SYSTEM GUIDELINES. (a) The Texas Department of Insurance, in conjunction with the commission, shall establish . . . complaint system guidelines for managed care organizations that serve recipients.
>
> (b) The guidelines must require that information regarding a managed care organization's complaint process be made available to a recipient in an appropriate communication format when the recipient enrolls in the Medicaid managed care program.

SUBCHAPTER C. FISCAL PROVISIONS

Revised Law

Sec. 540.0101. FISCAL SOLVENCY STANDARDS. The Texas Department of Insurance, in conjunction with the commission, shall establish fiscal solvency standards for Medicaid managed care organizations. (Gov. Code, Sec. 533.020(a) (part).)

Source Law

> Sec. 533.020. MANAGED CARE ORGANIZATIONS: FISCAL SOLVENCY AND COMPLAINT SYSTEM GUIDELINES. (a) The Texas Department of Insurance, in conjunction with the commission, shall establish fiscal solvency standards and . . . for managed care organizations that serve recipients.

Revised Law

Sec. 540.0102. PROFIT SHARING. (a) The executive commissioner shall adopt rules regarding the sharing of profits earned by a Medicaid managed care organization through a Medicaid managed care plan.

(b) Except as provided by Subsection (c), any amount this state receives under this section shall be deposited in the general revenue fund.

(c) If cost-effective, the commission may use amounts this state receives under this section to provide incentives to specific Medicaid managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization. (Gov. Code, Sec. 533.014.)

Source Law

> Sec. 533.014. PROFIT SHARING. (a) The executive commissioner shall adopt rules regarding the sharing of profits earned by a managed care organization through a managed care plan providing health care services under a contract with the commission under this chapter.
>
> (b) Except as provided by Subsection (c), any amount received by the state under this section shall be deposited in the general revenue fund.
>
> (c) If cost-effective, the commission may use amounts received by the state under this section to provide incentives to specific managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.

Revised Law

Sec. 540.0103. TREATMENT OF STATE TAXES IN CALCULATING EXPERIENCE REBATE OR PROFIT SHARING. The commission shall ensure that any experience rebate or profit sharing for Medicaid managed care organizations is calculated by treating premium, maintenance, and other taxes under the Insurance Code and any other taxes payable to this state as allowable expenses to determine the amount of the experience rebate or profit sharing. (Gov. Code, Sec. 533.0132.)

Source Law

> Sec. 533.0132. STATE TAXES. The commission shall ensure that any experience rebate or profit sharing for managed care organizations is calculated by treating premium, maintenance, and other taxes under the Insurance Code and any other taxes payable to this state as allowable expenses for purposes of determining the amount of the experience rebate or profit sharing.

SUBCHAPTER D. STRATEGY FOR MANAGING AUDIT RESOURCES

Revised Law

Sec. 540.0151. DEFINITIONS. In this subchapter:

(1) "Accounts receivable tracking system" means the system the commission uses to track experience rebates and other payments collected from managed care organizations.

(2) "Agreed-upon procedures engagement" means an evaluation of a managed care organization's financial statistical reports or other data conducted by an independent auditing firm the commission engages as agreed in the managed care organization's contract with the commission.

(3) "Experience rebate" means the amount a managed care organization is required to pay this state according to the graduated rebate method described in the organization's contract with the commission.

(4) "External quality review organization" means an organization that performs an external quality review of a managed care organization in accordance with 42 C.F.R. Section 438.350. (Gov. Code, Sec. 533.051.)

Source Law

Sec. 533.051. DEFINITIONS. In this subchapter:

(1) "Accounts receivable tracking system" means the system the commission uses to track experience rebates and other payments collected from managed care organizations.

(2) "Agreed-upon procedures engagement" means an evaluation of a managed care organization's financial statistical reports or other data conducted by an independent auditing firm engaged by the commission as agreed in the managed care organization's contract with the commission.

(3) "Experience rebate" means the amount a managed care organization is required to pay the state according to the graduated rebate method described in the managed care organization's contract with the commission.

(4) "External quality review organization" means an organization that performs an external quality review of a managed care organization in accordance with 42 C.F.R. Section 438.350.

Revised Law

Sec. 540.0152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission's office of inspector general under the authority provided by Subchapter C, Chapter 544, including an audit of a managed care organization the office conducts after coordinating the office's audit and oversight activities with the commission as required by Section 544.0109(c). (Gov. Code, Sec. 533.052.)

Source Law

Sec. 533.052. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission's office of inspector general under the authority provided by Subchapter C, Chapter 531, including an audit of a managed care organization conducted by the office after coordinating the office's audit and oversight activities with the commission as required by Section 531.102(q), as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

Revisor's Note

Section 533.052, Government Code, refers to Section 531.102(q), Government Code, "as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015," because another Section 531.102(q), Government Code, was added by Chapter 945

(S.B. 207), Acts of the 84th Legislature, Regular Session, 2015. The revised law omits the quoted language as unnecessary because Section 531.102(q), as added by Chapter 945 (S.B. 207), was redesignated as Section 531.102(x), Government Code, by Chapter 324 (S.B. 1488), Acts of the 85th Legislature, Regular Session, 2017.

Revised Law

Sec. 540.0153. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES. The commission shall develop and implement an overall strategy for planning, managing, and coordinating audit resources that the commission uses to verify the accuracy and reliability of program and financial information managed care organizations report. (Gov. Code, Sec. 533.053.)

Source Law

> Sec. 533.053. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES. The commission shall develop and implement an overall strategy for planning, managing, and coordinating audit resources that the commission uses to verify the accuracy and reliability of program and financial information reported by managed care organizations.

Revised Law

Sec. 540.0154. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP. (a) To improve the commission's processes for performance audits of managed care organizations, the commission shall:

(1) document the process by which the commission selects organizations to audit;

(2) include previous audit coverage as a risk factor in selecting organizations to audit; and

(3) prioritize the highest risk organizations to audit.

(b) To verify that managed care organizations correct negative performance audit findings, the commission shall:

(1) establish a process to:

(A) document how the commission follows up on

those findings; and

(B) verify that organizations implement performance audit recommendations; and

(2) establish and implement policies and procedures to:

(A) determine under what circumstances the commission must issue a corrective action plan to an organization based on a performance audit; and

(B) follow up on the organization's implementation of the plan. (Gov. Code, Sec. 533.054.)

Source Law

Sec. 533.054. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP. (a) To improve the commission's processes for performance audits of managed care organizations, the commission shall:

(1) document the process by which the commission selects managed care organizations to audit;

(2) include previous audit coverage as a risk factor in selecting managed care organizations to audit; and

(3) prioritize the highest risk managed care organizations to audit.

(b) To verify that managed care organizations correct negative performance audit findings, the commission shall:

(1) establish a process to:

(A) document how the commission follows up on negative performance audit findings; and

(B) verify that managed care organizations implement performance audit recommendations; and

(2) establish and implement policies and procedures to:

(A) determine under what circumstances the commission must issue a corrective action plan to a managed care organization based on a performance audit; and

(B) follow up on the managed care organization's implementation of the corrective action plan.

Revised Law

Sec. 540.0155. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:

(1) ensure that financial risks identified in

agreed-upon procedures engagements are adequately and consistently addressed; and

(2) establish policies and procedures to determine under what circumstances the commission must issue a corrective action plan based on an agreed-upon procedures engagement. (Gov. Code, Sec. 533.055.)

Source Law

> Sec. 533.055. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:
>
> (1) ensure that financial risks identified in agreed-upon procedures engagements are adequately and consistently addressed; and
>
> (2) establish policies and procedures to determine under what circumstances the commission must issue a corrective action plan based on an agreed-upon procedures engagement.

Revised Law

Sec. 540.0156. AUDITS OF PHARMACY BENEFIT MANAGERS. To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:

(1) periodically audit each pharmacy benefit manager that contracts with a managed care organization; and

(2) develop, document, and implement a monitoring process to ensure that managed care organizations correct and resolve negative findings reported in performance audits or agreed-upon procedures engagements of pharmacy benefit managers. (Gov. Code, Sec. 533.056.)

Source Law

> Sec. 533.056. AUDITS OF PHARMACY BENEFIT MANAGERS. To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:
>
> (1) periodically audit each pharmacy benefit manager that contracts with a managed care organization; and
>
> (2) develop, document, and implement a monitoring process to ensure that managed care organizations correct and resolve negative findings reported in performance audits or agreed-upon procedures engagements of pharmacy benefit managers.

Revised Law

Sec. 540.0157. COLLECTING COSTS FOR AUDIT-RELATED SERVICES. The commission shall develop, document, and implement billing processes in the commission's Medicaid and CHIP services department to ensure that managed care organizations reimburse the commission for audit-related services as required by contract. (Gov. Code, Sec. 533.057.)

Source Law

> Sec. 533.057. COLLECTION OF COSTS FOR AUDIT-RELATED SERVICES. The commission shall develop, document, and implement billing processes in the Medicaid and CHIP services department of the commission to ensure that managed care organizations reimburse the commission for audit-related services as required by contract.

Revised Law

Sec. 540.0158. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING. To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the commission's Medicaid and CHIP services department to ensure that the commission:

(1) identifies experience rebates deposited in the commission's suspense account and timely transfers those rebates to the appropriate accounts; and

(2) timely follows up on and resolves disputes over experience rebates managed care organizations claim. (Gov. Code, Sec. 533.058.)

Source Law

> Sec. 533.058. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING. To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the Medicaid and CHIP services department of the commission to ensure that the commission:
>
> (1) identifies experience rebates deposited in the commission's suspense account and timely transfers those rebates to the appropriate accounts; and
>
> (2) timely follows up on and resolves disputes over experience rebates claimed by managed care organizations.

Revised Law

Sec. 540.0159. USING INFORMATION FROM EXTERNAL QUALITY REVIEWS. (a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:

(1) detailed data from results of surveys of:

(A) recipients and, if applicable, child health plan program enrollees;

(B) caregivers of those recipients and enrollees; and

(C) Medicaid and, as applicable, child health plan program providers; and

(2) the validation results of matching paid claims data with medical records.

(b) The commission shall document how the commission uses the information described by Subsection (a) to monitor managed care organizations. (Gov. Code, Sec. 533.059.)

Source Law

Sec. 533.059. USE OF INFORMATION FROM EXTERNAL QUALITY REVIEWS. (a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:

(1) detailed data from results of surveys of Medicaid recipients and, if applicable, child health plan program enrollees, caregivers of those recipients and enrollees, and Medicaid and, as applicable, child health plan program providers; and

(2) the validation results of matching paid claims data with medical records.

(b) The commission shall document how the commission uses the information described by Subsection (a) to monitor managed care organizations.

Revisor's Note

Section 533.059(a)(1), Government Code, refers to "Medicaid recipients." The revised law omits "Medicaid" in that context because the term is included within the definition of "recipient" in Section 533.001, Government Code, revised in this chapter as Section 540.0001.

Revised Law

Sec. 540.0160. SECURITY OF AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS. The commission shall:

(1) strengthen user access controls for the commission's accounts receivable tracking system and network folders that the commission uses to manage the collection of experience rebates;

(2) document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in:

(A) the commission's cost accounting system for all health and human services agencies; and

(B) the uniform statewide accounting system; and

(3) develop, document, and implement a process to ensure that the commission formally documents:

(A) all programming changes made to the accounts receivable tracking system; and

(B) the authorization and testing of the changes described by Paragraph (A). (Gov. Code, Sec. 533.060.)

Source Law

Sec. 533.060. SECURITY AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS. The commission shall:

(1) strengthen user access controls for the commission's accounts receivable tracking system and network folders that the commission uses to manage the collection of experience rebates;

(2) document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in:

(A) the commission's cost accounting system for all health and human services agencies; and

(B) the uniform statewide accounting system; and

(3) develop, document, and implement a process to ensure that the commission formally documents:

(A) all programming changes made to the accounts receivable tracking system; and

(B) the authorization and testing of the changes described by Paragraph (A).

SUBCHAPTER E. CONTRACT ADMINISTRATION

Revised Law

Sec. 540.0201. CONTRACT ADMINISTRATION IMPROVEMENT

EFFORTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve contract administration, the commission shall:

(1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program;

(2) evaluate options for Medicaid payment recovery from a managed care organization if an enrolled recipient:

(A) dies;

(B) is incarcerated;

(C) is enrolled in more than one state program; or

(D) is covered by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in recovering capitation payments, payments from other liable third parties, and other payments made to a managed care organization with respect to an enrolled recipient who leaves the managed care program;

(4) decrease the administrative burdens of managed care for this state, managed care organizations, and providers in managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including by:

(A) where possible, decreasing duplicate administrative reporting and process requirements for managed care organizations and providers, such as requirements for submitting:

(i) encounter data;

(ii) quality reports;

(iii) historically underutilized business reports; and

(iv) claims payment summary reports;

(B) allowing a managed care organization to provide updated address information directly to the commission for

correction in the state system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to:

(i) the preauthorization process;

(ii) lengths of hospital stays;

(iii) filing deadlines;

(iv) levels of care; and

(v) case management services;

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to:

(i) including a separate cover sheet for all communications;

(ii) submitting handwritten communications instead of electronic or typed review processes; and

(iii) admitting patients listed on separate notices; and

(E) providing a portal through which a provider in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

(5) reserve the right to amend a managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process the commission establishes for final determination of these disputes. (Gov. Code, Sec. 533.0071.)

Source Law

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, the commission shall:

(1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program;

(2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered

by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to enrollees who leave the managed care program;

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A) where possible, decreasing the duplication of administrative reporting and process requirements for the managed care organizations and providers, such as requirements for the submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address information directly to the commission for correction in the state system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to the preauthorization process, lengths of hospital stays, filing deadlines, levels of care, and case management services;

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications; and

(E) providing a portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

(5) reserve the right to amend the managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes.

Revised Law

Sec. 540.0202. PUBLIC NOTICE OF REQUEST FOR CONTRACT APPLICATIONS. Not later than the 30th day before the date the commission plans to issue a request for applications to enter into a contract with the commission to provide health care services to recipients in a region, the commission shall publish notice of and make available for public review the request for applications and all related nonproprietary documents, including the proposed contract. (Gov. Code, Sec. 533.011.)

Source Law

Sec. 533.011. PUBLIC NOTICE. Not later than the 30th day before the commission plans to issue a request for applications to enter into a contract with the commission to provide health care services to recipients in a region, the commission shall publish notice of and make available for public review the request for applications and all related nonproprietary documents, including the proposed contract.

Revised Law

Sec. 540.0203. CERTIFICATION BY COMMISSION. (a) Before the commission may award a contract under this chapter to a managed care organization, the commission shall evaluate and certify that the organization is reasonably able to fulfill the contract terms, including all federal and state law requirements. Notwithstanding any other law, the commission may not award a contract under this chapter to an organization that does not receive the required certification.

(b) A managed care organization may appeal the commission's denial of certification. (Gov. Code, Sec. 533.0035.)

Source Law

Sec. 533.0035. CERTIFICATION BY COMMISSION. (a) Before the commission may award a contract under this chapter to a managed care organization, the commission shall evaluate and certify that the organization is reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law.

(b) Notwithstanding any other law, the commission may not award a contract under this chapter to a managed care organization that does not receive the certification required under this section.

(c) A managed care organization may appeal a denial of certification by the commission under this section.

Revisor's Note

Sections 533.0035(a) and (b), Government Code, require the Health and Human Services Commission to evaluate and certify a managed care organization before awarding to the organization a contract under "this chapter," meaning Chapter 533, Government Code. The relevant provisions of Chapter 533 relating to awarding contracts to those organizations are revised

in this chapter. The revised law is drafted accordingly.

Revised Law

Sec. 540.0204. CONTRACT CONSIDERATIONS RELATING TO MANAGED CARE ORGANIZATIONS. In awarding contracts to managed care organizations, the commission shall:

(1) give preference to an organization that has significant participation in the organization's provider network from each health care provider in the region who has traditionally provided care to Medicaid and charity care patients;

(2) give extra consideration to an organization that agrees to assure continuity of care for at least three months beyond a recipient's Medicaid eligibility period;

(3) consider the need to use different managed care plans to meet the needs of different populations; and

(4) consider the ability of an organization to process Medicaid claims electronically. (Gov. Code, Sec. 533.003(a) (part).)

Source Law

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. (a) In awarding contracts to managed care organizations, the commission shall:

(1) give preference to organizations that have significant participation in the organization's provider network from each health care provider in the region who has traditionally provided care to Medicaid and charity care patients;

(2) give extra consideration to organizations that agree to assure continuity of care for at least three months beyond the period of Medicaid eligibility for recipients;

(3) consider the need to use different managed care plans to meet the needs of different populations;

(4) consider the ability of organizations to process Medicaid claims electronically; and

. . .

Revisor's Note

Section 533.003(a)(5), Government Code, requires the Health and Human Services Commission to give extra consideration to certain managed care organizations when awarding contracts to provide health care

services during the commission's initial implementation of managed care in the South Texas service region. According to the commission, the commission has implemented managed care in that region. Accordingly, the revised law omits the provision as executed. The omitted law reads:

> [Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. (a) In awarding contracts to managed care organizations, the commission shall:]
>
> . . .
>
> (5) in the initial implementation of managed care in the South Texas service region, give extra consideration to an organization that either:
>
> (A) is locally owned, managed, and operated, if one exists; or
>
> (B) is in compliance with the requirements of Section 533.004.

Revised Law

Sec. 540.0205. CONTRACT CONSIDERATIONS RELATING TO PHARMACY BENEFIT MANAGERS. In considering approval of a subcontract between a managed care organization and a pharmacy benefit manager to provide Medicaid prescription drug benefits, the commission shall review and consider whether in the preceding three years the pharmacy benefit manager has been:

(1) convicted of:

(A) an offense involving a material misrepresentation or an act of fraud; or

(B) another violation of state or federal criminal law;

(2) adjudicated to have committed a breach of contract; or

(3) assessed a penalty or fine of $500,000 or more in a state or federal administrative proceeding. (Gov. Code, Sec. 533.003(b).)

Source Law

> (b) The commission, in considering approval of a subcontract between a managed care organization and a pharmacy benefit manager for the provision of prescription drug benefits under Medicaid, shall

review and consider whether the pharmacy benefit manager has been in the preceding three years:

(1) convicted of an offense involving a material misrepresentation or an act of fraud or of another violation of state or federal criminal law;

(2) adjudicated to have committed a breach of contract; or

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

Revised Law

Sec. 540.0206. MANDATORY CONTRACTS. (a) Subject to the certification required under Section 540.0203 and the considerations required under Section 540.0204, in providing health care services through Medicaid managed care to recipients in a health care service region, the commission shall contract with a managed care organization in that region that holds a certificate of authority issued under Chapter 843, Insurance Code, to provide health care in that region and that is:

(1) wholly owned and operated by a hospital district in that region;

(2) created by a nonprofit corporation that:

(A) has a contract, agreement, or other arrangement with a hospital district in that region or with a municipality in that region that owns a hospital licensed under Chapter 241, Health and Safety Code, and has an obligation to provide health care to indigent patients; and

(B) under the contract, agreement, or other arrangement, assumes the obligation to provide health care to indigent patients and leases, manages, or operates a hospital facility the hospital district or municipality owns; or

(3) created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to arrange for services under the Medicaid expansion for children as authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995.

(b) A managed care organization described by Subsection (a)

is subject to all terms to which other managed care organizations are subject, including all contractual, regulatory, and statutory provisions relating to participation in the Medicaid managed care program.

(c) The commission shall make the awarding and renewal of a mandatory contract under this section to a managed care organization affiliated with a hospital district or municipality contingent on the district or municipality entering into a matching funds agreement to expand Medicaid for children as authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995. The commission shall make compliance with the matching funds agreement a condition of the continuation of the contract with the managed care organization to provide health care services to recipients.

(d) Subsection (c) does not apply if:

(1) the commission does not expand Medicaid for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995; or

(2) a waiver from a federal agency necessary for the expansion is not granted.

(e) In providing health care services through Medicaid managed care to recipients in a health care service region, with the exception of the Harris service area for the STAR Medicaid managed care program, as the commission defined as of September 1, 1999, the commission shall also contract with a managed care organization in that region that holds a certificate of authority as a health maintenance organization issued under Chapter 843, Insurance Code, and that:

(1) is certified under Section 162.001, Occupations Code;

(2) is created by The University of Texas Medical Branch at Galveston; and

(3) has obtained a certificate of authority as a health maintenance organization to serve one or more counties in

that region from the Texas Department of Insurance before September 2, 1999. (Gov. Code, Sec. 533.004.)

Source Law

Sec. 533.004. MANDATORY CONTRACTS. (a) Subject to the considerations required under Section 533.003 and the certification required under Section 533.0035, in providing health care services through Medicaid managed care to recipients in a health care service region, the commission shall contract with a managed care organization in that region that is licensed under Chapter 843, Insurance Code, to provide health care in that region and that is:

(1) wholly owned and operated by a hospital district in that region;

(2) created by a nonprofit corporation that:

(A) has a contract, agreement, or other arrangement with a hospital district in that region or with a municipality in that region that owns a hospital licensed under Chapter 241, Health and Safety Code, and has an obligation to provide health care to indigent patients; and

(B) under the contract, agreement, or other arrangement, assumes the obligation to provide health care to indigent patients and leases, manages, or operates a hospital facility owned by the hospital district or municipality; or

(3) created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to arrange for services under the Medicaid expansion for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995.

(b) A managed care organization described by Subsection (a) is subject to all terms and conditions to which other managed care organizations are subject, including all contractual, regulatory, and statutory provisions relating to participation in the Medicaid managed care program.

(c) The commission shall make the awarding and renewal of a mandatory contract under this section to a managed care organization affiliated with a hospital district or municipality contingent on the district or municipality entering into a matching funds agreement to expand Medicaid for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995. The commission shall make compliance with the matching funds agreement a condition of the continuation of the contract with the managed care organization to provide health care services to recipients.

(d) Subsection (c) does not apply if:

(1) the commission does not expand Medicaid for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995; or

(2) a waiver from a federal agency necessary for the expansion is not granted.

(e) In providing health care services through Medicaid managed care to recipients in a health care service region, with the exception of the Harris

service area for the STAR Medicaid managed care program, as defined by the commission as of September 1, 1999, the commission shall also contract with a managed care organization in that region that holds a certificate of authority as a health maintenance organization under Chapter 843, Insurance Code, and that:

(1) is certified under Section 162.001, Occupations Code;

(2) is created by The University of Texas Medical Branch at Galveston; and

(3) has obtained a certificate of authority as a health maintenance organization to serve one or more counties in that region from the Texas Department of Insurance before September 2, 1999.

Revisor's Note

(1) Section 533.004(a), Government Code, refers to the Health and Human Services Commission contracting with a managed care organization, "[s]ubject to the considerations required under Section 533.003," Government Code. Section 533.003 is revised in this chapter as Sections 540.0204 and 540.0205. The relevant provisions relating to contract considerations for managed care organizations are revised as Section 540.0204 of this chapter, and the revised law is drafted accordingly.

(2) Section 533.004(a), Government Code, refers to a managed care organization that "is licensed" under Chapter 843, Insurance Code. The revised law substitutes "holds a certificate of authority" for the quoted language because Section 843.071, Insurance Code, requires a health maintenance organization to hold a certificate of authority, not a license, to engage in business in this state.

(3) Section 533.004(b), Government Code, refers to certain "terms and conditions" to which a managed care organization is subject. The revised law omits "conditions" from the quoted phrase because, in that context, the meaning of "conditions" is included in the meaning of "terms."

Revised Law

Sec. 540.0207. CONTRACTUAL OBLIGATIONS REVIEW. The commission shall review each Medicaid managed care organization to determine whether the organization is prepared to meet the organization's contractual obligations. (Gov. Code, Sec. 533.007(a).)

Source Law

> Sec. 533.007. CONTRACT COMPLIANCE. (a) The commission shall review each managed care organization that contracts with the commission to provide health care services to recipients through a managed care plan issued by the organization to determine whether the organization is prepared to meet its contractual obligations.

Revised Law

Sec. 540.0208. CONTRACT IMPLEMENTATION PLAN. (a) Each Medicaid managed care organization that contracts to provide health care services to recipients in a health care service region shall submit an implementation plan not later than the 90th day before the date the organization plans to begin providing those services in that region through managed care. The implementation plan must include:

(1) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training; and

(2) specific time frames for demonstrating preparedness for implementation before the date the organization plans to begin providing those services in that region through managed care.

(b) The commission shall respond to an implementation plan not later than the 10th day after the date a Medicaid managed care organization submits the plan if the plan does not adequately meet preparedness guidelines.

(c) Each Medicaid managed care organization that contracts to provide health care services to recipients in a health care service region shall submit status reports on the implementation

plan:

(1) not later than the 60th day and the 30th day before the date the organization plans to begin providing those services in that region through managed care; and

(2) every 30th day after that date until the 180th day after that date. (Gov. Code, Secs. 533.007(b), (c), (d).)

Source Law

> (b) Each managed care organization that contracts with the commission to provide health care services to recipients in a health care service region shall submit an implementation plan not later than the 90th day before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care. The implementation plan must include:
>
> (1) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training; and
>
> (2) specific time frames for demonstrating preparedness for implementation before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care.
>
> (c) The commission shall respond to an implementation plan not later than the 10th day after the date a managed care organization submits the plan if the plan does not adequately meet preparedness guidelines.
>
> (d) Each managed care organization that contracts with the commission to provide health care services to recipients in a region shall submit status reports on the implementation plan not later than the 60th day and the 30th day before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care and every 30th day after that date until the 180th day after that date.

Revised Law

Sec. 540.0209. COMPLIANCE AND READINESS REVIEW. (a) The commission shall conduct a compliance and readiness review of each Medicaid managed care organization:

(1) not later than the 15th day before the date the process of enrolling recipients in a managed care plan the organization issues is to begin in a region; and

(2) not later than the 15th day before the date the organization plans to begin providing health care services to recipients in that region through managed care.

(b) The compliance and readiness review must include an on-site inspection and tests of service authorization and claims payment systems, including:

(1) the Medicaid managed care organization's ability to process claims electronically;

(2) the Medicaid managed care organization's complaint processing systems; and

(3) any other process or system the contract between the Medicaid managed care organization and the commission requires.

(c) The commission may delay recipient enrollment in a managed care plan a Medicaid managed care organization issues if the compliance and readiness review reveals that the organization is not prepared to meet the organization's contractual obligations. The commission shall notify the organization of a decision to delay enrollment in a plan the organization issues. (Gov. Code, Secs. 533.007(e), (f).)

Source Law

> (e) The commission shall conduct a compliance and readiness review of each managed care organization that contracts with the commission not later than the 15th day before the date on which the process of enrolling recipients in a managed care plan issued by the managed care organization is to begin in a region and again not later than the 15th day before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care. The review must include an on-site inspection and tests of service authorization and claims payment systems, including the ability of the managed care organization to process claims electronically, complaint processing systems, and any other process or system required by the contract.
>
> (f) The commission may delay enrollment of recipients in a managed care plan issued by a managed care organization if the review reveals that the managed care organization is not prepared to meet its contractual obligations. The commission shall notify a managed care organization of a decision to delay enrollment in a plan issued by that organization.

Revised Law

Sec. 540.0210. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and maintain a record of each enforcement action the commission initiates that results in a sanction, including a penalty, being

imposed against a managed care organization for failure to comply with the terms of a contract to provide health care services to recipients through a Medicaid managed care plan the organization issues.

(b) The record must include:

(1) the managed care organization's name and address;

(2) a description of the contractual obligation the organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed;

(5) the maximum sanction that may be imposed under the contract for the violation; and

(6) the actual sanction imposed against the organization.

(c) The commission shall:

(1) post and maintain on the commission's Internet website the records required by this section:

(A) in English and Spanish; and

(B) in a format that is readily accessible to and understandable by the public; and

(2) update the list of records on the website at least quarterly.

(d) The commission may not post information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) A record prepared under this section may not include information that is excepted from disclosure under Chapter 552.

(f) The executive commissioner shall adopt rules as necessary to implement this section. (Gov. Code, Sec. 533.0072.)

Source Law

Sec. 533.0072. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and maintain a record of each enforcement action initiated by the commission that results in a sanction, including a penalty, being imposed against a managed care organization for failure to comply with the terms of a contract to

provide health care services to recipients through a managed care plan issued by the organization.

(b) The record must include:

(1) the name and address of the organization;

(2) a description of the contractual obligation the organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed;

(5) the maximum sanction that may be imposed under the contract for the violation; and

(6) the actual sanction imposed against the organization.

(c) The commission shall post and maintain the records required by this section on the commission's Internet website in English and Spanish. The records must be posted in a format that is readily accessible to and understandable by a member of the public. The commission shall update the list of records on the website at least quarterly.

(d) The commission may not post information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) A record prepared under this section may not include information that is excepted from disclosure under Chapter 552.

(f) The executive commissioner shall adopt rules as necessary to implement this section.

Revised Law

Sec. 540.0211. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS. (a) The commission shall establish outcome-based performance measures and incentives to include in each contract between the commission and a health maintenance organization to provide health care services to recipients that is procured and managed under a value-based purchasing model. The performance measures and incentives must:

(1) be designed to facilitate and increase recipient access to appropriate health care services; and

(2) to the extent possible, align with other state and regional quality care improvement initiatives.

(b) Subject to Subsection (c), the commission shall include the performance measures and incentives in each contract described by Subsection (a) in addition to all other contract provisions required by this chapter and Chapter 540A.

(c) The commission may use a graduated approach to including the performance measures and incentives in contracts described by Subsection (a) to ensure incremental and continued improvements

over time.

(d) Subject to Subsection (e), the commission shall assess the feasibility and cost-effectiveness of including provisions in a contract described by Subsection (a) that require the health maintenance organization to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in recipient care. Pay-for-performance opportunities may include incentives for providers to:

(1) provide care after normal business hours;

(2) participate in the early and periodic screening, diagnosis, and treatment program; and

(3) participate in other activities that improve recipient access to care.

(e) The commission shall, to the extent possible, base an assessment of feasibility and cost-effectiveness under Subsection (d) on publicly available, scientifically valid, evidence-based criteria appropriate for assessing the Medicaid population.

(f) In assessing feasibility and cost-effectiveness under Subsection (d), the commission may consult with participating Medicaid providers, including providers with expertise in quality improvement and performance measurement.

(g) If the commission determines that the provisions described by Subsection (d) are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission will include the provisions in contracts with health maintenance organizations offering Medicaid managed care plans in the region.

(h) The commission shall post the financial statistical report on the commission's Internet website in a comprehensive and understandable format. (Gov. Code, Sec. 533.0051.)

Source Law

Sec. 533.0051. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS. (a) The commission shall establish outcome-based performance

measures and incentives to include in each contract between a health maintenance organization and the commission for the provision of health care services to recipients that is procured and managed under a value-based purchasing model. The performance measures and incentives must:

(1) be designed to facilitate and increase recipients' access to appropriate health care services; and

(2) to the extent possible, align with other state and regional quality care improvement initiatives.

(b) Subject to Subsection (c), the commission shall include the performance measures and incentives established under Subsection (a) in each contract described by that subsection in addition to all other contract provisions required by this chapter.

(c) The commission may use a graduated approach to including the performance measures and incentives established under Subsection (a) in contracts described by that subsection to ensure incremental and continued improvements over time.

(d) Subject to Subsection (f), the commission shall assess the feasibility and cost-effectiveness of including provisions in a contract described by Subsection (a) that require the health maintenance organization to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in the care of recipients. Pay-for-performance opportunities may include incentives for providers to provide care after normal business hours and to participate in the early and periodic screening, diagnosis, and treatment program and other activities that improve recipients' access to care. If the commission determines that the provisions are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission will include the provisions in contracts with health maintenance organizations offering managed care plans in the region.

(e) The commission shall post the financial statistical report on the commission's web page in a comprehensive and understandable format.

(f) The commission shall, to the extent possible, base an assessment of feasibility and cost-effectiveness under Subsection (d) on publicly available, scientifically valid, evidence-based criteria appropriate for assessing the Medicaid population.

(g) In performing the commission's duties under Subsection (d) with respect to assessing feasibility and cost-effectiveness, the commission may consult with participating Medicaid providers, including those with expertise in quality improvement and performance measurement.

Revisor's Note

(1) Section 533.0051(b), Government Code, requires a contract between the Health and Human Services Commission and a health maintenance organization for the provision of health care services

to Medicaid recipients to include certain performance measures and incentives in addition to the contract provisions required by "this chapter," meaning Chapter 533, Government Code. The provisions of Chapter 533 are revised in this subtitle as Chapters 540 and 540A. Throughout this chapter, the revised law is drafted accordingly.

(2) Section 533.0051(e), Government Code, refers to the Health and Human Services Commission's "web page." The revised law substitutes the term "Internet website" for "web page" because the terms are synonymous and "Internet website" is more commonly used.

Revised Law

Sec. 540.0212. MONITORING COMPLIANCE WITH BEHAVIORAL HEALTH INTEGRATION. (a) In this section, "behavioral health services" has the meaning assigned by Section 540.0703.

(b) In monitoring contracts the commission enters into with Medicaid managed care organizations under this chapter, the commission shall:

(1) ensure the organizations fully integrate behavioral health services into a recipient's primary care coordination;

(2) use performance audits and other oversight tools to improve monitoring of the provision and coordination of behavioral health services; and

(3) establish performance measures that may be used to determine the effectiveness of the behavioral health services integration.

(c) In monitoring a Medicaid managed care organization's compliance with behavioral health services integration requirements under this section, the commission shall give particular attention to an organization that provides behavioral health services through a contract with a third party. (Gov. Code,

Sec. 533.002551.)

Source Law

Sec. 533.002551. MONITORING OF COMPLIANCE WITH BEHAVIORAL HEALTH INTEGRATION. (a) In this section, "behavioral health services" has the meaning assigned by Section 533.00255.

(b) In monitoring contracts the commission enters into with managed care organizations under this chapter, the commission shall:

(1) ensure managed care organizations fully integrate behavioral health services into a recipient's primary care coordination;

(2) use performance audits and other oversight tools to improve monitoring of the provision and coordination of behavioral health services; and

(3) establish performance measures that may be used to determine the effectiveness of the integration of behavioral health services.

(c) In monitoring a managed care organization's compliance with behavioral health services integration requirements under this section, the commission shall give particular attention to a managed care organization that provides behavioral health services through a contract with a third party.

SUBCHAPTER F. REQUIRED CONTRACT PROVISIONS

Revised Law

Sec. 540.0251. APPLICABILITY. This subchapter applies to a contract between a Medicaid managed care organization and the commission to provide health care services to recipients. (Gov. Code, Sec. 533.005(a) (part).)

Source Law

Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

Revised Law

Sec. 540.0252. ACCOUNTABILITY TO STATE. A contract to which this subchapter applies must contain procedures to ensure accountability to this state for providing health care services, including procedures for:

(1) financial reporting;

(2) quality assurance;

(3) utilization review; and

(4) assurance of contract and subcontract compliance.

(Gov. Code, Sec. 533.005(a)(1).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

. . .

Revised Law

Sec. 540.0253. CAPITATION RATES. A contract to which this subchapter applies must contain capitation rates that:

(1) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the Medicaid managed care plan; and

(2) ensure the cost-effective provision of quality health care. (Gov. Code, Sec. 533.005(a)(2).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(2) capitation rates that:

(A) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the plan; and

(B) ensure the cost-effective provision of quality health care;

. . .

Revisor's Note

Section 533.005(a)(2)(A), Government Code, refers to capitation rates for services and supports provided under a Medicaid managed care organization's "plan." Because an organization that contracts with the Health and Human Services Commission under Chapter 533, Government Code, to provide health care services to Medicaid recipients provides those services through a Medicaid managed care plan, and because it is clear from the context that is the plan to which the source

law refers, the revised law substitutes "Medicaid managed care plan" for "plan" for the convenience of the reader.

Revised Law

Sec. 540.0254. COST INFORMATION. A contract to which this subchapter applies must require the contracting Medicaid managed care organization and any entity with which the organization contracts to perform services under a Medicaid managed care plan to disclose at no cost to the commission and, on request, the office of the attorney general all agreements affecting the net cost of goods or services provided under the plan, including:

(1) discounts;

(2) incentives;

(3) rebates;

(4) fees;

(5) free goods; and

(6) bundling arrangements. (Gov. Code, Sec. 533.005(a)(24).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan;

. . .

Revised Law

Sec. 540.0255. FRAUD CONTROL. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to:

(1) provide the information required by Section 540.0058; and

(2) otherwise comply and cooperate with the

commission's office of inspector general and the office of the attorney general. (Gov. Code, Sec. 533.005(a)(10).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

. . .

Revised Law

Sec. 540.0256. RECIPIENT OUTREACH AND EDUCATION. A contract to which this subchapter applies must:

(1) require the contracting Medicaid managed care organization to provide:

(A) information about the availability of and referral to educational, social, and other community services that could benefit a recipient; and

(B) special programs and materials for recipients with limited English proficiency or low literacy skills; and

(2) contain procedures for recipient outreach and education. (Gov. Code, Secs. 533.005(a)(5), (6), (18).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

. . .

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

. . .

Revised Law

Sec. 540.0257. NOTICE OF MEDICAID CERTIFICATION DATE. A

contract to which this subchapter applies must require the commission to inform the contracting Medicaid managed care organization, on the date of a recipient's enrollment in a Medicaid managed care plan the organization issues, of the recipient's Medicaid certification date. (Gov. Code, Sec. 533.005(a)(8).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

. . .

Revised Law

Sec. 540.0258. PRIMARY CARE PROVIDER ASSIGNMENT. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to make initial and subsequent primary care provider assignments and changes. (Gov. Code, Sec. 533.005(a)(26).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

Revised Law

Sec. 540.0259. COMPLIANCE WITH PROVIDER NETWORK REQUIREMENTS. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to comply with Sections 540.0651(a)(1) and (2) and (b) as a condition of contract retention and renewal. (Gov. Code, Sec. 533.005(a)(9).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(9) a requirement that the managed care

organization comply with Section 533.006 as a condition of contract retention and renewal;

. . .

Revised Law

Sec. 540.0260. COMPLIANCE WITH PROVIDER ACCESS STANDARDS; REPORT. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to:

(1) develop and submit to the commission, before the organization begins providing health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards the commission establishes under Section 540.0652;

(2) as a condition of contract retention and renewal:

(A) continue to comply with the provider access standards; and

(B) make substantial efforts, as the commission determines, to mitigate or remedy any noncompliance with the provider access standards;

(3) pay liquidated damages for each failure, as the commission determines, to comply with the provider access standards in amounts that are reasonably related to the noncompliance; and

(4) regularly, as the commission determines, submit to the commission and make available to the public a report containing:

(A) data on the organization's provider network sufficiency with regard to providing the care and services described by Section 540.0652(a); and

(B) specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a

request for prior authorization for the care or service and the date the care or service is initiated. (Gov. Code, Sec. 533.005(a)(20).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(20) a requirement that the managed care organization:

(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a) and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated;

. . .

Revised Law

Sec. 540.0261. PROVIDER NETWORK SUFFICIENCY. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to demonstrate to the commission, before the organization begins providing health care services to recipients, that, subject to the provider access standards the commission establishes under Section 540.0652:

(1) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a Medicaid managed care plan the organization offers;

(2) the organization's provider network includes:

(A) a sufficient number of primary care providers;

(B) a sufficient variety of provider types;

(C) a sufficient number of long-term services and supports providers and specialty pediatric care providers of home and community-based services; and

(D) providers located throughout the region in which the organization will provide health care services; and

(3) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service model or primary care case management Medicaid managed care model. (Gov. Code, Sec. 533.005(a)(21).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that, subject to the provider access standards established under Section 533.0061:

(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types;

(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(iv) providers located throughout the region where the organization will provide health care services; and

(C) health care services will be accessible to recipients through the organization's

provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

. . .

Revised Law

Sec. 540.0262. QUALITY MONITORING PROGRAM FOR HEALTH CARE SERVICES. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(1) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(2) focuses on measuring outcomes; and

(3) includes collecting and analyzing clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance use disorder. (Gov. Code, Sec. 533.005(a)(22).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

. . .

Revisor's Note

Section 533.005(a)(22)(C), Government Code, refers to the treatment of "substance abuse." The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), published by the American Psychiatric Association to assist in classifying mental disorders, combines the categories of substance abuse and substance dependence into a single disorder referred to as "substance use disorder." Therefore, the revised law substitutes "substance use disorder" for "substance abuse" to reflect modern terminology regarding the disorder.

Revised Law

Sec. 540.0263. OUT-OF-NETWORK PROVIDER USAGE AND REIMBURSEMENT. (a) A contract to which this subchapter applies must require that:

(1) the contracting Medicaid managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits the commission determines for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions; and

(2) the organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services as determined under Sections 32.028 and 32.0281, Human Resources Code, if the commission finds that the organization violated Subdivision (1).

(b) In accordance with Subsection (a)(2), a Medicaid managed care organization must reimburse an out-of-network provider of poststabilization services for providing the services at the allowable rate for those services until the organization arranges for the recipient's timely transfer, as the recipient's attending physician determines, to a provider in the organization's provider network. The organization may not refuse to reimburse an out-of-network provider for emergency or poststabilization

services provided as a result of the organization's failure to arrange for and authorize a recipient's timely transfer. (Gov. Code, Secs. 533.005(a)(11), (12), (b).)

Source Law

> [Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]
>
> . . .
>
> (11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;
>
> (12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;
>
> . . .
>
> (b) In accordance with Subsection (a)(12), all post-stabilization services provided by an out-of-network provider must be reimbursed by the managed care organization at the allowable rate for those services until the managed care organization arranges for the timely transfer of the recipient, as determined by the recipient's attending physician, to a provider in the network. A managed care organization may not refuse to reimburse an out-of-network provider for emergency or post-stabilization services provided as a result of the managed care organization's failure to arrange for and authorize a timely transfer of a recipient.

Revised Law

Sec. 540.0264. PROVIDER REIMBURSEMENT RATE REDUCTION. (a) A contract to which this subchapter applies must require that the contracting Medicaid managed care organization not implement a significant, nonnegotiated, across-the-board provider reimbursement rate reduction unless:

(1) subject to Subsection (b), the organization has the commission's prior approval to implement the reduction; or

(2) the rate reduction is based on changes to the Medicaid fee schedule or cost containment initiatives the commission implements.

(b) A provider reimbursement rate reduction a Medicaid managed care organization proposes is considered to have received

the commission's prior approval unless the commission issues a written statement of disapproval not later than the 45th day after the date the commission receives notice of the proposed rate reduction from the organization. (Gov. Code, Secs. 533.005(a)(25), (a-3).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reductions; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; and

. . .

(a-3) For purposes of Subsection (a)(25)(A), a provider reimbursement rate reduction is considered to have received the commission's prior approval unless the commission issues a written statement of disapproval not later than the 45th day after the date the commission receives notice of the proposed rate reduction from the managed care organization.

Revised Law

Sec. 540.0265. PROMPT PAYMENT OF CLAIMS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to pay a physician or provider for health care services provided to a recipient under a Medicaid managed care plan on any claim for payment the organization receives with documentation reasonably necessary for the organization to process the claim:

(1) not later than:

(A) the 10th day after the date the organization receives the claim if the claim relates to services a nursing facility, intermediate care facility, or group home provided;

(B) the 30th day after the date the organization receives the claim if the claim relates to the provision of long-term services and supports not subject to Paragraph (A); and

(C) the 45th day after the date the organization receives the claim if the claim is not subject to Paragraph (A) or (B); or

(2) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the organization.

(b) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to demonstrate to the commission that the organization pays claims described by Subsection (a)(1)(B) on average not later than the 21st day after the date the organization receives the claim. (Gov. Code, Secs. 533.005(a)(7), (7-a).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

. . .

Revised Law

Sec. 540.0266. REIMBURSEMENT FOR CERTAIN SERVICES PROVIDED OUTSIDE REGULAR BUSINESS HOURS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed

care organization to reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician.

(b) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (a). (Gov. Code, Secs. 533.005(a)(14), (c).)

Source Law

> [Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]
>
> . . .
>
> (14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;
>
> . . .
>
> (c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (a)(14).

Revised Law

Sec. 540.0267. PROVIDER APPEALS PROCESS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop, implement, and maintain a system for tracking and resolving provider appeals related to claims payment. The system must include a process that requires:

(1) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(2) contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes that:

(A) relate to denial on the basis of medical necessity; and

(B) remain unresolved after a provider appeal;

(3) the determination of the physician resolving the dispute to be binding on the organization and provider; and

(4) the organization to allow a provider to initiate an appeal of a claim that has not been paid before the time prescribed by Section 540.0265(a)(1)(B).

(b) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop and establish a process for responding to provider appeals in the region in which the organization provides health care services. (Gov. Code, Secs. 533.005(a)(15), (19).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal;

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider; and

(D) the managed care organization to allow a provider with a claim that has not been paid before the time prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

. . .

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

. . .

Revised Law

Sec. 540.0268. ASSISTANCE RESOLVING RECIPIENT AND PROVIDER ISSUES. A contract to which this subchapter applies must require

the contracting Medicaid managed care organization to provide ready access to a person who assists:

(1) a recipient in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures; and

(2) a provider in resolving issues relating to payment, plan administration, education and training, and grievance procedures. (Gov. Code, Secs. 533.005(a)(3), (4).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

. . .

Revised Law

Sec. 540.0269. USE OF ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, to:

(1) use advanced practice registered nurses and physician assistants as primary care providers in addition to physicians to increase the availability of primary care providers in the organization's provider network; and

(2) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(A) selection and assignment as primary care providers;

(B) inclusion as primary care providers in the

organization's provider network; and

(C) inclusion as primary care providers in any provider network directory the organization maintains.

(b) For purposes of this section, an advanced practice registered nurse may be included as a primary care provider in a Medicaid managed care organization's provider network regardless of whether the physician supervising the advanced practice registered nurse is in the provider network. This subsection may not be construed as authorizing a Medicaid managed care organization to supervise or control the practice of medicine as prohibited by Subtitle B, Title 3, Occupations Code. (Gov. Code, Secs. 533.005(a)(13), (d).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

. . .

(d) For purposes of Subsection (a)(13), an advanced practice registered nurse may be included as a primary care provider in a managed care organization's provider network regardless of whether the physician supervising the advanced practice registered nurse is in the provider network. This subsection may not be construed as authorizing a managed care organization to supervise or control the practice of medicine as prohibited by Subtitle B, Title 3, Occupations Code.

Revised Law

Sec. 540.0270. MEDICAL DIRECTOR AVAILABILITY. A contract to which this subchapter applies must require that a medical

director who is authorized to make medical necessity determinations be available to the region in which the contracting Medicaid managed care organization provides health care services. (Gov. Code, Sec. 533.005(a)(16).)

Source Law

> [Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]
>
> . . .
>
> (16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;
>
> . . .

Revised Law

Sec. 540.0271. PERSONNEL REQUIRED IN CERTAIN SERVICE REGIONS. A contract to which this subchapter applies must require a contracting Medicaid managed care organization that provides a Medicaid managed care plan in the South Texas service region to ensure the following personnel are located in that region:

(1) a medical director;

(2) patient care coordinators; and

(3) provider and recipient support services personnel. (Gov. Code, Sec. 533.005(a)(17).)

Source Law

> [Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]
>
> . . .
>
> (17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;
>
> . . .

Revised Law

Sec. 540.0272. CERTAIN SERVICES PERMITTED IN LIEU OF OTHER MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES; ANNUAL REPORT. A contract to which this subchapter applies must contain language permitting the contracting Medicaid managed care organization to

offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee and included in the contract in lieu of mental health or substance use disorder services specified in the state Medicaid plan. A recipient is not required to use a service from the list included in the contract in lieu of another mental health or substance use disorder service specified in the state Medicaid plan. The commission shall:

(1) prepare and submit to the legislature an annual report on the number of times during the preceding year a service from the list included in the contract is used; and

(2) consider the actual cost and use of any services from the list included in the contract that are offered by a Medicaid managed care organization when setting the capitation rates for that organization under the contract. (Gov. Code, Sec. 533.005(h).)

Source Law

(h) In addition to the requirements specified by Subsection (a), a contract described by that subsection must contain language permitting a managed care organization to offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee and included in the contract in lieu of mental health or substance use disorder services specified in the state Medicaid plan. A recipient is not required to use a service from the list included in the contract in lieu of another mental health or substance use disorder service specified in the state Medicaid plan. The commission shall:

(1) prepare and submit an annual report to the legislature on the number of times during the preceding year a service from the list included in the contract is used; and

(2) take into consideration the actual cost and use of any services from the list included in the contract that are offered by a managed care organization when setting the capitation rates for that organization under the contract.

Revisor's Note

Section 533.005(h), Government Code, specifies certain language that must be included in a contract under Section 533.005(a), Government Code, that is "[i]n addition to the requirements specified by

Subsection (a)" of Section 533.005. The revised law omits the quoted language as unnecessary because the requirements specified by Section 533.005(a), which is revised throughout this subchapter, apply by their own terms and do not require a separate statement to that effect.

Revised Law

Sec. 540.0273. OUTPATIENT PHARMACY BENEFIT PLAN. (a) Subject to Subsection (b), a contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop, implement, and maintain an outpatient pharmacy benefit plan for the organization's enrolled recipients that:

(1) except as provided by Section 540.0280(2), exclusively employs the vendor drug program formulary and preserves this state's ability to reduce Medicaid fraud, waste, and abuse;

(2) adheres to the applicable preferred drug list the commission adopts under Subchapter E, Chapter 549;

(3) except as provided by Section 540.0280(1), includes the prior authorization procedures and requirements prescribed by or implemented under Sections 549.0257(a) and (c) and 549.0259 for the vendor drug program;

(4) does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, as defined by Section 549.0252, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse; and

(5) does not require prior authorization for a nonpreferred antipsychotic drug prescribed to an adult recipient if the requirements of Section 549.0253(a) are met.

(b) The requirements imposed by Subsections (a)(1)-(3) do not apply, and may not be enforced, on and after August 31, 2023. (Gov. Code, Secs. 533.005(a)(23)(A), (B), (C), (C-1), (C-2), (a-1).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that, except as provided by Paragraph (L)(ii), exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under Medicaid;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that, except as provided by Paragraph (L)(i), includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(C-1) that does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, as defined by Section 531.073, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse;

(C-2) that does not require prior authorization for a nonpreferred antipsychotic drug prescribed to an adult recipient if the requirements of Section 531.073(a-3) are met;

. . .

(a-1) The requirements imposed by Subsections (a)(23)(A), (B), and (C) do not apply, and may not be enforced, on and after August 31, 2023.

Revisor's Note

Section 531.005(23)(C), Government Code, refers to preferred drug lists adopted under Section 531.072, Government Code. The provisions of Section 531.072 relating to the adoption of preferred drug lists are revised in this subtitle as Subchapter E, Chapter 549, and the revised law is drafted accordingly.

Revised Law

Sec. 540.0274. PHARMACY BENEFIT PLAN: REBATES AND RECEIPT OF CONFIDENTIAL INFORMATION PROHIBITED. A Medicaid managed care organization, for purposes of the organization's outpatient pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, may not:

(1) negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; or

(2) receive drug rebate or pricing information that is confidential under Subchapter D, Chapter 549. (Gov. Code, Sec. 533.005(a)(23)(D).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) . . . a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

. . .

Revisor's Note

Section 531.005(a)(23)(D), Government Code, refers to confidential drug rebate or pricing information under Section 531.071, Government Code. Section 531.071 is revised in this subtitle as Subchapter D, Chapter 549, and the revised law is drafted accordingly.

Revised Law

Sec. 540.0275. PHARMACY BENEFIT PLAN: CERTAIN PHARMACY BENEFITS FOR SEX OFFENDERS PROHIBITED. A Medicaid managed care organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies must comply with the prohibition under Section 549.0004. (Gov. Code, Sec. 533.005(a)(23)(E).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) . . . a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(E) that complies with the prohibition under Section 531.089;

. . .

Revised Law

Sec. 540.0276. PHARMACY BENEFIT PLAN: RECIPIENT SELECTION OF PHARMACEUTICAL SERVICES PROVIDER. A Medicaid managed care organization, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice to provide pharmaceutical services under the plan by imposing different copayments. (Gov. Code, Sec. 533.005(a)(23)(F).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) . . . a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

. . .

Revised Law

Sec. 540.0277. PHARMACY BENEFIT PLAN: PHARMACY BENEFIT PROVIDERS. (a) A Medicaid managed care organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies must allow the organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(1) the organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for administering the pharmacy benefit program; and

(2) the organization and pharmacy benefit manager must

adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs that:

(A) are consistent with rules the executive commissioner adopts; and

(B) include notice to network pharmacy providers from the organization.

(b) A Medicaid managed care organization, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies:

(1) may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms, as well as other reasonable administrative and professional terms, of the contract;

(2) may include mail-order pharmacies in the organization's networks, but may not require enrolled recipients to use those pharmacies; and

(3) may not charge an enrolled recipient who opts to use a mail-order pharmacy a fee, including a postage or handling fee. (Gov. Code, Secs. 533.005(a)(23)(G), (H), (I).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) . . . a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and

include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

. . .

Revisor's Note

Section 533.005(a)(23)(H), Government Code, refers to a pharmacy or pharmacist's agreement to comply with "terms and conditions" of a contract between a Medicaid managed care organization or pharmacy benefit manager and the pharmacy or pharmacist. The revised law omits "conditions" from the quoted phrase for the reason stated in Revisor's Note (3) to Section 540.0206.

Revised Law

Sec. 540.0278. PHARMACY BENEFIT PLAN: PROMPT PAYMENT OF PHARMACY BENEFIT CLAIMS. A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must pay claims in accordance with Section 843.339, Insurance Code. (Gov. Code, Sec. 533.005(a)(23)(J).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) . . . a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code;

. . .

Revised Law

Sec. 540.0279. PHARMACY BENEFIT PLAN: MAXIMUM ALLOWABLE COST PRICE AND LIST FOR PHARMACY BENEFITS. (a) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must:

(1) ensure that, to place a drug on a maximum allowable cost list:

(A) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(B) the drug is generally available for purchase by pharmacies in this state from national or regional wholesalers and is not obsolete;

(2) review and update maximum allowable cost price information at least once every seven days to reflect any maximum allowable cost pricing modification;

(3) in formulating a drug's maximum allowable cost price, use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(4) establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and

(5) notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail.

(b) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy

benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must:

(1) provide a procedure for a network pharmacy provider to challenge a drug's listed maximum allowable cost price;

(2) respond to a challenge not later than the 15th day after the date the provider makes the challenge;

(3) if the challenge is successful, adjust the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as the Medicaid managed care organization or pharmacy benefit manager, as appropriate, determines;

(4) if the challenge is denied, provide the reason for the denial; and

(5) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period.

(c) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must provide:

(1) to a network pharmacy provider, at the time the organization or pharmacy benefit manager enters into or renews a contract with the provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider; and

(2) a process for each network pharmacy provider to readily access the maximum allowable cost list specific to that provider.

(d) Except as provided by Subsection (c)(2), a maximum allowable cost list specific to a provider that a Medicaid managed care organization or pharmacy benefit manager maintains is confidential. (Gov. Code, Secs. 533.005(a)(23)(K), (a-2).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, must ensure that:

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(b) the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(iii) must review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing;

(iv) must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(v) must establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(vi) must:

(a) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

(b) respond to a challenge not later than the 15th day after the date the challenge is made;

(c) if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager, as appropriate;

(d) if the challenge is denied, provide the reason for the denial; and

(e) report to the commission every 90 days the total number of

challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail; and

(viii) must provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider; and

. . .

(a-2) Except as provided by Subsection (a)(23)(K)(viii), a maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefit manager is confidential.

Revised Law

Sec. 540.0280. PHARMACY BENEFIT PLAN: PHARMACY BENEFITS FOR CHILD ENROLLED IN STAR KIDS MANAGED CARE PROGRAM. A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies:

(1) may not require a prior authorization, other than a clinical prior authorization or a prior authorization the commission imposes to minimize the opportunity for fraud, waste, or abuse, for or impose any other barriers to a drug that is prescribed to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list the commission adopts under Subchapter E, Chapter 549;

(2) must provide continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the organization's formulary;

(3) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug the

child's physician recommends for the child's treatment before the organization will cover the recommended drug; and

(4) must pay liquidated damages to the commission for each failure, as the commission determines, to comply with this section in an amount that is a reasonable forecast of the damages caused by the noncompliance. (Gov. Code, Sec. 533.005(a)(23)(L).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(L) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) may not require a prior authorization, other than a clinical prior authorization or a prior authorization imposed by the commission to minimize the opportunity for waste, fraud, or abuse, for or impose any other barriers to a drug that is prescribed to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list adopted under Section 531.072;

(ii) must provide for continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the managed care organization's formulary;

(iii) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug that the child's physician recommends for the child's treatment before the managed care organization provides coverage for the recommended drug; and

(iv) must pay liquidated damages to the commission for each failure, as determined by the commission, to comply with this paragraph in an amount that is a reasonable forecast of the damages caused by the noncompliance;

. . .

Revisor's Note

Section 533.005(a)(23)(L), Government Code, refers to preferred drug lists adopted under "Section 531.072." The revised law substitutes "Subchapter E, Chapter 549" for "Section 531.072" for the reason

stated in the revisor's note to Section 540.0273 of this chapter.

SUBCHAPTER G. PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCEDURES

Revised Law

Sec. 540.0301. INAPPLICABILITY OF CERTAIN OTHER LAW TO MEDICAID MANAGED CARE UTILIZATION REVIEWS. Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization. (Gov. Code, Sec. 533.00282(a).)

Source Law

> Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. (a) Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization.

Revised Law

Sec. 540.0302. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. (a) This section applies only to a prior authorization request submitted with respect to a recipient who is hospitalized at the time of the request.

(b) In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that, notwithstanding any other law, the organization review and issue a determination on a prior authorization request to which this section applies according to the following time frames:

(1) within one business day after the organization receives the request, except as provided by Subdivisions (2) and (3);

(2) within 72 hours after the organization receives the request if a provider of acute care inpatient services submits the request and the request is for services or equipment necessary to discharge the recipient from an inpatient facility; or

(3) within one hour after the organization receives the request if the request is related to poststabilization care or a life-threatening condition. (Gov. Code, Sec. 533.002821.)

Source Law

Sec. 533.002821. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission described by that section must require that, notwithstanding any other law, the organization review and issue determinations on prior authorization requests with respect to a recipient who is hospitalized at the time of the request according to the following time frames:

(1) within one business day after receiving the request, except as provided by Subdivisions (2) and (3);

(2) within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility; or

(3) within one hour after receiving the request if the request is related to poststabilization care or a life-threatening condition.

Revisor's Note

Section 533.002821, Government Code, refers to the "requirements of Section 533.005," Government Code, meaning the required provisions in a contract between a Medicaid managed care organization and the Health and Human Services Commission for the organization to provide health care services to Medicaid recipients. The required contract provisions of Section 533.005 are revised in this chapter as Subchapter F. Accordingly, the revised law throughout this subchapter substitutes a reference to the "requirements of Subchapter F" for the quoted phrase.

Revised Law

Sec. 540.0303. PRIOR AUTHORIZATION PROCEDURES FOR NONHOSPITALIZED RECIPIENT. (a) This section applies only to a prior authorization request submitted with respect to a recipient who is not hospitalized at the time of the request.

(b) In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the

commission to which that subchapter applies must require that the organization review and issue a determination on a prior authorization request to which this section applies according to the following time frames:

(1) within three business days after the organization receives the request; or

(2) within the time frame and following the process the commission establishes if the organization receives a prior authorization request that does not include sufficient or adequate documentation.

(c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request to which this section applies that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(1). (Gov. Code, Secs. 533.00282(b) (part), (c).)

Source Law

> (b) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must require that:
>
> . . .
>
> (2) the organization review and issue determinations on prior authorization requests with respect to a recipient who is not hospitalized at the time of the request according to the following time frames:
>
> (A) within three business days after receiving the request; or
>
> (B) within the time frame and following the process established by the commission if the organization receives a request for prior authorization that does not include sufficient or adequate documentation.
>
> (c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request, with respect to a recipient who is not hospitalized at the time of the request, that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(2)(A) within which a Medicaid

managed care organization must issue a determination on a prior authorization request.

Revised Law

Sec. 540.0304. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by contract, shall develop and implement a process for conducting an annual review of the organization's prior authorization requirements. The annual review process does not apply to a prior authorization requirement prescribed by or implemented under Subchapter F, Chapter 549, for the vendor drug program.

(b) In conducting an annual review, a Medicaid managed care organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that, as appropriate, distinguish between categories of recipients for whom prior authorization requests are submitted, including age categories.

(c) A Medicaid managed care organization may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Subchapter F, Chapter 549, for the vendor drug program, unless the organization reviewed the requirement during the most recent annual review.

(d) The commission shall periodically review each Medicaid managed care organization to ensure the organization's compliance with this section. (Gov. Code, Sec. 533.00283.)

Source Law

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by contract, shall develop and implement a process to conduct an annual review of the organization's prior authorization requirements, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug

program. In conducting a review, the organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted.

(b) A Medicaid managed care organization may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program, unless the organization has reviewed the requirement during the most recent annual review required under this section.

(c) The commission shall periodically review each Medicaid managed care organization to ensure the organization's compliance with this section.

Revisor's Note

Sections 533.00283(a) and (b), Government Code, refer to the prior authorization system prescribed by or implemented under Section 531.073, Government Code, which is revised in this subtitle in Subchapter F, Chapter 549. That subchapter also includes the revision of Section 531.072(f), Government Code. The revised law substitutes a reference to Subchapter F, Chapter 549, in its entirety for the reference to Section 531.073 because the provision of that subchapter derived from Section 531.072(f) relates to the same prior authorization system, and its inclusion in the reference has no substantive effect.

Revised Law

Sec. 540.0305. PHYSICIAN CONSULTATION BEFORE ADVERSE PRIOR AUTHORIZATION DETERMINATION. In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that, before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who:

(1) practices in the same or a similar specialty, but

not necessarily the same subspecialty; and

(2) has experience in treating the same category of population as the recipient on whose behalf the physician submitted the request. (Gov. Code, Sec. 533.00282(b) (part).)

Source Law

> (b) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must require that:
>
> (1) before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and
>
> . . .

Revised Law

Sec. 540.0306. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and timeline for a Medicaid managed care organization to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must include a requirement that the organization implement the process and timeline.

(b) The process and timeline must:

(1) allow a provider to submit any documentation identified as insufficient or inadequate in the notice provided under Section 532.0403;

(2) allow the provider requesting the prior authorization to discuss the request with another provider who:

(A) practices in the same or a similar specialty, but not necessarily the same subspecialty; and

(B) has experience in treating the same category of population as the recipient on whose behalf the provider submitted the request; and

(3) require the Medicaid managed care organization to amend the determination on the prior authorization request as necessary, considering the additional documentation.

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3) to approve the request.

(d) The process and timeline for reconsidering an adverse determination on a prior authorization request under this section do not affect:

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; or

(2) any rights of a recipient to appeal a determination on a prior authorization request. (Gov. Code, Sec. 533.00284.)

Source Law

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and timeline for Medicaid managed care organizations to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must include a requirement that the organization implement the process and timeline.

(b) The process and timeline must:

(1) allow a provider to submit any documentation that was identified as insufficient or inadequate in the notice provided under Section 531.024162;

(2) allow the provider requesting the prior authorization to discuss the request with another provider who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

(3) require the Medicaid managed care organization to amend the determination on the prior

authorization request as necessary, considering the additional documentation.

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3) to approve the request.

(d) The process and timeline for reconsidering an adverse determination on a prior authorization request under this section do not affect:

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; or

(2) any rights of a recipient to appeal a determination on a prior authorization request.

Revised Law

Sec. 540.0307. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The combined amount of time provided for the time frames prescribed by the utilization review and prior authorization procedures described by Sections 540.0301, 540.0303, and 540.0305 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 540.0306 may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care. (Gov. Code, Sec. 533.002841.)

Source Law

Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The time frames prescribed by the utilization review and prior authorization procedures described by Section 533.00282 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 533.00284 together may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care.

SUBCHAPTER H. PREMIUM PAYMENT RATES

Revised Law

Sec. 540.0351. PREMIUM PAYMENT RATE DETERMINATION. (a) In determining premium payment rates paid to a managed care organization under a managed care plan, the commission shall consider:

(1) the regional variation in health care service costs;

(2) the range and type of health care services that premium payment rates are to cover;

(3) the number of managed care plans in a region;

(4) the current and projected number of recipients in each region, including the current and projected number for each category of recipient;

(5) the managed care plan's ability to meet operating costs under the proposed premium payment rates;

(6) the requirements of the Balanced Budget Act of 1997 (Pub. L. No. 105-33) and implementing regulations that require adequacy of premium payments to Medicaid managed care organizations;

(7) the adequacy of the management fee paid for assisting enrollees of Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) who are voluntarily enrolled in the managed care plan;

(8) the impact of reducing premium payment rates for the category of pregnant recipients; and

(9) the managed care plan's ability under the proposed premium payment rates to pay inpatient and outpatient hospital provider payment rates that are comparable to the inpatient and outpatient hospital provider payment rates the commission pays under a primary care case management model or a partially capitated model.

(b) The premium payment rates paid to a managed care organization that holds a certificate of authority issued under Chapter 843, Insurance Code, must be established by a competitive bid process but may not exceed the maximum premium payment rates the commission establishes under Section 540.0352(b).

(c) The commission shall pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider

practices. In pursuing the strategies, the commission shall review and consider strategies employed or under consideration by other states. If necessary, the commission may request a waiver or other authorization from a federal agency to implement strategies the commission identifies under this subsection. (Gov. Code, Secs. 533.013(a), (c), (e).)

Source Law

Sec. 533.013. PREMIUM PAYMENT RATE DETERMINATION; REVIEW AND COMMENT. (a) In determining premium payment rates paid to a managed care organization under a managed care plan, the commission shall consider:

(1) the regional variation in costs of health care services;

(2) the range and type of health care services to be covered by premium payment rates;

(3) the number of managed care plans in a region;

(4) the current and projected number of recipients in each region, including the current and projected number for each category of recipient;

(5) the ability of the managed care plan to meet costs of operation under the proposed premium payment rates;

(6) the applicable requirements of the federal Balanced Budget Act of 1997 and implementing regulations that require adequacy of premium payments to managed care organizations participating in Medicaid;

(7) the adequacy of the management fee paid for assisting enrollees of Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) who are voluntarily enrolled in the managed care plan;

(8) the impact of reducing premium payment rates for the category of recipients who are pregnant; and

(9) the ability of the managed care plan to pay under the proposed premium payment rates inpatient and outpatient hospital provider payment rates that are comparable to the inpatient and outpatient hospital provider payment rates paid by the commission under a primary care case management model or a partially capitated model.

(c) The premium payment rates paid to a managed care organization that is licensed under Chapter 843, Insurance Code, shall be established by a competitive bid process but may not exceed the maximum premium payment rates established by the commission under Subsection (b).

(e) The commission shall pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practices. In pursuing premium rate-setting strategies under this section, the commission shall review and consider strategies employed or under consideration by other states. If necessary, the commission may request a waiver or other authorization

from a federal agency to implement strategies identified under this subsection.

Revisor's Note

Section 533.013(c), Government Code, refers to a managed care organization that "is licensed" under Chapter 843, Insurance Code. The revised law substitutes "holds a certificate of authority" for the quoted language for the reason stated in Revisor's Note (2) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0352. MAXIMUM PREMIUM PAYMENT RATES FOR CERTAIN PROGRAMS. (a) This section applies only to a Medicaid managed care organization that holds a certificate of authority issued under Chapter 843, Insurance Code, and with respect to Medicaid managed care pilot programs, Medicaid behavioral health pilot programs, and Medicaid STAR+PLUS pilot programs implemented in a health care service region after June 1, 1999.

(b) In determining the maximum premium payment rates paid to a Medicaid managed care organization to which this section applies, the commission shall consider and adjust for the regional variation in costs of services under the traditional fee-for-service component of Medicaid, utilization patterns, and other factors that influence the potential for cost savings. For a service area with a service area factor of .93 or less, or another appropriate service area factor, as the commission determines, the commission may not discount premium payment rates in an amount that is more than the amount necessary to meet federal budget neutrality requirements for projected fee-for-service costs unless:

(1) a historical review of managed care financial results among managed care organizations in the service area the organization serves demonstrates that additional savings are warranted; or

(2) a review of Medicaid fee-for-service delivery in the service area the organization serves has historically shown:

(A) significant recipient overutilization of

certain services covered by the premium payment rates in comparison to utilization patterns throughout the rest of this state; or

(B) an above-market cost for services for which there is substantial evidence that Medicaid managed care delivery will reduce the cost of those services. (Gov. Code, Secs. 533.013(b), (d).)

Source Law

(b) In determining the maximum premium payment rates paid to a managed care organization that is licensed under Chapter 843, Insurance Code, the commission shall consider and adjust for the regional variation in costs of services under the traditional fee-for-service component of Medicaid, utilization patterns, and other factors that influence the potential for cost savings. For a service area with a service area factor of .93 or less, or another appropriate service area factor, as determined by the commission, the commission may not discount premium payment rates in an amount that is more than the amount necessary to meet federal budget neutrality requirements for projected fee-for-service costs unless:

(1) a historical review of managed care financial results among managed care organizations in the service area served by the organization demonstrates that additional savings are warranted;

(2) a review of Medicaid fee-for-service delivery in the service area served by the organization has historically shown a significant overutilization by recipients of certain services covered by the premium payment rates in comparison to utilization patterns throughout the rest of the state; or

(3) a review of Medicaid fee-for-service delivery in the service area served by the organization has historically shown an above-market cost for services for which there is substantial evidence that Medicaid managed care delivery will reduce the cost of those services.

(d) Subsection (b) applies only to a managed care organization with respect to Medicaid managed care pilot programs, Medicaid behavioral health pilot programs, and Medicaid Star + Plus pilot programs implemented in a health care service region after June 1, 1999.

Revisor's Note

Section 533.013(b), Government Code, refers to a managed care organization that "is licensed" under Chapter 843, Insurance Code. The revised law substitutes "holds a certificate of authority" for the quoted language for the reason stated in Revisor's Note (2) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0353. USE OF ENCOUNTER DATA IN DETERMINING PREMIUM PAYMENT RATES AND OTHER PAYMENT AMOUNTS. (a) In determining premium payment rates and other amounts paid to managed care organizations under a managed care plan, the commission may not base or derive the rates or amounts on or from encounter data, or incorporate in the determination an analysis of encounter data, unless a certifier of encounter data certifies that:

(1) the encounter data for the most recent state fiscal year is complete, accurate, and reliable; and

(2) there is no statistically significant variability in the encounter data attributable to incompleteness, inaccuracy, or another deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.

(b) In determining whether data is equivalent data for similar populations under Subsection (a)(2), a certifier of encounter data shall, at a minimum, consider:

(1) the regional variation in recipient utilization patterns and health care service costs;

(2) the range and type of health care services premium payment rates are to cover;

(3) the number of managed care plans in the region; and

(4) the current number of recipients in each region, including the number for each recipient category. (Gov. Code, Sec. 533.0131.)

Source Law

Sec. 533.0131. USE OF ENCOUNTER DATA IN DETERMINING PREMIUM PAYMENT RATES. (a) In determining premium payment rates and other amounts paid to managed care organizations under a managed care plan, the commission may not base or derive the rates or amounts on or from encounter data, or incorporate in the determination an analysis of encounter data, unless a certifier of encounter data certifies that:

(1) the encounter data for the most recent state fiscal year is complete, accurate, and reliable; and

(2) there is no statistically significant

variability in the encounter data attributable to incompleteness, inaccuracy, or another deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.

(b) For purposes of determining whether data is equivalent data for similar populations under Subsection (a)(2), a certifier of encounter data shall, at a minimum, consider:

(1) the regional variation in utilization patterns of recipients and costs of health care services;

(2) the range and type of health care services to be covered by premium payment rates;

(3) the number of managed care plans in the region; and

(4) the current number of recipients in each region, including the number for each category of recipient.

SUBCHAPTER I. ENCOUNTER DATA

Revised Law

Sec. 540.0401. PROVIDER REPORTING OF ENCOUNTER DATA. The commission shall collaborate with Medicaid managed care organizations and health care providers in the organizations' provider networks to develop incentives and mechanisms to encourage providers to report complete and accurate encounter data to the organizations in a timely manner. (Gov. Code, Sec. 533.016.)

Source Law

Sec. 533.016. PROVIDER REPORTING OF ENCOUNTER DATA. The commission shall collaborate with managed care organizations that contract with the commission and health care providers under the organizations' provider networks to develop incentives and mechanisms to encourage providers to report complete and accurate encounter data to managed care organizations in a timely manner.

Revised Law

Sec. 540.0402. CERTIFIER OF ENCOUNTER DATA QUALIFICATIONS. (a) The state Medicaid director shall appoint a person as the certifier of encounter data.

(b) The certifier of encounter data must have:

(1) demonstrated expertise in estimating premium payment rates paid to a managed care organization under a managed care plan; and

(2) access to actuarial expertise, including expertise in estimating premium payment rates paid to a managed care organization under a managed care plan.

(c) A person may not be appointed as the certifier of encounter data if the person participated with the commission in developing premium payment rates for managed care organizations under managed care plans in this state during the three-year period before the date the certifier is appointed. (Gov. Code, Sec. 533.017.)

Source Law

> Sec. 533.017. QUALIFICATIONS OF CERTIFIER OF ENCOUNTER DATA. (a) The person acting as the state Medicaid director shall appoint a person as the certifier of encounter data.
>
> (b) The certifier of encounter data must have:
>
> (1) demonstrated expertise in estimating premium payment rates paid to a managed care organization under a managed care plan; and
>
> (2) access to actuarial expertise, including expertise in estimating premium payment rates paid to a managed care organization under a managed care plan.
>
> (c) A person may not be appointed under this section as the certifier of encounter data if the person participated with the commission in developing premium payment rates for managed care organizations under managed care plans in this state during the three-year period before the date the certifier is appointed.

Revised Law

Sec. 540.0403. ENCOUNTER DATA CERTIFICATION. (a) The certifier of encounter data shall certify the completeness, accuracy, and reliability of encounter data for each state fiscal year.

(b) The commission shall make available to the certifier of encounter data all records and data the certifier considers appropriate for evaluating whether to certify the encounter data. The commission shall provide to the certifier selected resources and assistance in obtaining, compiling, and interpreting the records and data. (Gov. Code, Sec. 533.018.)

Source Law

> Sec. 533.018. CERTIFICATION OF ENCOUNTER DATA. (a) The certifier of encounter data shall certify the completeness, accuracy, and reliability of encounter data for each state fiscal year.
>
> (b) The commission shall make available to the certifier all records and data the certifier considers appropriate for evaluating whether to certify the encounter data. The commission shall provide to the certifier selected resources and assistance in

obtaining, compiling, and interpreting the records and data.

SUBCHAPTER J. MANAGED CARE PLAN REQUIREMENTS

Revised Law

Sec. 540.0451. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A Medicaid managed care plan must be accredited by a nationally recognized accreditation organization. The commission may:

(1) require all Medicaid managed care plans to be accredited by the same organization; or

(2) allow for accreditation by different organizations.

(b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight process. (Gov. Code, Sec. 533.0031.)

Source Law

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A managed care plan offered by a Medicaid managed care organization must be accredited by a nationally recognized accreditation organization. The commission may choose whether to require all managed care plans offered by Medicaid managed care organizations to be accredited by the same organization or to allow for accreditation by different organizations.

(b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight processes.

Revised Law

Sec. 540.0452. MEDICAL DIRECTOR QUALIFICATIONS. An individual who serves as a medical director for a managed care plan must be a physician licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec. 533.0073.)

Source Law

Sec. 533.0073. MEDICAL DIRECTOR QUALIFICATIONS. A person who serves as a medical director for a managed care plan must be a physician licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

Revisor's Note

Section 533.0073, Government Code, requires a

"person" who serves as a medical director for a managed care plan to be a physician. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to this code.

SUBCHAPTER K. MEDICAID MANAGED CARE PLAN ENROLLMENT AND DISENROLLMENT

Revised Law

Sec. 540.0501. RECIPIENT ENROLLMENT IN AND DISENROLLMENT FROM MEDICAID MANAGED CARE PLAN. The commission shall:

(1) encourage recipients to choose appropriate Medicaid managed care plans and primary health care providers by:

(A) providing initial information to recipients and providers in a region about the need for recipients to choose plans and providers not later than the 90th day before the date a Medicaid managed care organization plans to begin providing health care services to recipients in that region through managed care;

(B) providing follow-up information before assignment of plans and providers and after assignment, if necessary, to recipients who delay in choosing plans and providers; and

(C) allowing plans and providers to provide information to recipients or engage in marketing activities under marketing guidelines the commission establishes under Section 540.0055(a) after the commission approves the information or activities;

(2) in assigning plans and providers to recipients who fail to choose plans and providers, consider:

(A) the importance of maintaining existing provider-patient and physician-patient relationships, including

relationships with specialists, public health clinics, and community health centers;

(B) to the extent possible, the need to assign family members to the same providers and plans; and

(C) geographic convenience of plans and providers for recipients;

(3) retain responsibility for enrolling recipients in and disenrolling recipients from plans, except that the commission may delegate the responsibility to an independent contractor who receives no form of payment from, and has no financial ties to, any managed care organization;

(4) develop and implement an expedited process for determining eligibility for and enrolling pregnant women and newborn infants in plans; and

(5) ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in plans, including ensuring that a pregnant woman may obtain an appointment with an obstetrical care provider for an initial maternity evaluation not later than the 30th day after the date the woman applies for Medicaid. (Gov. Code, Sec. 533.0075.)

Source Law

Sec. 533.0075. RECIPIENT ENROLLMENT. The commission shall:

(1) encourage recipients to choose appropriate managed care plans and primary health care providers by:

(A) providing initial information to recipients and providers in a region about the need for recipients to choose plans and providers not later than the 90th day before the date on which a managed care organization plans to begin to provide health care services to recipients in that region through managed care;

(B) providing follow-up information before assignment of plans and providers and after assignment, if necessary, to recipients who delay in choosing plans and providers; and

(C) allowing plans and providers to provide information to recipients or engage in marketing activities under marketing guidelines established by the commission under Section 533.008 after the commission approves the information or activities;

(2) consider the following factors in assigning managed care plans and primary health care providers to recipients who fail to choose plans and

providers:

(A) the importance of maintaining existing provider-patient and physician-patient relationships, including relationships with specialists, public health clinics, and community health centers;

(B) to the extent possible, the need to assign family members to the same providers and plans; and

(C) geographic convenience of plans and providers for recipients;

(3) retain responsibility for enrollment and disenrollment of recipients in managed care plans, except that the commission may delegate the responsibility to an independent contractor who receives no form of payment from, and has no financial ties to, any managed care organization;

(4) develop and implement an expedited process for determining eligibility for and enrolling pregnant women and newborn infants in managed care plans; and

(5) ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in managed care plans, including ensuring that a pregnant woman may obtain an appointment with an obstetrical care provider for an initial maternity evaluation not later than the 30th day after the date the woman applies for Medicaid.

Revisor's Note

Section 533.0075(1)(C), Government Code, refers to marketing guidelines the Health and Human Services Commission establishes under Section 533.008, Government Code. The relevant portion of Section 533.008 requiring the commission to establish those guidelines is revised in this chapter as Section 540.0055(a), and the revised law is drafted accordingly.

Revised Law

Sec. 540.0502. AUTOMATIC ENROLLMENT IN MEDICAID MANAGED CARE PLAN. (a) If the commission determines that it is feasible and notwithstanding any other law, the commission may implement an automatic enrollment process under which an applicant determined eligible for Medicaid is automatically enrolled in a Medicaid managed care plan the applicant chooses.

(b) The commission may elect to implement the automatic enrollment process for certain recipient populations. (Gov. Code, Sec. 533.0025(h).)

Source Law

(h) If the commission determines that it is feasible, the commission may, notwithstanding any other law, implement an automatic enrollment process under which applicants determined eligible for Medicaid benefits are automatically enrolled in a Medicaid managed care plan chosen by the applicant. The commission may elect to implement the automatic enrollment process as to certain populations of recipients.

Revised Law

Sec. 540.0503. ENROLLMENT OF CERTAIN RECIPIENTS IN SAME MEDICAID MANAGED CARE PLAN. The commission shall ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same Medicaid managed care plan. (Gov. Code, Sec. 533.0027.)

Source Law

Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN RECIPIENTS ARE ENROLLED IN SAME MANAGED CARE PLAN. The commission shall ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same managed care plan.

Revised Law

Sec. 540.0504. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MEDICAID MANAGED CARE ORGANIZATIONS. The commission shall create an incentive program that automatically enrolls in a Medicaid managed care plan a greater percentage of recipients who did not actively choose a plan, based on:

(1) the quality of care provided through the Medicaid managed care organization offering the plan;

(2) the organization's ability to efficiently and effectively provide services, considering the acuity of populations the organization primarily serves; and

(3) the organization's performance with respect to exceeding or failing to achieve appropriate outcome and process measures the commission develops, including measures based on potentially preventable events. (Gov. Code, Sec. 533.00511(b).)

Source Law

(b) The commission shall create an incentive program that automatically enrolls a greater

percentage of recipients who did not actively choose their managed care plan in a managed care plan, based on:

(1) the quality of care provided through the managed care organization offering that managed care plan;

(2) the organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization; and

(3) the organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by the commission, including measures based on potentially preventable events.

Revised Law

Sec. 540.0505. LIMITATIONS ON RECIPIENT DISENROLLMENT FROM MEDICAID MANAGED CARE PLAN. (a) Except as provided by Subsections (b) and (c) and to the extent permitted by federal law, a recipient enrolled in a Medicaid managed care plan may not disenroll from that plan and enroll in another Medicaid managed care plan during the 12-month period after the date the recipient initially enrolls in a plan.

(b) At any time before the 91st day after the date of a recipient's initial enrollment in a Medicaid managed care plan, the recipient may disenroll from that plan for any reason and enroll in another Medicaid managed care plan.

(c) The commission shall allow a recipient who is enrolled in a Medicaid managed care plan to disenroll from that plan and enroll in another Medicaid managed care plan:

(1) at any time for cause in accordance with federal law; and

(2) once for any reason after the periods described by Subsections (a) and (b). (Gov. Code, Sec. 533.0076.)

Source Law

Sec. 533.0076. LIMITATIONS ON RECIPIENT DISENROLLMENT. (a) Except as provided by Subsections (b) and (c), and to the extent permitted by federal law, a recipient enrolled in a managed care plan under this chapter may not disenroll from that plan and enroll in another managed care plan during the 12-month period after the date the recipient initially enrolls in a plan.

(b) At any time before the 91st day after the date of a recipient's initial enrollment in a managed care plan under this chapter, the recipient may disenroll in that plan for any reason and enroll in

another managed care plan under this chapter.

(c) The commission shall allow a recipient who is enrolled in a managed care plan under this chapter to disenroll from that plan and enroll in another managed care plan:

(1) at any time for cause in accordance with federal law; and

(2) once for any reason after the periods described by Subsections (a) and (b).

SUBCHAPTER L. CONTINUITY OF CARE AND COORDINATION OF BENEFITS

Revised Law

Sec. 540.0551. GUIDANCE REGARDING CONTINUATION OF SERVICES UNDER CERTAIN CIRCUMSTANCES. The commission shall provide guidance and additional education to Medicaid managed care organizations regarding federal law requirements to continue providing services during an internal appeal, a Medicaid fair hearing, or any other review. (Gov. Code, Sec. 533.005(g).)

Source Law

(g) The commission shall provide guidance and additional education to managed care organizations with which the commission enters into contracts described by Subsection (a) regarding requirements under federal law to continue to provide services during an internal appeal, a Medicaid fair hearing, or any other review.

Revisor's Note

Section 533.005(g), Government Code, refers to "managed care organizations with which the commission enters into contracts described by Subsection (a)" of Section 533.005, Government Code. Section 533.005(a) describes a contract between a managed care organization and the commission for the organization to provide health care services to Medicaid recipients. The revised law substitutes "Medicaid managed care organizations" for the quoted language for the reason stated in the revisor's note to Section 540.0053.

Revised Law

Sec. 540.0552. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS. (a) In this section, "Medicaid wrap-around benefit" means a Medicaid-covered service,

including a pharmacy or medical benefit, that is provided to a recipient who has primary health benefit plan coverage in addition to Medicaid coverage when:

(1) the recipient has exceeded the primary health benefit plan coverage limit; or

(2) the service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations and in consultation with the STAR Kids Managed Care Advisory Committee, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients who have primary health benefit plan coverage in addition to Medicaid coverage. In developing the policy, the commission shall consider requiring a Medicaid managed care organization to allow, notwithstanding Subchapter F, Chapter 549, Section 540.0273, and Section 540.0280 or any other law, a recipient using a prescription drug for which the recipient's primary health benefit plan issuer previously provided coverage to continue receiving the prescription drug without requiring additional prior authorization.

(c) If the commission determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the Medicaid managed care organization that paid the claim shall:

(1) work with the commission on the recovery process; and

(2) make every attempt to reduce health care provider and recipient abrasion.

(d) The executive commissioner may seek a waiver from the federal government as needed to:

(1) address federal policies related to coordination of benefits and third-party liability; and

(2) maximize federal financial participation for

recipients who have primary health benefit plan coverage in addition to Medicaid coverage.

(e) The commission may include in the Medicaid managed care eligibility files an indication of whether a recipient has primary health benefit plan coverage or is enrolled in a group health benefit plan for which the commission provides premium assistance under the health insurance premium payment program. For a recipient with that coverage or for whom that premium assistance is provided, the files may include the following up-to-date, accurate information related to primary health benefit plan coverage to the extent the information is available to the commission:

(1) the primary health benefit plan issuer's name and address;

(2) the recipient's policy number;

(3) the primary health benefit plan coverage start and end dates; and

(4) the primary health benefit plan coverage benefits, limits, copayment, and coinsurance information.

(f) To the extent allowed by federal law, the commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed, regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with

complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider, regardless of whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage.

(h) If a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the Medicaid managed care plan in which the recipient is enrolled, the organization shall develop a simple, timely, and efficient process to, and shall make a good-faith effort to, negotiate a single-case agreement with the specialty provider. Until the organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rules, including 1 T.A.C. Section 353.4.

(i) A single-case agreement entered into under this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements. (Gov. Code, Sec. 533.038.)

Source Law

Sec. 533.038. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS. (a) In this section, "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient with both Medicaid and primary health benefit plan coverage when the recipient has exceeded the primary health benefit plan coverage limit or when the service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations and in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage. In developing the policy, the commission shall consider requiring a Medicaid managed care organization to allow, notwithstanding Sections 531.073 and 533.005(a)(23) or any other law, a recipient using a prescription drug for which the recipient's primary health benefit plan issuer previously provided coverage to continue receiving the prescription drug without requiring additional prior authorization.

(c) If the commission determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the Medicaid managed care organization that paid the claim shall work with the commission on the recovery process and make every attempt to reduce health care provider and recipient abrasion.

(d) The executive commissioner may seek a waiver from the federal government as needed to:

(1) address federal policies related to coordination of benefits and third-party liability; and

(2) maximize federal financial participation for recipients with both primary health benefit plan coverage and Medicaid coverage.

(e) The commission may include in the Medicaid managed care eligibility files an indication of whether a recipient has primary health benefit plan coverage or is enrolled in a group health benefit plan for which the commission provides premium assistance under the health insurance premium payment program. For recipients with that coverage or for whom that premium assistance is provided, the files may include the following up-to-date, accurate information related to primary health benefit plan coverage to the extent the information is available to the commission:

(1) the health benefit plan issuer's name and address and the recipient's policy number;

(2) the primary health benefit plan coverage start and end dates; and

(3) the primary health benefit plan coverage benefits, limits, copayment, and coinsurance information.

(f) To the extent allowed by federal law, the commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed, regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider, regardless of whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage.

(h) If a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, the managed care organization shall develop a simple, timely, and efficient process to and shall make a good-faith effort to, negotiate a single-case agreement with the specialty provider. Until the

Medicaid managed care organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rule, including 1 T.A.C. Section 353.4.

(i) A single-case agreement entered into under this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements.

Revisor's Note

(1) Section 533.038(b), Government Code, requires the Health and Human Services Commission to consult with the STAR Kids Managed Care Advisory Committee "described by Section 533.00254," Government Code. Section 533.00254 expired December 31, 2023, in accordance with Section 533.00254(b). Because the effective date of the revised law is later than the date the cited section expired, the revised law omits the reference to the section as obsolete.

(2) Section 533.038(b), Government Code, refers to the prior authorization system implemented under Section 531.073, Government Code, which is revised in this subtitle in Subchapter F, Chapter 549. The revised law substitutes a reference to Subchapter F in its entirety for the reference to Section 531.073 for the reason stated in the revisor's note to Section 540.0304.

(3) Section 533.038(b), Government Code, refers to continuous receipt of certain prescription drugs without additional prior authorization, notwithstanding Section 533.005(a)(23), Government Code. The provisions of Section 533.005(a)(23) that require Medicaid managed care organizations to maintain an outpatient pharmacy benefit plan that includes or allows for certain prior authorization requirements are revised in this chapter as Sections 540.0273 and 540.0280, and the revised law is drafted

accordingly.

SUBCHAPTER M. PROVIDER NETWORK ADEQUACY

Revised Law

Sec. 540.0601. MONITORING OF PROVIDER NETWORKS. The commission shall establish and implement a process for the direct monitoring of a Medicaid managed care organization's provider network and providers in the network. The process:

(1) must be used to ensure compliance with contractual obligations related to:

(A) the number of providers accepting new patients under the Medicaid managed care program; and

(B) the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider;

(2) may use reasonable methods to ensure compliance with contractual obligations, including telephone calls made at random times without notice to assess the availability of providers and services to new and existing recipients; and

(3) may be implemented directly by the commission or through a contractor. (Gov. Code, Sec. 533.007(l).)

Source Law

> (l) The commission shall establish and implement a process for the direct monitoring of a managed care organization's provider network and providers in the network. The process:
>
> (1) must be used to ensure compliance with contractual obligations related to:
>
> (A) the number of providers accepting new patients under the Medicaid managed care program; and
>
> (B) the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider;
>
> (2) may use reasonable methods to ensure compliance with contractual obligations, including telephone calls made at random times without notice to assess the availability of providers and services to new and existing recipients; and
>
> (3) may be implemented directly by the commission or through a contractor.

Revised Law

Sec. 540.0602. REPORT ON OUT-OF-NETWORK PROVIDER SERVICES. To ensure appropriate access to an adequate provider network, each

Medicaid managed care organization providing health care services to recipients in a health care service region shall submit to the commission, in the format and manner the commission prescribes, a report detailing the number, type, and scope of services out-of-network providers provide to recipients enrolled in a Medicaid managed care plan the organization provides. (Gov. Code, Sec. 533.007(g) (part).)

Source Law

> (g) To ensure appropriate access to an adequate provider network, each managed care organization that contracts with the commission to provide health care services to recipients in a health care service region shall submit to the commission, in the format and manner prescribed by the commission, a report detailing the number, type, and scope of services provided by out-of-network providers to recipients enrolled in a managed care plan provided by the managed care organization. . . .

Revised Law

Sec. 540.0603. REPORT ON COMMISSION INVESTIGATION OF PROVIDER COMPLAINT. Not later than the 60th day after the date a provider files a complaint with the commission regarding reimbursement for or overuse of out-of-network providers by a Medicaid managed care organization, the commission shall provide to the provider a report regarding the conclusions of the commission's investigation. The report must include:

(1) a description of any corrective action required of the organization that was the subject of the complaint; and

(2) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider. (Gov. Code, Sec. 533.007(i).)

Source Law

> (i) Not later than the 60th day after the date a provider files a complaint with the commission regarding reimbursement for or overuse of out-of-network providers by a managed care organization, the commission shall provide to the provider a report regarding the conclusions of the commission's investigation. The report must include:
>
> (1) a description of the corrective action, if any, required of the managed care organization that was the subject of the complaint; and
>
> (2) if applicable, a conclusion regarding

the amount of reimbursement owed to an out-of-network provider.

Revised Law

Sec. 540.0604. ADDITIONAL REIMBURSEMENT FOLLOWING PROVIDER COMPLAINT. (a) If, after an investigation, the commission determines that a Medicaid managed care organization owes additional reimbursement to a provider, the organization shall, not later than the 90th day after the date the provider filed the complaint, pay the additional reimbursement or provide to the provider a reimbursement payment plan under which the organization must pay the entire amount of the additional reimbursement not later than the 120th day after the date the provider filed the complaint.

(b) The commission may require a Medicaid managed care organization to pay interest on any amount of the additional reimbursement that is not paid on or before the 90th day after the date the provider to whom the amount is owed filed the complaint. If the commission requires the organization to pay interest, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount beginning on the 90th day after the date the provider to whom the amount is owed filed the complaint and accrues until the date the organization pays the entire reimbursement amount. (Gov. Code, Sec. 533.007(j).)

Source Law

(j) If, after an investigation, the commission determines that additional reimbursement is owed to a provider, the managed care organization shall, not later than the 90th day after the date the provider filed the complaint, pay the additional reimbursement or provide to the provider a reimbursement payment plan under which the managed care organization must pay the entire amount of the additional reimbursement not later than the 120th day after the date the provider filed the complaint. If the managed care organization does not pay the entire amount of the additional reimbursement on or before the 90th day after the date the provider filed the complaint, the commission may require the managed care organization to pay interest on the unpaid amount. If required by the commission, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount from the 90th day after the date the provider filed the complaint until the date the entire amount of the additional reimbursement is paid.

Revised Law

Sec. 540.0605. CORRECTIVE ACTION PLAN FOR INADEQUATE NETWORK AND PROVIDER REIMBURSEMENT. (a) The commission shall initiate a corrective action plan requiring a Medicaid managed care organization to maintain an adequate provider network, provide reimbursement to support that network, and educate recipients enrolled in Medicaid managed care plans provided by the organization regarding the proper use of the plan's provider network, if:

(1) as the commission determines, the organization exceeds maximum limits the commission established for out-of-network access to health care services; or

(2) based on the commission's investigation of a provider complaint regarding reimbursement, the commission determines that the organization did not reimburse an out-of-network provider based on a reasonable reimbursement methodology.

(b) The corrective action plan required by Subsection (a) must include at least one of the following elements:

(1) a requirement that reimbursements the Medicaid managed care organization pays to out-of-network providers for a health care service provided to a recipient enrolled in a Medicaid managed care plan provided by the organization equal the allowable rate for the service, as determined under Sections 32.028 and 32.0281, Human Resources Code, for all health care services provided during the period the organization:

(A) is not in compliance with the utilization benchmarks the commission determines; or

(B) is not reimbursing out-of-network providers based on a reasonable methodology, as the commission determines;

(2) an immediate freeze on the enrollment of additional recipients in a Medicaid managed care plan the organization provides that continues until the commission determines that the provider network under the plan can adequately

meet the needs of additional recipients; and

(3) other actions the commission determines are necessary to ensure that recipients enrolled in a Medicaid managed care plan the organization provides have access to appropriate health care services and that providers are properly reimbursed for providing medically necessary health care services to those recipients. (Gov. Code, Secs. 533.007(g) (part), (h).)

Source Law

(g) . . . If, as determined by the commission, a managed care organization exceeds maximum limits established by the commission for out-of-network access to health care services, or if, based on an investigation by the commission of a provider complaint regarding reimbursement, the commission determines that a managed care organization did not reimburse an out-of-network provider based on a reasonable reimbursement methodology, the commission shall initiate a corrective action plan requiring the managed care organization to maintain an adequate provider network, provide reimbursement to support that network, and educate recipients enrolled in managed care plans provided by the managed care organization regarding the proper use of the provider network under the plan.

(h) The corrective action plan required by Subsection (g) must include at least one of the following elements:

(1) a requirement that reimbursements paid by the managed care organization to out-of-network providers for a health care service provided to a recipient enrolled in a managed care plan provided by the managed care organization equal the allowable rate for the service, as determined under Sections 32.028 and 32.0281, Human Resources Code, for all health care services provided during the period:

(A) the managed care organization is not in compliance with the utilization benchmarks determined by the commission; or

(B) the managed care organization is not reimbursing out-of-network providers based on a reasonable methodology, as determined by the commission;

(2) an immediate freeze on the enrollment of additional recipients in a managed care plan provided by the managed care organization, to continue until the commission determines that the provider network under the managed care plan can adequately meet the needs of additional recipients; and

(3) other actions the commission determines are necessary to ensure that recipients enrolled in a managed care plan provided by the managed care organization have access to appropriate health care services and that providers are properly reimbursed for providing medically necessary health care services to those recipients.

Revised Law

Sec. 540.0606. REMEDIES FOR NONCOMPLIANCE WITH CORRECTIVE

ACTION PLAN. The commission shall pursue any appropriate remedy authorized in the contract between the Medicaid managed care organization and the commission if the organization fails to comply with a corrective action plan under Section 540.0605(a). (Gov. Code, Sec. 533.007(k).)

Source Law

(k) The commission shall pursue any appropriate remedy authorized in the contract between the managed care organization and the commission if the managed care organization fails to comply with a corrective action plan under Subsection (g).

Revisor's Note

Section 533.007(k), Government Code, refers to a corrective action plan under Section 533.007(g), Government Code. The relevant portion of Section 533.007(g) is revised in this chapter as Section 540.0605(a), and the revised law is drafted accordingly.

SUBCHAPTER N. PROVIDERS

Revised Law

Sec. 540.0651. INCLUSION OF CERTAIN PROVIDERS IN MEDICAID MANAGED CARE ORGANIZATION PROVIDER NETWORK. (a) The commission shall require that each managed care organization that contracts with the commission under any managed care model or arrangement to provide health care services to recipients in a region:

(1) seek participation in the organization's provider network from:

(A) each health care provider in the region who has traditionally provided care to recipients;

(B) each hospital in the region that has been designated as a disproportionate share hospital under Medicaid; and

(C) each specialized pediatric laboratory in the region, including a laboratory located in a children's hospital;

(2) include in the organization's provider network for at least three years:

(A) each health care provider in the region who:

(i) previously provided care to Medicaid and charity care recipients at a significant level as the commission prescribes;

(ii) agrees to accept the organization's prevailing provider contract rate; and

(iii) has the credentials the organization requires, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network;

(B) each accredited primary care residency program in the region; and

(C) each disproportionate share hospital the commission designates as a statewide significant traditional provider; and

(3) subject to Section 32.047, Human Resources Code, and notwithstanding any other law, include in the organization's provider network each optometrist, therapeutic optometrist, and ophthalmologist described by Section 532.0153(b)(1)(A) or (B) who, and an institution of higher education described by Section 532.0153(a)(4) in the region that:

(A) agrees to comply with the organization's terms;

(B) agrees to accept the organization's prevailing provider contract rate;

(C) agrees to abide by the organization's required standards of care; and

(D) is an enrolled Medicaid provider.

(b) A contract between a Medicaid managed care organization and the commission for the organization to provide health care services to recipients in a health care service region that includes a rural area must require the organization to include in the organization's provider network rural hospitals, physicians, home and community support services agencies, and other rural health care providers who:

(1) are sole community providers;

(2) provide care to Medicaid and charity care recipients at a significant level as the commission prescribes;

(3) agree to accept the organization's prevailing provider contract rate; and

(4) have the credentials the organization requires, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network. (Gov. Code, Secs. 533.006, 533.0067.)

Source Law

Sec. 533.006. PROVIDER NETWORKS. (a) The commission shall require that each managed care organization that contracts with the commission to provide health care services to recipients in a region:

(1) seek participation in the organization's provider network from:

(A) each health care provider in the region who has traditionally provided care to recipients;

(B) each hospital in the region that has been designated as a disproportionate share hospital under Medicaid; and

(C) each specialized pediatric laboratory in the region, including those laboratories located in children's hospitals; and

(2) include in its provider network for not less than three years:

(A) each health care provider in the region who:

(i) previously provided care to Medicaid and charity care recipients at a significant level as prescribed by the commission;

(ii) agrees to accept the prevailing provider contract rate of the managed care organization; and

(iii) has the credentials required by the managed care organization, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network;

(B) each accredited primary care residency program in the region; and

(C) each disproportionate share hospital designated by the commission as a statewide significant traditional provider.

(b) A contract between a managed care organization and the commission for the organization to provide health care services to recipients in a health care service region that includes a rural area must require that the organization include in its provider network rural hospitals, physicians, home and community support services agencies, and other rural health care providers who:

(1) are sole community providers;

(2) provide care to Medicaid and charity care recipients at a significant level as prescribed

by the commission;

(3) agree to accept the prevailing provider contract rate of the managed care organization; and

(4) have the credentials required by the managed care organization, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network.

Sec. 533.0067. EYE HEALTH CARE SERVICE PROVIDERS. Subject to Section 32.047, Human Resources Code, but notwithstanding any other law, the commission shall require that each managed care organization that contracts with the commission under any Medicaid managed care model or arrangement to provide health care services to recipients in a region include in the organization's provider network each optometrist, therapeutic optometrist, and ophthalmologist described by Section 531.021191(b)(1)(A) or (B) and an institution of higher education described by Section 531.021191(a)(4) in the region who:

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

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

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

(4) is an enrolled provider under Medicaid.

Revisor's Note

Section 533.0067(1), Government Code, refers to the "terms and conditions" imposed by a managed care organization. The revised law omits "conditions" from the quoted phrase for the reason stated in Revisor's Note (3) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0652. PROVIDER ACCESS STANDARDS; BIENNIAL REPORT. (a) The commission shall establish minimum provider access standards for a Medicaid managed care organization's provider network. The provider access standards must ensure that a Medicaid managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services the commission identifies.

(b) To the extent feasible, the provider access standards must:

(1) distinguish between access to providers in urban and rural settings;

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area; and

(3) subject to Section 548.0054(a) and consistent with Section 111.007, Occupations Code, consider and include the availability of telehealth services and telemedicine medical services in a Medicaid managed care organization's provider network.

(c) The commission shall biennially submit to the legislature and make available to the public a report that contains:

(1) information and statistics on:

(A) recipient access to providers through Medicaid managed care organizations' provider networks; and

(B) Medicaid managed care organization compliance with contractual obligations related to provider access standards;

(2) a compilation and analysis of information Medicaid managed care organizations submit to the commission under Section 540.0260(4);

(3) for both primary care providers and specialty providers, information on provider-to-recipient ratios in a Medicaid managed care organization's provider network and benchmark ratios to indicate whether deficiencies exist in a given network; and

(4) a description of, and analysis of the results from, the commission's monitoring process established under Section 540.0601. (Gov. Code, Sec. 533.0061.)

Source Law

Sec. 533.0061. PROVIDER ACCESS STANDARDS; REPORT. (a) The commission shall establish minimum provider access standards for the provider network of a managed care organization that contracts with the commission to provide health care services to recipients. The access standards must ensure that a managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services identified by the commission.

(b) To the extent it is feasible, the provider access standards established under this section must:

(1) distinguish between access to providers in urban and rural settings;

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area; and

(3) subject to Section 531.0216(c) and consistent with Section 111.007, Occupations Code, consider and include the availability of telehealth services and telemedicine medical services within the provider network of a Medicaid managed care organization.

(c) The commission shall biennially submit to the legislature and make available to the public a report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations and managed care organization compliance with contractual obligations related to provider access standards established under this section. The report must contain:

(1) a compilation and analysis of information submitted to the commission under Section 533.005(a)(20)(D);

(2) for both primary care providers and specialty providers, information on provider-to-recipient ratios in an organization's provider network, as well as benchmark ratios to indicate whether deficiencies exist in a given network; and

(3) a description of, and analysis of the results from, the commission's monitoring process established under Section 533.007(l).

Revised Law

Sec. 540.0653. PENALTIES AND OTHER REMEDIES FOR FAILURE TO

COMPLY WITH PROVIDER ACCESS STANDARDS. If a Medicaid managed care organization fails to comply with one or more provider access standards the commission establishes under Section 540.0652 and the commission determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, the commission:

(1) may:

(A) elect to not retain or renew the commission's contract with the organization; or

(B) require the organization to pay liquidated damages in accordance with Section 540.0260(3); and

(2) if the organization's noncompliance occurs in a given service delivery area for two consecutive calendar quarters, shall suspend default enrollment to the organization in that service delivery area for at least one calendar quarter. (Gov. Code, Sec. 533.0062.)

Source Law

> Sec. 533.0062. PENALTIES AND OTHER REMEDIES FOR FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS. If a managed care organization that has contracted with the commission to provide health care services to recipients fails to comply with one or more provider access standards established under Section 533.0061 and the commission determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, the commission:
>
> (1) may:
>
> (A) elect to not retain or renew the commission's contract with the organization; or
>
> (B) require the organization to pay liquidated damages in accordance with Section 533.005(a)(20)(C); and
>
> (2) shall suspend default enrollment to the organization in a given service delivery area for at least one calendar quarter if the organization's noncompliance occurs in the service delivery area for two consecutive calendar quarters.

Revised Law

Sec. 540.0654. PROVIDER NETWORK DIRECTORIES. (a) The commission shall ensure that a Medicaid managed care organization:

(1) posts on the organization's Internet website:

(A) the organization's provider network directory; and

(B) a direct telephone number and e-mail address

through which a recipient enrolled in the organization's managed care plan or the recipient's provider may contact the organization to receive assistance with:

(i) identifying in-network providers and services available to the recipient; and

(ii) scheduling an appointment for the recipient with an available in-network provider or to access available in-network services; and

(2) updates the online directory required under Subdivision (1)(A) at least monthly.

(b) A Medicaid managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who requests to receive the directory in paper form. (Gov. Code, Sec. 533.0063.)

Source Law

Sec. 533.0063. PROVIDER NETWORK DIRECTORIES. (a) The commission shall ensure that a managed care organization that contracts with the commission to provide health care services to recipients:

(1) posts on the organization's Internet website:

(A) the organization's provider network directory; and

(B) a direct telephone number and e-mail address through which a recipient enrolled in the organization's managed care plan or the recipient's provider may contact the organization to receive assistance with:

(i) identifying in-network providers and services available to the recipient; and

(ii) scheduling an appointment for the recipient with an available in-network provider or to access available in-network services; and

(2) updates the online directory required under Subdivision (1)(A) at least monthly.

(b) A managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who requests to receive the directory in paper form.

Revised Law

Sec. 540.0655. PROVIDER PROTECTION PLAN. (a) The commission shall develop and implement a provider protection plan designed to:

(1) reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement

implemented under this chapter or Chapter 540A; and

(2) ensure efficient provider enrollment and reimbursement.

(b) To the greatest extent possible, the commission shall incorporate the measures in the provider protection plan into each contract between a managed care organization and the commission to provide health care services to recipients.

(c) The provider protection plan must provide for:

(1) a Medicaid managed care organization's prompt payment to and proper reimbursement of providers;

(2) prompt and accurate claim adjudication through:

(A) educating providers on properly submitting clean claims and on appeals;

(B) accepting uniform forms, including HCFA Forms 1500 and UB-92 and subsequent versions of those forms, through an electronic portal; and

(C) establishing standards for claims payments in accordance with a provider's contract;

(3) adequate and clearly defined provider network standards that:

(A) are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards in effect on January 1, 2013; and

(B) ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for Medicaid managed care organizations for submitting and tracking preauthorization requests for Medicaid services;

(6) establishing an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:

(A) submit electronic claims, prior

authorization requests, claims appeals and reconsiderations, clinical data, and other documents that the organization requests for prior authorization and claims processing; and

(B) obtain electronic remittance advice, explanation of benefits statements, and other standardized reports;

(7) measuring Medicaid managed care organization retention rates of significant traditional providers;

(8) creating a work group to review and make recommendations to the commission concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submitting and accepting attachments for claims processing and prior authorization requests through an electronic process under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected:

(A) fiscal impact of implementing the requirement; and

(B) timeline for implementing the requirement; and

(9) any other provision the commission determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement. (Gov. Code, Sec. 533.0055.)

Source Law

Sec. 533.0055. PROVIDER PROTECTION PLAN. (a) The commission shall develop and implement a provider protection plan that is designed to reduce administrative burdens placed on providers participating in a Medicaid managed care model or arrangement implemented under this chapter and to ensure efficiency in provider enrollment and reimbursement. The commission shall incorporate the measures identified in the plan, to the greatest extent possible, into each contract between a managed care organization and the commission for the provision of health care services to recipients.

(b) The provider protection plan required under this section must provide for:

(1) prompt payment and proper

reimbursement of providers by managed care organizations;

(2) prompt and accurate adjudication of claims through:

(A) provider education on the proper submission of clean claims and on appeals;

(B) acceptance of uniform forms, including HCFA Forms 1500 and UB-92 and subsequent versions of those forms, through an electronic portal; and

(C) the establishment of standards for claims payments in accordance with a provider's contract;

(3) adequate and clearly defined provider network standards that are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards in effect on January 1, 2013, and that ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for managed care organizations for the submission and tracking of preauthorization requests for services provided under Medicaid;

(6) establishment of an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:

(A) submit electronic claims, prior authorization requests, claims appeals and reconsiderations, clinical data, and other documentation that the managed care organization requests for prior authorization and claims processing; and

(B) obtain electronic remittance advice, explanation of benefits statements, and other standardized reports;

(7) the measurement of the rates of retention by managed care organizations of significant traditional providers;

(8) the creation of a work group to review and make recommendations to the commission concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submission and acceptance of attachments for claims processing and prior authorization requests through an electronic process under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected:

(A) fiscal impact of implementing the requirement; and

(B) timeline for implementation of the requirement; and

(9) any other provision that the commission determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement.

Revised Law

Sec. 540.0656. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a

physician or other health care provider applying for expedited credentialing.

(b) Notwithstanding any other law and subject to Subsection (c), a Medicaid managed care organization shall establish and implement an expedited credentialing process that allows an applicant provider to provide services to recipients on a provisional basis.

(c) The commission shall identify the types of providers for which a Medicaid managed care organization must establish and implement an expedited credentialing process.

(d) To qualify for expedited credentialing and payment under Subsection (e), an applicant provider must:

(1) be a member of an established health care provider group that has a current contract with a Medicaid managed care organization;

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) submit all documentation and other information the Medicaid managed care organization requires as necessary to enable the organization to begin the credentialing process the organization requires to include a provider in the organization's provider network.

(e) On an applicant provider's submission of the information the Medicaid managed care organization requires under Subsection (d), and for Medicaid reimbursement purposes only, the organization shall treat the provider as if the provider were in the organization's provider network when the provider provides services to recipients, subject to Subsections (f) and (g).

(f) Except as provided by Subsection (g), a Medicaid managed care organization that determines on completion of the credentialing process that an applicant provider does not meet the organization's credentialing requirements may recover from the provider the difference between payments for in-network benefits

and out-of-network benefits.

(g) A Medicaid managed care organization that determines on completion of the credentialing process that an applicant provider does not meet the organization's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing may recover from the provider the entire amount the organization paid the provider. (Gov. Code, Sec. 533.0064.)

Source Law

Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a physician or other health care provider applying for expedited credentialing under this section.

(b) Notwithstanding any other law and subject to Subsection (c), a managed care organization that contracts with the commission to provide health services to recipients shall, in accordance with this section, establish and implement an expedited credentialing process that would allow applicant providers to provide services to recipients on a provisional basis.

(c) The commission shall identify the types of providers for which an expedited credentialing process must be established and implemented under this section.

(d) To qualify for expedited credentialing under this section and payment under Subsection (e), an applicant provider must:

(1) be a member of an established health care provider group that has a current contract in force with a managed care organization described by Subsection (b);

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) submit all documentation and other information required by the managed care organization as necessary to enable the organization to begin the credentialing process required by the organization to include a provider in the organization's provider network.

(e) On submission by the applicant provider of the information required by the managed care organization under Subsection (d), and for Medicaid reimbursement purposes only, the organization shall treat the provider as if the provider were in the organization's provider network when the provider provides services to recipients, subject to Subsections (f) and (g).

(f) Except as provided by Subsection (g), if, on completion of the credentialing process, a managed care organization determines that the applicant provider does not meet the organization's credentialing requirements, the organization may recover from the provider the difference between payments for in-network benefits and out-of-network benefits.

(g) If a managed care organization determines on completion of the credentialing process that the applicant provider does not meet the organization's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing, the organization may recover from the provider the entire amount of any payment paid to the provider.

Revised Law

Sec. 540.0657. FREQUENCY OF PROVIDER RECREDENTIALING. (a) A Medicaid managed care organization shall formally recredential a physician or other provider with the frequency required by the single, consolidated Medicaid provider enrollment and credentialing process, if that process is created under Section 532.0151.

(b) Notwithstanding any other law, the required frequency of recredentialing may be less frequent than once in any three-year period. (Gov. Code, Sec. 533.0065.)

Source Law

Sec. 533.0065. FREQUENCY OF PROVIDER CREDENTIALING. A managed care organization that contracts with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization shall formally recredential a physician or other provider with the frequency required by the single, consolidated Medicaid provider enrollment and credentialing process, if that process is created under Section 531.02118. The required frequency of recredentialing may be less frequent than once in any three-year period, notwithstanding any other law.

Revised Law

Sec. 540.0658. PROVIDER INCENTIVES FOR PROMOTING PREVENTIVE SERVICES. To the extent possible, the commission shall work to ensure that a Medicaid managed care organization provides payment incentives to a health care provider in the organization's provider network whose performance in promoting recipient use of preventive services exceeds minimum established standards. (Gov. Code, Sec. 533.0066.)

Source Law

Sec. 533.0066. PROVIDER INCENTIVES. The commission shall, to the extent possible, work to ensure that managed care organizations provide payment incentives to health care providers in the organizations' networks whose performance in promoting recipients' use of preventive services exceeds minimum

established standards.

Revised Law

Sec. 540.0659. REIMBURSEMENT RATE FOR CERTAIN SERVICES PROVIDED BY CERTAIN HEALTH CENTERS AND CLINICS OUTSIDE REGULAR BUSINESS HOURS. (a) This section applies only to a recipient receiving benefits through a Medicaid managed care model or arrangement.

(b) The commission shall ensure that a federally qualified health center, rural health clinic, or municipal health department's public clinic is reimbursed for health care services provided to a recipient outside of regular business hours, including on a weekend or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, regardless of whether the recipient has a referral from the recipient's primary care provider.

(c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (b). (Gov. Code, Sec. 533.01315.)

Source Law

> Sec. 533.01315. REIMBURSEMENT FOR SERVICES PROVIDED OUTSIDE OF REGULAR BUSINESS HOURS. (a) This section applies only to a recipient receiving benefits through any Medicaid managed care model or arrangement.
>
> (b) The commission shall ensure that a federally qualified health center, rural health clinic, or municipal health department's public clinic is reimbursed for health care services provided to a recipient outside of regular business hours, including on a weekend or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, regardless of whether the recipient has a referral from the recipient's primary care provider.
>
> (c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (b).

SUBCHAPTER O. DELIVERY OF SERVICES: GENERAL PROVISIONS

Revised Law

Sec. 540.0701. ACUTE CARE SERVICE DELIVERY THROUGH MOST COST-EFFECTIVE MODEL; MANAGED CARE SERVICE DELIVERY AREAS. (a)

Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care as the commission determines. The commission shall require mandatory participation in a Medicaid capitated managed care program for all individuals eligible for Medicaid acute care benefits, but may implement alternative models or arrangements, including a traditional fee-for-service arrangement, if the commission determines the alternative would be more cost-effective or efficient.

(b) In determining whether a model or arrangement described by Subsection (a) is more cost-effective, the executive commissioner must consider:

(1) the scope, duration, and types of health benefits or services to be provided in a certain part of this state or to a certain recipient population;

(2) administrative costs necessary to meet federal and state statutory and regulatory requirements;

(3) the anticipated effect of market competition associated with the configuration of Medicaid service delivery models the commission determines; and

(4) the gain or loss to this state of a tax collected under Chapter 222, Insurance Code.

(c) If the commission determines that it is not more cost-effective to use a Medicaid managed care model to provide certain types of Medicaid acute care in a certain area or to certain recipients as prescribed by this section, the commission shall provide Medicaid acute care through a traditional fee-for-service arrangement.

(d) The commission shall determine the most cost-effective alignment of managed care service delivery areas. The executive commissioner may consider:

(1) the number of lives impacted;

(2) the usual source of health care services for

residents in an area; and

(3) other factors that impact health care service delivery in the area. (Gov. Code, Secs. 533.0025(b), (c), (d), (e).)

Source Law

Sec. 533.0025. DELIVERY OF SERVICES. (b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care as determined by the commission. The commission shall require mandatory participation in a Medicaid capitated managed care program for all persons eligible for Medicaid acute care benefits, but may implement alternative models or arrangements, including a traditional fee-for-service arrangement, if the commission determines the alternative would be more cost-effective or efficient.

(c) In determining whether a model or arrangement described by Subsection (b) is more cost-effective, the executive commissioner must consider:

(1) the scope, duration, and types of health benefits or services to be provided in a certain part of this state or to a certain population of recipients;

(2) administrative costs necessary to meet federal and state statutory and regulatory requirements;

(3) the anticipated effect of market competition associated with the configuration of Medicaid service delivery models determined by the commission; and

(4) the gain or loss to this state of a tax collected under Chapter 222, Insurance Code.

(d) If the commission determines that it is not more cost-effective to use a Medicaid managed care model to provide certain types of Medicaid acute care in a certain area or to certain recipients as prescribed by this section, the commission shall provide Medicaid acute care through a traditional fee-for-service arrangement.

(e) The commission shall determine the most cost-effective alignment of managed care service delivery areas. The executive commissioner may consider the number of lives impacted, the usual source of health care services for residents in an area, and other factors that impact the delivery of health care services in the area.

Revisor's Note

Section 533.0025(b), Government Code, requires the Health and Human Services Commission to provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care "[e]xcept as otherwise provided by this section,"

meaning Section 533.0025, Government Code. Section 533.0025 is revised in various provisions of this chapter. The revised law refers only to the provisions revised as this section because the relevant exceptions to Section 533.0025(b) are revised in this section.

Revised Law

Sec. 540.0702. TRANSITION OF CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MEDICAID MANAGED CARE PROGRAM. (a) In this section, "children and pregnant women program" means the Medicaid benefits program administered by the Department of State Health Services that provides case management services to children who have a health condition or health risk and pregnant women who have a high-risk condition.

(b) The commission shall transition to a Medicaid managed care model all case management services provided to children and pregnant women program recipients. In transitioning the services, the commission shall ensure a recipient is provided case management services through the Medicaid managed care plan in which the recipient is enrolled.

(c) In implementing this section, the commission shall ensure that:

(1) there is a seamless transition in case management services for children and pregnant women program recipients; and

(2) case management services provided under the program are not interrupted. (Gov. Code, Sec. 533.002555.)

Source Law

Sec. 533.002555. TRANSITION OF CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) In this section, "children and pregnant women program" means the benefits program provided under Medicaid and administered by the Department of State Health Services that provides case management services to children who have a health condition or health risk and pregnant women who have a high-risk condition.

(b) The commission shall transition to a Medicaid managed care model all case management services provided to recipients under the children and pregnant women program. In transitioning services

under this section, the commission shall ensure a recipient is provided case management services through the managed care plan in which the recipient is enrolled.

(c) In implementing this section, the commission shall ensure:

(1) a seamless transition in case management for recipients receiving benefits under the children and pregnant women program; and

(2) case management services provided under the program are not interrupted.

Revised Law

Sec. 540.0703. BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES. (a) In this section, "behavioral health services" means mental health and substance use disorder services.

(b) To the greatest extent possible, the commission shall integrate the following services into the Medicaid managed care program:

(1) behavioral health services, including targeted case management and psychiatric rehabilitation services; and

(2) physical health services.

(c) A Medicaid managed care organization shall:

(1) develop a network of public and private behavioral health services providers; and

(2) ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.

(d) In implementing this section, the commission shall ensure that:

(1) an appropriate assessment tool is used to authorize services;

(2) providers are well-qualified and able to provide an appropriate array of services;

(3) appropriate performance and quality outcomes are measured;

(4) two health home pilot programs are established in two health service areas, representing two distinct regions of this state, for individuals who are diagnosed with:

(A) a serious mental illness; and

(B) at least one other chronic health condition;

(5) a health home established under a pilot program under Subdivision (4) complies with the principles for patient-centered medical homes described in Section 540.0712; and

(6) all behavioral health services provided under this section are based on an approach to treatment in which the expected outcome of treatment is recovery.

(e) If the commission determines that it is cost-effective and beneficial to recipients, the commission shall include a peer specialist as a benefit to recipients or as a provider type.

(f) To the extent of any conflict between this section and any other law relating to behavioral health services, this section prevails.

(g) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 533.00255.)

Source Law

Sec. 533.00255. BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES NETWORK. (a) In this section, "behavioral health services" means mental health and substance abuse disorder services.

(b) The commission shall, to the greatest extent possible, integrate into the Medicaid managed care program implemented under this chapter the following services for Medicaid-eligible persons:

(1) behavioral health services, including targeted case management and psychiatric rehabilitation services; and

(2) physical health services.

(c) A managed care organization that contracts with the commission under this chapter shall develop a network of public and private providers of behavioral health services and ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.

(d) In implementing this section, the commission shall ensure that:

(1) an appropriate assessment tool is used to authorize services;

(2) providers are well-qualified and able to provide an appropriate array of services;

(3) appropriate performance and quality outcomes are measured;

(4) two health home pilot programs are established in two health service areas, representing two distinct regions of the state, for persons who are diagnosed with:

(A) a serious mental illness; and

(B) at least one other chronic health condition;

(5) a health home established under a

pilot program under Subdivision (4) complies with the principles for patient-centered medical homes described in Section 533.0029; and

(6) all behavioral health services provided under this section are based on an approach to treatment where the expected outcome of treatment is recovery.

(g) The commission shall, if the commission determines that it is cost-effective and beneficial to recipients, include a peer specialist as a benefit to recipients or as a provider type.

(h) To the extent of any conflict between this section and any other law relating to behavioral health services, this section prevails.

(i) The executive commissioner shall adopt rules necessary to implement this section.

Revisor's Note

(1) Section 533.00255(a), Government Code, refers to "substance abuse" disorder services. The revised law substitutes "substance use" for "substance abuse" for the reason stated in the revisor's note to Section 540.0262 of this chapter.

(2) Section 533.00255(b), Government Code, requires the Health and Human Services Commission to integrate certain services "for Medicaid-eligible persons" into the Medicaid managed care program "implemented under this chapter," meaning Chapter 533, Government Code. Chapter 533, Government Code, revised in relevant part as this chapter, is the only chapter under which the Medicaid managed care program is implemented, and only Medicaid-eligible persons may receive services through the Medicaid managed care program. The revised law omits the quoted language as superfluous.

Revised Law

Sec. 540.0704. TARGETED CASE MANAGEMENT AND PSYCHIATRIC REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES. (a) A provider in the provider network of a Medicaid managed care organization that contracts with the commission to provide behavioral health services under Section 540.0703 may contract with the organization to provide targeted case management and psychiatric rehabilitative services to children, adolescents, and

their families.

(b) Commission rules and guidelines concerning contract and training requirements applicable to the provision of behavioral health services may apply to a provider that contracts with a Medicaid managed care organization under Subsection (a) only to the extent those contract and training requirements are specific to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(c) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization under Subsection (a) may not require the provider to provide a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week. This subsection does not prohibit a Medicaid managed care organization that contracts with the commission to provide behavioral health services under Section 540.0703 from specifically contracting with a provider for the provision of a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week.

(d) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization to provide targeted case management and psychiatric rehabilitative services specific to children and adolescents who are at risk of juvenile justice involvement, expulsion from school, displacement from the home, hospitalization, residential treatment, or serious injury to self, others, or animals may not require the provider to also provide less intensive psychiatric rehabilitative services specified by commission rules and guidelines as applicable to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families, if that provider has a referral arrangement to provide access to those less intensive psychiatric rehabilitative services.

(e) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization under Subsection (a) may not require the provider to provide services not covered under Medicaid. (Gov. Code, Sec. 533.002552.)

Source Law

Sec. 533.002552. TARGETED CASE MANAGEMENT AND PSYCHIATRIC REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES. (a) A provider in the provider network of a managed care organization that contracts with the commission to provide behavioral health services under Section 533.00255 may contract with the managed care organization to provide targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(b) Commission rules and guidelines concerning contract and training requirements applicable to the provision of behavioral health services may apply to a provider that contracts with a managed care organization under Subsection (a) only to the extent those contract and training requirements are specific to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(c) Commission rules and guidelines applicable to a provider that contracts with a managed care organization under Subsection (a) may not require the provider to provide a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week. This subsection does not prohibit a managed care organization that contracts with the commission to provide behavioral health services under Section 533.00255 from specifically contracting with a provider for the provision of a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week.

(d) Commission rules and guidelines applicable to a provider that contracts with a managed care organization to provide targeted case management and psychiatric rehabilitative services specific to children and adolescents who are at risk of juvenile justice involvement, expulsion from school, displacement from the home, hospitalization, residential treatment, or serious injury to self, others, or animals may not require the provider to also provide less intensive psychiatric rehabilitative services specified by commission rules and guidelines as applicable to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families, if that provider has a referral arrangement to provide access to those less intensive psychiatric rehabilitative services.

(e) Commission rules and guidelines applicable to a provider that contracts with a managed care organization under Subsection (a) may not require the provider to provide services not covered under Medicaid.

Revised Law

Sec. 540.0705. BEHAVIORAL HEALTH SERVICES PROVIDED THROUGH

THIRD PARTY OR SUBSIDIARY. (a) In this section, "behavioral health services" has the meaning assigned by Section 540.0703.

(b) For a Medicaid managed care organization that provides behavioral health services through a contract with a third party or an arrangement with a subsidiary of the organization, the commission shall:

(1) require the effective sharing and integration of care coordination, service authorization, and utilization management data between the organization and the third party or subsidiary;

(2) encourage the colocation of physical health and behavioral health care coordination staff, to the extent feasible;

(3) require warm call transfers between physical health and behavioral health care coordination staff;

(4) require the organization and the third party or subsidiary to implement joint rounds for physical health and behavioral health services network providers or some other effective means for sharing clinical information; and

(5) ensure that the organization makes available a seamless provider portal for both physical health and behavioral health services network providers, to the extent allowed by federal law. (Gov. Code, Sec. 533.002553.)

Source Law

Sec. 533.002553. BEHAVIORAL HEALTH SERVICES PROVIDED THROUGH THIRD PARTY OR SUBSIDIARY. (a) In this section, "behavioral health services" has the meaning assigned by Section 533.00255.

(b) For a managed care organization that contracts with the commission under this chapter and that provides behavioral health services through a contract with a third party or an arrangement with a subsidiary of the managed care organization, the commission shall:

(1) require the effective sharing and integration of care coordination, service authorization, and utilization management data between the managed care organization and the third party or subsidiary;

(2) encourage, to the extent feasible, the colocation of physical health and behavioral health care coordination staff;

(3) require warm call transfers between physical health and behavioral health care coordination staff;

(4) require the managed care organization and the third party or subsidiary to implement joint rounds for physical health and behavioral health services network providers or some other effective means for sharing clinical information; and

(5) ensure that the managed care organization makes available a seamless provider portal for both physical health and behavioral health services network providers, to the extent allowed by federal law.

Revised Law

Sec. 540.0706. PSYCHOTROPIC MEDICATION MONITORING SYSTEM FOR CERTAIN CHILDREN. (a) In this section, "psychotropic medication" has the meaning assigned by Section 266.001, Family Code.

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic medications for:

(1) children who are in the conservatorship of the Department of Family and Protective Services and enrolled in the STAR Health program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter 162, Family Code.

(c) The commission shall include as a component of the monitoring system a medical review of a prescription to which Subsection (b) applies when that review is appropriate. (Gov. Code, Sec. 533.0161.)

Source Law

Sec. 533.0161. MONITORING OF PSYCHOTROPIC DRUG PRESCRIPTIONS FOR CERTAIN CHILDREN. (a) In this section, "psychotropic drug" has the meaning assigned by Section 261.111, Family Code.

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for:

(1) children who are in the conservatorship of the Department of Family and Protective Services and enrolled in the STAR Health Medicaid managed care program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter

162, Family Code.

(c) The commission shall include as a component of the monitoring system required by this section a medical review of a prescription to which Subsection (b) applies when that review is appropriate.

Revisor's Note

(1) Section 533.0161(a), Government Code, provides that the term "psychotropic drug" has the meaning assigned by Section 261.111, Family Code. Section 261.111, Family Code, provides that the term "psychotropic medication" has the meaning assigned by Section 266.001, Family Code. For the convenience of the reader, the revised law substitutes the term "psychotropic medication" for "psychotropic drug" and substitutes a reference to Section 266.001, Family Code, for the reference to Section 261.111, Family Code.

(2) Section 533.0161(b)(1), Government Code, refers to the "STAR Health Medicaid managed care program." The revised law substitutes "STAR Health program" for "STAR Health Medicaid managed care program" because the terms are synonymous and "STAR Health program" is more commonly used.

Revised Law

Sec. 540.0707. MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events. (Gov. Code, Sec. 533.00515.)

Source Law

Sec. 533.00515. MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.

Revised Law

Sec. 540.0708. SPECIAL DISEASE MANAGEMENT. (a) The commission shall ensure that a Medicaid managed care organization

develops and implements special disease management programs to manage a disease or other chronic health condition with respect to which disease management would be cost-effective for populations the commission identifies. The special disease management programs may manage a disease or other chronic health condition such as:

(1) heart disease;

(2) chronic kidney disease and related medical complications;

(3) respiratory illness, including asthma;

(4) diabetes;

(5) end-stage renal disease;

(6) HIV infection; or

(7) AIDS.

(b) A Medicaid managed care plan must provide, in the manner the commission requires, disease management services including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care.

(c) The executive commissioner by rule shall prescribe the minimum requirements that a Medicaid managed care organization must meet in providing a special disease management program to be eligible to receive a contract under this section. The organization must at a minimum be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease management services under Section 32.057, Human Resources Code;

(2) show evidence of ability to manage complex diseases in the Medicaid population; and

(3) if a special disease management program the organization provides has low active participation rates, identify the reason for the low rates and develop an approach to increase active participation in special disease management programs for high-risk recipients.

(d) If a Medicaid managed care organization implements a special disease management program to manage chronic kidney disease and related medical complications as provided by Subsection (a) and the organization develops a program to provide screening for and diagnosis and treatment of chronic kidney disease and related medical complications to recipients under the organization's Medicaid managed care plan, the program for screening, diagnosis, and treatment must use generally recognized clinical practice guidelines and laboratory assessments that identify chronic kidney disease on the basis of impaired kidney function or the presence of kidney damage. (Gov. Code, Sec. 533.009.)

Source Law

Sec. 533.009. SPECIAL DISEASE MANAGEMENT. (a) The commission shall ensure that managed care organizations under contract with the commission to provide health care services to recipients develop and implement special disease management programs to manage a disease or other chronic health conditions, such as heart disease, chronic kidney disease and its medical complications, respiratory illness, including asthma, diabetes, end-stage renal disease, HIV infection, or AIDS, and with respect to which the commission identifies populations for which disease management would be cost-effective.

(b) A managed health care plan provided under this chapter must provide disease management services in the manner required by the commission, including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care.

(c) The executive commissioner, by rule, shall prescribe the minimum requirements that a managed care organization, in providing a disease management program, must meet to be eligible to receive a contract under this section. The managed care organization must, at a minimum, be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease

management services under Section 32.057, Human Resources Code;

(2) show evidence of ability to manage complex diseases in the Medicaid population; and

(3) if a disease management program provided by the organization has low active participation rates, identify the reason for the low rates and develop an approach to increase active participation in disease management programs for high-risk recipients.

(f) If a managed care organization implements a special disease management program to manage chronic kidney disease and its medical complications as provided by Subsection (a) and the managed care organization develops a program to provide screening for and diagnosis and treatment of chronic kidney disease and its medical complications to recipients under the organization's managed care plan, the program for screening, diagnosis, and treatment must use generally recognized clinical practice guidelines and laboratory assessments that identify chronic kidney disease on the basis of impaired kidney function or the presence of kidney damage.

Revised Law

Sec. 540.0709. SPECIAL PROTOCOLS FOR INDIGENT POPULATIONS. In conjunction with an academic center, the commission may study the treatment of indigent populations to develop special protocols for use by Medicaid managed care organizations in providing health care services to recipients. (Gov. Code, Sec. 533.010.)

Source Law

Sec. 533.010. SPECIAL PROTOCOLS. In conjunction with an academic center, the commission may study the treatment of indigent populations to develop special protocols for managed care organizations to use in providing health care services to recipients.

Revised Law

Sec. 540.0710. DIRECT ACCESS TO EYE HEALTH CARE SERVICES. (a) Notwithstanding any other law, the commission shall ensure that a Medicaid managed care plan offered by a Medicaid managed care organization and any other Medicaid managed care model or arrangement implemented under this chapter allow a recipient receiving services through the plan or other model or arrangement to, in the manner and to the extent required by Section 32.072, Human Resources Code:

(1) select an in-network ophthalmologist or therapeutic optometrist in the managed care network to provide eye health care services other than surgery; and

(2) have direct access to the selected in-network ophthalmologist or therapeutic optometrist for the nonsurgical services.

(b) This section does not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms of the Medicaid managed care plan. (Gov. Code, Sec. 533.0026.)

Source Law

> Sec. 533.0026. DIRECT ACCESS TO EYE HEALTH CARE SERVICES UNDER MEDICAID MANAGED CARE MODEL OR ARRANGEMENT. (a) Notwithstanding any other law, the commission shall ensure that a managed care plan offered by a managed care organization that contracts with the commission under this chapter and any other Medicaid managed care model or arrangement implemented under this chapter allow a recipient who receives services through the plan or other model or arrangement to, in the manner and to the extent required by Section 32.072, Human Resources Code:
>
> (1) select an in-network ophthalmologist or therapeutic optometrist in the managed care network to provide eye health care services, other than surgery; and
>
> (2) have direct access to the selected in-network ophthalmologist or therapeutic optometrist for the provision of the nonsurgical services.
>
> (b) This section does not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms and conditions of the managed care plan.

Revisor's Note

Section 533.0026(b), Government Code, refers to the "terms and conditions" of a Medicaid managed care plan. The revised law omits "conditions" from the quoted phrase for the reason stated in Revisor's Note (3) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0711. DELIVERY OF BENEFITS USING TELECOMMUNICATIONS OR INFORMATION TECHNOLOGY. (a) The commission shall establish policies and procedures to improve access to care under the Medicaid managed care program by encouraging the use under the program of:

(1) telehealth services;

(2) telemedicine medical services;

(3) home telemonitoring services; and

(4) other telecommunications or information technology.

(b) To the extent allowed by federal law, the executive commissioner by rule shall establish policies and procedures that allow a Medicaid managed care organization to conduct assessments and provide care coordination services using telecommunications or information technology. In establishing the policies and procedures, the executive commissioner shall consider:

(1) the extent to which a Medicaid managed care organization determines using the telecommunications or information technology is appropriate;

(2) whether the recipient requests that the assessment or service be provided using telecommunications or information technology;

(3) whether the recipient consents to receiving the assessment or service using telecommunications or information technology;

(4) whether conducting the assessment, including an assessment for an initial waiver eligibility determination, or providing the service in person is not feasible because of the existence of an emergency or state of disaster, including a public health emergency or natural disaster; and

(5) whether the commission determines using the telecommunications or information technology is appropriate under the circumstances.

(c) If a Medicaid managed care organization conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the organization shall:

(1) monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse; and

(2) determine whether additional social services or supports are needed.

(d) To the extent allowed by federal law, the commission shall allow a recipient who is assessed or provided with care coordination services by a Medicaid managed care organization using telecommunications or information technology to provide consent or other authorizations to receive services verbally instead of in writing.

(e) The commission shall determine categories of recipients of home and community-based services who must receive in-person visits. Except during circumstances described by Subsection (b)(4), a Medicaid managed care organization shall, for a recipient of home and community-based services for which the commission requires in-person visits, conduct:

(1) at least one in-person visit with the recipient to make an initial waiver eligibility determination; and

(2) additional in-person visits with the recipient if necessary, as determined by the organization.

(f) Notwithstanding this section, the commission may, on a case-by-case basis, require a Medicaid managed care organization to discontinue the use of telecommunications or information technology for assessment or care coordination services if the commission determines that the discontinuation is in the recipient's best interest. (Gov. Code, Sec. 533.039.)

Source Law

Sec. 533.039. DELIVERY OF BENEFITS USING TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY. (a) The commission shall establish policies and procedures to improve access to care under the Medicaid managed care program by encouraging the use of telehealth services, telemedicine medical services, home telemonitoring services, and other telecommunications or information technology under the program.

(b) To the extent permitted by federal law, the executive commissioner by rule shall establish policies and procedures that allow a Medicaid managed care organization to conduct assessments and provide care coordination services using telecommunications or information technology. In establishing the policies and procedures, the executive commissioner shall consider:

(1) the extent to which a managed care organization determines using the telecommunications or information technology is appropriate;

(2) whether the recipient requests that the assessment or service be provided using

telecommunications or information technology;

(3) whether the recipient consents to receiving the assessment or service using telecommunications or information technology;

(4) whether conducting the assessment, including an assessment for an initial waiver eligibility determination, or providing the service in person is not feasible because of the existence of an emergency or state of disaster, including a public health emergency or natural disaster; and

(5) whether the commission determines using the telecommunications or information technology is appropriate under the circumstances.

(c) If a Medicaid managed care organization conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the managed care organization shall:

(1) monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse; and

(2) determine whether additional social services or supports are needed.

(d) To the extent permitted by federal law, the commission shall allow a recipient who is assessed or provided with care coordination services by a Medicaid managed care organization using telecommunications or information technology to provide consent or other authorizations to receive services verbally instead of in writing.

(e) The commission shall determine categories of recipients of home and community-based services who must receive in-person visits. Except during circumstances described by Subsection (b)(4), a Medicaid managed care organization shall, for a recipient of home and community-based services for which the commission requires in-person visits, conduct:

(1) at least one in-person visit with the recipient to make an initial waiver eligibility determination; and

(2) additional in-person visits with the recipient if necessary, as determined by the managed care organization.

(f) Notwithstanding the provisions of this section, the commission may, on a case-by-case basis, require a Medicaid managed care organization to discontinue the use of telecommunications or information technology for assessment or service coordination services if the commission determines that the discontinuation is in the best interest of the recipient.

Revisor's Note

Section 533.039(f), Government Code, refers to requiring the discontinuation of the use of telecommunications or information technology under certain circumstances for "service coordination services." Sections 533.039(b), (c), and (d), Government Code, refer to providing "care coordination services" using telecommunications or information

technology. Accordingly, the revised law substitutes "care coordination services" for "service coordination services" for consistency in the terminology used within the section.

Revised Law

Sec. 540.0712. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOME. (a) In this section, "patient-centered medical home" means a medical relationship:

(1) between a primary care physician and a patient in which the physician:

(A) provides comprehensive primary care to the patient; and

(B) facilitates partnerships between the physician, the patient, any acute care and other care providers, and, when appropriate, the patient's family; and

(2) that encompasses the following primary principles:

(A) the patient has an ongoing relationship with the physician, who is trained to be the first contact for and to provide continuous and comprehensive care to the patient;

(B) the physician leads a team of individuals at the practice level who are collectively responsible for the patient's ongoing care;

(C) the physician is responsible for providing all of the care the patient needs or for coordinating with other qualified providers to provide care to the patient throughout the patient's life, including preventive care, acute care, chronic care, and end-of-life care;

(D) the patient's care is coordinated across health care facilities and the patient's community and is facilitated by registries, information technology, and health information exchange systems to ensure that the patient receives care when and where the patient wants and needs the care and in a culturally and linguistically appropriate manner; and

(E) quality and safe care is provided.

(b) The commission shall, to the extent possible, work to ensure that Medicaid managed care organizations:

(1) promote the development of patient-centered medical homes for recipients; and

(2) provide payment incentives for providers that meet the requirements of a patient-centered medical home. (Gov. Code, Sec. 533.0029.)

Source Law

Sec. 533.0029. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOMES FOR RECIPIENTS. (a) For purposes of this section, a "patient-centered medical home" means a medical relationship:

(1) between a primary care physician and a child or adult patient in which the physician:

(A) provides comprehensive primary care to the patient; and

(B) facilitates partnerships between the physician, the patient, acute care and other care providers, and, when appropriate, the patient's family; and

(2) that encompasses the following primary principles:

(A) the patient has an ongoing relationship with the physician, who is trained to be the first contact for the patient and to provide continuous and comprehensive care to the patient;

(B) the physician leads a team of individuals at the practice level who are collectively responsible for the ongoing care of the patient;

(C) the physician is responsible for providing all of the care the patient needs or for coordinating with other qualified providers to provide care to the patient throughout the patient's life, including preventive care, acute care, chronic care, and end-of-life care;

(D) the patient's care is coordinated across health care facilities and the patient's community and is facilitated by registries, information technology, and health information exchange systems to ensure that the patient receives care when and where the patient wants and needs the care and in a culturally and linguistically appropriate manner; and

(E) quality and safe care is provided.

(b) The commission shall, to the extent possible, work to ensure that managed care organizations:

(1) promote the development of patient-centered medical homes for recipients; and

(2) provide payment incentives for providers that meet the requirements of a patient-centered medical home.

Revised Law

Sec. 540.0713. VALUE-ADDED SERVICES. The commission shall

actively encourage Medicaid managed care organizations to offer benefits, including health care services or benefits or other types of services, that:

(1) are in addition to the services ordinarily covered by the Medicaid managed care plan the organization offers; and

(2) have the potential to improve the health status of recipients enrolled in the plan. (Gov. Code, Sec. 533.019.)

Source Law

Sec. 533.019. VALUE-ADDED SERVICES. The commission shall actively encourage managed care organizations that contract with the commission to offer benefits, including health care services or benefits or other types of services, that:

(1) are in addition to the services ordinarily covered by the managed care plan offered by the managed care organization; and

(2) have the potential to improve the health status of enrollees in the plan.

Revisor's Note

Section 533.019(2), Government Code, refers to "enrollees," meaning Medicaid recipients who are enrolled in a Medicaid managed care plan a Medicaid managed care organization offers. Throughout this chapter, the revised law substitutes "recipients enrolled" and "enrolled recipients" for "enrollees" in a particular Medicaid managed care plan or program for clarity and consistency in the terminology used within the chapter.

SUBCHAPTER P. DELIVERY OF SERVICES: STAR+PLUS MEDICAID MANAGED CARE PROGRAM

Revised Law

Sec. 540.0751. DELIVERY OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS. Subject to Sections 540.0701 and 540.0753, the commission shall expand the STAR+PLUS Medicaid managed care program to all areas of this state to serve individuals eligible for Medicaid acute care services and long-term services and supports. (Gov. Code, Sec. 533.00251(b).)

Source Law

(b) Subject to Section 533.0025, the commission shall expand the STAR + PLUS Medicaid managed care program to all areas of this state to serve individuals eligible for acute care services and long-term services and supports under Medicaid.

Revisor's Note

Section 533.00251(b), Government Code, refers to the expansion of the STAR+PLUS Medicaid managed care program, "[s]ubject to Section 533.0025," Government Code. The relevant provisions of Section 533.0025 requiring delivering Medicaid services through the most cost-effective model of managed care are revised in this chapter as Sections 540.0701 and 540.0753. The revised law is drafted accordingly.

Revised Law

Sec. 540.0752. DELIVERY OF MEDICAID BENEFITS TO NURSING FACILITY RESIDENTS. (a) In this section:

(1) "Clean claim" means a claim that meets the same criteria the commission uses for a clean claim in reimbursing nursing facility claims.

(2) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to recipients.

(b) Subject to Section 540.0701 and notwithstanding any other law, the commission shall provide Medicaid benefits through the STAR+PLUS Medicaid managed care program to recipients who reside in nursing facilities. In implementing this subsection, the commission shall ensure that:

(1) a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;

(2) services are used appropriately, consistent with criteria the commission establishes;

(3) the incidence of potentially preventable events and unnecessary institutionalizations is reduced;

(4) a Medicaid managed care organization providing services under the program:

(A) provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(B) assists in collecting applied income from recipients; and

(C) provides payment incentives to nursing facility providers that:

(i) reward reductions in preventable acute care costs; and

(ii) encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(5) a portal is established that complies with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the program may submit claims to any participating Medicaid managed care organization;

(6) rules and procedures relating to certifying and decertifying nursing facility beds under Medicaid are not affected;

(7) a Medicaid managed care organization providing services under the program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(8) the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the program.

(c) The commission shall establish credentialing and minimum performance standards for nursing facility providers

seeking to participate in the STAR+PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A Medicaid managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards the commission establishes under this section.

(d) In addition to the minimum performance standards the commission establishes for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program, the executive commissioner shall adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards and requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

(e) A managed care organization may not require prior authorization for a nursing facility resident in need of emergency hospital services. (Gov. Code, Secs. 533.00251(a)(2), (3), (c) as eff. Sept. 1, 2023, (e), (f), (h).)

Source Law

> Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS, INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this section and Sections 533.002515 and 533.00252:
>
> (2) "Clean claim" means a claim that meets the same criteria for a clean claim used by the Department of Aging and Disability Services for the reimbursement of nursing facility claims.
>
> (3) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to recipients.
>
> (c) [as effective on September 1, 2023] Subject to Section 533.0025 and notwithstanding any other law, the commission shall provide benefits under Medicaid to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. In implementing this subsection, the commission shall ensure:

(1) that a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;

(2) the appropriate utilization of services consistent with criteria established by the commission;

(3) a reduction in the incidence of potentially preventable events and unnecessary institutionalizations;

(4) that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(5) that a managed care organization providing services under the managed care program:

(A) assists in collecting applied income from recipients; and

(B) provides payment incentives to nursing facility providers that reward reductions in preventable acute care costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(6) the establishment of a portal that is in compliance with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization;

(7) that rules and procedures relating to the certification and decertification of nursing facility beds under Medicaid are not affected;

(8) that a managed care organization providing services under the managed care program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(9) that the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the managed care program.

(e) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by the commission under this section.

(f) A managed care organization may not require prior authorization for a nursing facility resident in need of emergency hospital services.

(h) In addition to the minimum performance standards the commission establishes for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program, the executive commissioner shall adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards and

requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

Revisor's Note

(1) Section 533.00251(a), Government Code, provides definitions applicable to Sections 533.00251, 533.002515, and 533.00252, Government Code. The revised law omits the reference to Section 533.002515, Government Code, because that section expired by its own terms September 1, 2015. The revised law also omits the reference to Section 533.00252, Government Code, because that section was repealed by Chapters 837 (S.B. 200) and 946 (S.B. 277), Acts of the 84th Legislature, Regular Session, 2015, effective January 1, 2016.

(2) Section 533.00251(a)(2), Government Code, refers to the Department of Aging and Disability Services. The Department of Aging and Disability Services was abolished September 1, 2017, in accordance with Section 531.0202(b), Government Code, which is executed law that expires September 1, 2023. The powers and duties of that department were transferred to the Health and Human Services Commission. Section 531.0011, Government Code, revised in this subtitle as Section 521.0002, provides that a reference to the department means the commission or the appropriate division of the commission. Because the department no longer exists and the commission has assumed the powers and duties of the department, the revised law substitutes "commission" for "Department of Aging and Disability Services."

(3) Section 533.00251(c), Government Code, requires the Health and Human Services Commission to

provide Medicaid benefits to nursing facility residents through the STAR+PLUS Medicaid managed care program, "[s]ubject to Section 533.0025," Government Code. The relevant provision of Section 533.0025 requiring delivering Medicaid services through the most cost-effective model of managed care is revised in this chapter as Section 540.0701. The revised law is drafted accordingly.

Revised Law

Sec. 540.0753. DELIVERY OF BASIC ATTENDANT AND HABILITATION SERVICES. Subject to Section 542.0152, the commission shall:

(1) implement the option for the delivery of basic attendant and habilitation services to individuals with disabilities under the STAR+PLUS Medicaid managed care program that:

(A) is the most cost-effective; and

(B) maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR+PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss a personal attendant providing basic attendant and habilitation services under the program. (Gov. Code, Sec. 533.0025(i).)

Source Law

(i) Subject to Section 534.152, the commission shall:

(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with disabilities under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.

Revised Law

Sec. 540.0754. EVALUATION OF CERTAIN PROGRAM SERVICES. The external quality review organization shall periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to recipients who are:

(1) enrolled in the STAR+PLUS Medicaid managed care program; and

(2) eligible to receive health care benefits under both Medicaid and the Medicare program. (Gov. Code, Sec. 533.0028.)

Source Law

> Sec. 533.0028. EVALUATION OF CERTAIN STAR + PLUS MEDICAID MANAGED CARE PROGRAM SERVICES. The external quality review organization shall periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to enrollees in the STAR + PLUS Medicaid managed care program who are eligible to receive health care benefits under both Medicaid and the Medicare program.

Revised Law

Sec. 540.0755. UTILIZATION REVIEW; ANNUAL REPORT. (a) The commission's office of contract management shall establish an annual utilization review process for Medicaid managed care organizations participating in the STAR+PLUS Medicaid managed care program. The commission shall determine the topics to be examined in the review process. The review process must include a thorough investigation of each Medicaid managed care organization's procedures for determining whether a recipient should be enrolled in the STAR+PLUS home and community-based services (HCBS) waiver program, including the conduct of functional assessments for that purpose and records relating to those assessments.

(b) The office of contract management shall use the utilization review process to review each fiscal year:

(1) every Medicaid managed care organization participating in the STAR+PLUS Medicaid managed care program; or

(2) only the Medicaid managed care organizations that, using a risk-based assessment process, the office determines have a higher likelihood of inappropriate recipient placement in the

STAR+PLUS home and community-based services (HCBS) waiver program.

(c) Not later than December 1 of each year and in conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over Medicaid. The report must:

(1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year;

(2) provide analysis of errors committed by each reviewed Medicaid managed care organization; and

(3) extrapolate those findings and make recommendations for improving the STAR+PLUS Medicaid managed care program's efficiency.

(d) If a utilization review conducted under this section results in a determination to recoup money from a Medicaid managed care organization, a service provider who contracts with the organization may not be held liable for providing services in good faith based on the organization's authorization. (Gov. Code, Sec. 533.00281.)

Source Law

Sec. 533.00281. UTILIZATION REVIEW FOR STAR + PLUS MEDICAID MANAGED CARE ORGANIZATIONS. (a) The commission's office of contract management shall establish an annual utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. The commission shall determine the topics to be examined in the review process, except that the review process must include a thorough investigation of each managed care organization's procedures for determining whether a recipient should be enrolled in the STAR + PLUS home and community-based services and supports (HCBS) program, including the conduct of functional assessments for that purpose and records relating to those assessments.

(b) The office of contract management shall use the utilization review process to review each fiscal year:

(1) every managed care organization participating in the STAR + PLUS Medicaid managed care program; or

(2) only the managed care organizations that, using a risk-based assessment process, the office determines have a higher likelihood of inappropriate client placement in the STAR + PLUS home and community-based services and supports (HCBS) program.

(d) In conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over Medicaid not later than December 1 of each year. The report must:

(1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year;

(2) provide analysis of errors committed by each reviewed managed care organization; and

(3) extrapolate those findings and make recommendations for improving the efficiency of the program.

(e) If a utilization review conducted under this section results in a determination to recoup money from a managed care organization, a service provider who contracts with the managed care organization may not be held liable for the good faith provision of services based on an authorization from the managed care organization.

Revisor's Note

(1) Sections 533.00281(a) and (b), Government Code, refer to the "home and community-based services and supports (HCBS) program." The revised law substitutes "home and community-based services (HCBS) waiver program" for the quoted language for consistency in terminology used throughout this chapter and because the terms are synonymous and the latter is more commonly used.

(2) Section 533.00281(b)(2), Government Code, refers to "client" placement in the STAR+PLUS home and community-based services and supports (HCBS) program. The revised law substitutes the term "recipient" for "client" for the reason stated in Revisor's Note (2) to Section 540.0054 of this chapter.

(3) Section 533.00281(d)(3), Government Code, requires the Health and Human Services Commission to prepare a report that includes recommendations on improving the efficiency of "the program." It is clear from the context of other portions of Section 533.00281 that "the program" to which Section 533.00281(d)(3) refers is the STAR+PLUS Medicaid managed care program. Therefore, the revised law

substitutes "STAR+PLUS Medicaid managed care program" for "program" for clarity and the convenience of the reader.

SUBCHAPTER Q. DELIVERY OF SERVICES: STAR HEALTH PROGRAM

Revised Law

Sec. 540.0801. TRAUMA-INFORMED CARE TRAINING. (a) A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require that trauma-informed care training be offered to each contracted physician or provider.

(b) The commission shall encourage each Medicaid managed care organization providing health care services to recipients under the STAR Health program to make training in post-traumatic stress disorder and attention-deficit/hyperactivity disorder available to a contracted physician or provider within a reasonable time after the date the physician or provider begins providing services under the Medicaid managed care plan the organization offers. (Gov. Code, Sec. 533.0052.)

Source Law

> Sec. 533.0052. STAR HEALTH PROGRAM: TRAUMA-INFORMED CARE TRAINING. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must include a requirement that trauma-informed care training be offered to each contracted physician or provider.
>
> (b) The commission shall encourage each managed care organization providing health care services to recipients under the STAR Health program to make training in post-traumatic stress disorder and attention-deficit/hyperactivity disorder available to a contracted physician or provider within a reasonable time after the date the physician or provider begins providing services under the managed care plan.

Revised Law

Sec. 540.0802. MENTAL HEALTH PROVIDERS. A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require the organization to ensure that the organization maintains a network of mental and behavioral health providers, including child psychiatrists and

other appropriate providers, in all Department of Family and Protective Services regions in this state, regardless of whether community-based care has been implemented in any region. (Gov. Code, Sec. 533.00522.)

Source Law

> Sec. 533.00522. STAR HEALTH PROGRAM: MENTAL HEALTH PROVIDERS. A contract between a Medicaid managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must require the organization to ensure the organization maintains a network of mental and behavioral health providers, including child psychiatrists and other appropriate providers, in all Department of Family and Protective Services regions in this state, regardless of whether community-based care has been implemented in any region.

Revised Law

Sec. 540.0803. HEALTH SCREENING REQUIREMENTS AND COMPLIANCE WITH TEXAS HEALTH STEPS. (a) A Medicaid managed care organization providing health care services to a recipient under the STAR Health program must ensure that the recipient receives a complete early and periodic screening, diagnosis, and treatment checkup in accordance with the requirements specified in the managed care contract between the organization and the commission.

(b) The commission shall encourage each Medicaid managed care organization providing health care services to a recipient under the STAR Health program to ensure that the organization's network providers comply with the regimen of care prescribed by the Texas Health Steps program under Section 32.056, Human Resources Code, if applicable, including the requirement to provide a mental health screening during each of the recipient's Texas Health Steps medical exams a network provider conducts.

(c) The commission shall include a provision in a STAR Health program managed care contract between a Medicaid managed care organization and the commission specifying progressive monetary penalties for the organization's failure to comply with Subsection (a). (Gov. Code, Secs. 533.0053, 533.0054.)

Source Law

Sec. 533.0053. COMPLIANCE WITH TEXAS HEALTH STEPS. The commission shall encourage each managed care organization providing health care services to a recipient under the STAR Health program to ensure that the organization's network providers comply with the regimen of care prescribed by the Texas Health Steps program under Section 32.056, Human Resources Code, if applicable, including the requirement to provide a mental health screening during each of the recipient's Texas Health Steps medical exams conducted by a network provider.

Sec. 533.0054. HEALTH SCREENING REQUIREMENTS FOR ENROLLEE UNDER STAR HEALTH PROGRAM. (a) A managed care organization that contracts with the commission to provide health care services to recipients under the STAR Health program must ensure that enrollees receive a complete early and periodic screening, diagnosis, and treatment checkup in accordance with the requirements specified in the contract between the managed care organization and the commission.

(b) The commission shall include a provision in a contract with a managed care organization to provide health care services to recipients under the STAR Health program specifying progressive monetary penalties for the organization's failure to comply with Subsection (a).

Revised Law

Sec. 540.0804. HEALTH CARE AND OTHER SERVICES FOR CHILDREN IN SUBSTITUTE CARE. (a) The commission shall annually evaluate the use of benefits offered to children in foster care under the STAR Health program and provide recommendations to the Department of Family and Protective Services and each single source continuum contractor in this state to better coordinate the provision of health care and use of those benefits for those children.

(b) In conducting the evaluation, the commission shall:

(1) collaborate with residential child-care providers regarding any unmet needs of children in foster care and the development of capacity for providing quality medical, behavioral health, and other services for those children; and

(2) identify options to obtain federal matching funds under Medicaid to pay for a safe home-like or community-based residential setting for a child in the conservatorship of the Department of Family and Protective Services:

(A) who is identified or diagnosed as having a serious behavioral or mental health condition that requires

intensive treatment;

(B) who is identified as a victim of serious abuse or serious neglect;

(C) for whom a traditional substitute care placement contracted for or purchased by the department is not available or would further denigrate the child's behavioral or mental health condition; or

(D) for whom the department determines a safe home-like or community-based residential placement could stabilize the child's behavioral or mental health condition in order to return the child to a traditional substitute care placement.

(c) The commission shall report the commission's findings to the standing committees of the senate and house of representatives having jurisdiction over the Department of Family and Protective Services. (Gov. Code, Sec. 533.00521.)

Source Law

Sec. 533.00521. STAR HEALTH PROGRAM: HEALTH CARE FOR FOSTER CHILDREN. (a) The commission shall annually evaluate the use of benefits under the Medicaid program in the STAR Health program offered to children in foster care and provide recommendations to the Department of Family and Protective Services and each single source continuum contractor in this state to better coordinate the provision of health care and use of those benefits for children in foster care.

(b) In conducting the evaluation required under Subsection (a), the commission shall:

(1) collaborate with residential child-care providers regarding any unmet needs of children in foster care and the development of capacity for providing quality medical, behavioral health, and other services for children in foster care; and

(2) identify options to obtain federal matching funds under the Medical Assistance Program to pay for a safe home-like or community-based residential setting for a child in the conservatorship of the Department of Family and Protective Services:

(A) who is identified or diagnosed as having a serious behavioral or mental health condition that requires intensive treatment;

(B) who is identified as a victim of serious abuse or serious neglect;

(C) for whom a traditional substitute care placement contracted for or purchased by the department is not available or would further denigrate the child's behavioral or mental health condition; or

(D) for whom the department determines a safe home-like or community-based residential placement could stabilize the child's behavioral or mental health condition in order to

return the child to a traditional substitute care placement.

(c) The commission shall report its findings to the standing committees of the senate and house of representatives having jurisdiction over the Department of Family and Protective Services.

Revisor's Note

Section 533.00521(b)(2), Government Code, refers to "the Medical Assistance Program," which is another term for Medicaid. The revised law substitutes "Medicaid" for the quoted language for consistency of terminology throughout this chapter.

Revised Law

Sec. 540.0805. PLACEMENT CHANGE NOTICE AND CARE COORDINATION. A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require the organization to ensure continuity of care for a child whose placement has changed by:

(1) notifying each specialist treating the child of the placement change; and

(2) coordinating the transition of care from the child's previous treating primary care physician and specialists to the child's new treating primary care physician and specialists, if any. (Gov. Code, Sec. 533.0056.)

Source Law

Sec. 533.0056. STAR HEALTH PROGRAM: NOTIFICATION OF PLACEMENT CHANGE. A contract between a managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must require the organization to ensure continuity of care for a child whose placement has changed by:

(1) notifying each specialist treating the child of the placement change; and

(2) coordinating the transition of care from the child's previous treating primary care physician and treating specialists to the child's new treating primary care physician and treating specialists, if any.

Revised Law

Sec. 540.0806. MEDICAID BENEFITS FOR CERTAIN CHILDREN FORMERLY IN FOSTER CARE. (a) This section applies only with respect to a child who:

(1) resides in this state; and

(2) is eligible for assistance or services under:

(A) Subchapter D, Chapter 162, Family Code; or

(B) Subchapter K, Chapter 264, Family Code.

(b) Except as provided by Subsection (c), the commission shall ensure that each child to whom this section applies remains or is enrolled in the STAR Health program until the child is enrolled in another Medicaid managed care program.

(c) A child to whom this section applies who received Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) or was receiving Supplemental Security Income before becoming eligible for assistance or services under Subchapter D, Chapter 162, Family Code, or Subchapter K, Chapter 264, Family Code, may receive Medicaid benefits in accordance with the program established under this subsection. To the extent allowed by federal law, the commission, in consultation with the Department of Family and Protective Services, shall develop and implement a program that allows the adoptive parent or permanent managing conservator of a child described by this subsection to elect on behalf of the child to receive or continue receiving Medicaid benefits under the:

(1) STAR Health program; or

(2) STAR Kids managed care program.

(d) The commission shall protect the continuity of care for each child to whom this section applies and ensure coordination between the STAR Health program and any other Medicaid managed care program for each child who is transitioning between Medicaid managed care programs.

(e) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 533.00531.)

Source Law

Sec. 533.00531. MEDICAID BENEFITS FOR CERTAIN CHILDREN FORMERLY IN FOSTER CARE. (a) This section applies only with respect to a child who:

(1) resides in this state; and

(2) is eligible for assistance or services under:

(A) Subchapter D, Chapter 162, Family

Code; or

(B) Subchapter K, Chapter 264, Family Code.

(b) Except as provided by Subsection (c), the commission shall ensure that each child described by Subsection (a) remains or is enrolled in the STAR Health program unless or until the child is enrolled in another Medicaid managed care program.

(c) If a child described by Subsection (a) received Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) or was receiving Supplemental Security Income before becoming eligible for assistance or services under Subchapter D, Chapter 162, Family Code, or Subchapter K, Chapter 264, Family Code, as applicable, the child may receive Medicaid benefits in accordance with the program established under this subsection. To the extent permitted by federal law, the commission, in consultation with the Department of Family and Protective Services, shall develop and implement a program that allows the adoptive parent or permanent managing conservator of a child described by this subsection to elect on behalf of the child to receive or, if applicable, continue receiving Medicaid benefits under the:

(1) STAR Health program; or

(2) STAR Kids managed care program.

(d) The commission shall protect the continuity of care for each child described under this section and, if applicable, ensure coordination between the STAR Health program and any other Medicaid managed care program for each child who is transitioning between Medicaid managed care programs.

(e) The executive commissioner shall adopt rules necessary to implement this section.

SUBCHAPTER R. DELIVERY OF SERVICES: STAR KIDS MANAGED CARE PROGRAM

Revised Law

Sec. 540.0851. STAR KIDS MANAGED CARE PROGRAM. (a) In this section, "health home" means a primary care provider practice or specialty care provider practice that incorporates several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid.

(b) Subject to Sections 540.0701 and 540.0753, the commission shall establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. The program must:

(1) provide Medicaid benefits customized to meet the health care needs of program recipients through a defined system of care;

(2) better coordinate recipient care under the

program;

(3) improve recipient:

(A) access to health care services; and

(B) health outcomes;

(4) achieve cost containment and cost efficiency;

(5) reduce:

(A) the administrative complexity of delivering Medicaid benefits; and

(B) the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(6) require a health home; and

(7) for recipients who receive long-term services and supports outside of the Medicaid managed care organization, coordinate and collaborate with long-term care service providers and long-term care management providers. (Gov. Code, Secs. 533.00253(a)(2), (b).)

Source Law

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(2) "Health home" means a primary care provider practice, or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid.

(b) Subject to Section 533.0025, the commission shall, in consultation with the Children's Policy Council established under Section 22.035, Human Resources Code, establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. The managed care program developed under this section must:

(1) provide Medicaid benefits that are customized to meet the health care needs of recipients under the program through a defined system of care;

(2) better coordinate care of recipients under the program;

(3) improve the health outcomes of recipients;

(4) improve recipients' access to health care services;

(5) achieve cost containment and cost efficiency;

(6) reduce the administrative complexity of delivering Medicaid benefits;

(7) reduce the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(8) require a health home; and

(9) coordinate and collaborate with long-term care service providers and long-term care management providers, if recipients are receiving long-term services and supports outside of the managed care organization.

Revisor's Note

(1) Section 533.00253(b), Government Code, requires the Health and Human Services Commission to establish a mandatory STAR Kids capitated managed care program, "[s]ubject to Section 533.0025," Government Code. The relevant provisions of Section 533.0025 requiring delivering Medicaid services through the most cost-effective model of Medicaid capitated managed care are revised in this chapter as Sections 540.0701 and 540.0753. The revised law is drafted accordingly.

(2) Section 533.00253(b), Government Code, refers to the Children's Policy Council established under former Section 22.035, Human Resources Code. Former Section 22.035(n), Human Resources Code, abolished the Children's Policy Council on September 1, 2017. Therefore, the revised law omits the reference to the Children's Policy Council.

Revised Law

Sec. 540.0852. CARE MANAGEMENT AND CARE NEEDS ASSESSMENT. (a) The commission may require that care management services made available as provided by Section 540.0851(b)(5)(B):

(1) incorporate best practices as the commission determines;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification

methodology that identifies recipients who have the greatest need for services;

(4) include a care needs assessment for a recipient;

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transitioning care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics the commission determines appropriate; and

(8) use innovations in providing services.

(b) To improve the care needs assessment tool used for a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission, in consultation and collaboration with the STAR Kids Managed Care Advisory Committee, shall consider changes that will:

(1) reduce the amount of time needed to complete the initial care needs assessment and a reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity. (Gov. Code, Secs. 533.00253(a)(1), (c), (c-1), (c-2).)

Source Law

(a) In this section:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee described by Section 533.00254.

(c) The commission may require that care management services made available as provided by Subsection (b)(7):

(1) incorporate best practices, as determined by the commission;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification methodology that identifies recipients who have the greatest need for services;

(4) provide a care needs assessment for a recipient;

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transition of care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics determined appropriate by the commission; and

(8) use innovations in the provision of services.

(c-1) To improve the care needs assessment tool used for purposes of a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission in consultation and collaboration with the advisory committee shall consider changes that will:

(1) reduce the amount of time needed to complete the care needs assessment initially and at reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c-2) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

Revisor's Note

Section 533.00253(a)(1), Government Code, defines "advisory committee" for purposes of Section 533.00253 to mean the STAR Kids Managed Care Advisory Committee described by Section 533.00254, Government Code. Because "advisory committee" is used only in

Section 533.00253(c-1), Government Code, the revised law omits the definition and substitutes the substance of the definition for the referenced advisory committee in that subsection. The revised law also omits the reference to Section 533.00254 for the reason stated in Revisor's Note (1) to Section 540.0552.

Revised Law

Sec. 540.0853. BENEFITS FOR CHILDREN IN MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM. The commission shall:

(1) provide Medicaid benefits through the STAR Kids managed care program to children receiving benefits under the medically dependent children (MDCP) waiver program; and

(2) ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this section. (Gov. Code, Sec. 533.00253(d).)

Source Law

(d) The commission shall provide Medicaid benefits through the STAR Kids managed care program established under this section to children who are receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this subsection.

Revised Law

Sec. 540.0854. BENEFITS TRANSITION FROM STAR KIDS TO STAR+PLUS MEDICAID MANAGED CARE PROGRAM. The commission shall ensure that there is a plan for transitioning the provision of Medicaid benefits to recipients 21 years of age or older from the STAR Kids managed care program to the STAR+PLUS Medicaid managed care program in a manner that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age. (Gov. Code, Sec. 533.00253(e).)

Source Law

(e) The commission shall ensure that there is a

plan for transitioning the provision of Medicaid benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age.

Revisor's Note

Section 533.00253(e), Government Code, refers to the "STAR Kids program." The revised law substitutes "STAR Kids managed care program" for consistency in the terminology used throughout the chapter and because the terms are synonymous and "STAR Kids managed care program" is more commonly used.

Revised Law

Sec. 540.0855. UTILIZATION REVIEW OF PRIOR AUTHORIZATIONS. At least once every two years, the commission shall conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care. (Gov. Code, Sec. 533.00253(n).)

Source Law

(n) The commission, at least once every two years, shall conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care.

Revisor's Note
(End of Chapter)

Section 533.083, Government Code, requires the Health and Human Services Commission, based on the results of a pilot program implemented under former Section 533.082, Government Code, which expired September 1, 2018, to identify appropriate incentive-based provider payment goals and outcome measures and require Medicaid managed care organizations to implement the payment goals and outcome measures not later than September 1, 2018. The

revised law omits that section as executed. The omitted law reads:

> Sec. 533.083. ASSESSMENT AND IMPLEMENTATION OF PILOT PROGRAM FINDINGS. Not later than September 1, 2018, and notwithstanding any other law, the commission shall:
>
> (1) based on the results of the pilot program, identify which types of incentive-based provider payment goals and outcome measures are most appropriate for statewide implementation and the services that can be provided using those goals and outcome measures; and
>
> (2) require that a managed care organization that has contracted with the commission to provide health care services to recipients implement the payment goals and outcome measures identified under Subdivision (1).

CHAPTER 540A. MEDICAID MANAGED TRANSPORTATION SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 540A.0001. DEFINITIONS . . . . . 535

SUBCHAPTER B. MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION DELIVERY MODEL

Sec. 540A.0051. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION ORGANIZATION . . . . . 540
Sec. 540A.0052. MINIMUM QUALITY AND EFFICIENCY MEASURES . . . . . 542
Sec. 540A.0053. MANAGED TRANSPORTATION ORGANIZATION: CONTRACT WITH MEDICAL TRANSPORTATION PROVIDER . . . . . 542
Sec. 540A.0054. MANAGED TRANSPORTATION ORGANIZATION: SUBCONTRACT WITH TRANSPORTATION NETWORK COMPANY . . . . . 543
Sec. 540A.0055. MANAGED TRANSPORTATION ORGANIZATION: VEHICLE FLEETS . . . . . 544
Sec. 540A.0056. PERIODIC SCREENING OF TRANSPORTATION NETWORK COMPANY OR MOTOR VEHICLE OPERATOR AUTHORIZED . . . . . 545

Sec. 540A.0057. ENROLLMENT AS MEDICAID PROVIDER BY CERTAIN MOTOR VEHICLE OPERATORS NOT REQUIRED . . . . . 546
Sec. 540A.0058. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS . . . . . 546
Sec. 540A.0059. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY . . . . . 547
SUBCHAPTER C. NONEMERGENCY TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION
Sec. 540A.0101. DELIVERY OF NONEMERGENCY TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION . . . . 547
Sec. 540A.0102. RULES FOR NONEMERGENCY TRANSPORTATION SERVICES . . . . . 549
Sec. 540A.0103. MEDICAID MANAGED CARE ORGANIZATION: SUBCONTRACT WITH TRANSPORTATION NETWORK COMPANY . . . . . 550
Sec. 540A.0104. PERIODIC SCREENING OF TRANSPORTATION NETWORK COMPANY OR MOTOR VEHICLE OPERATOR AUTHORIZED . . . . . 550
Sec. 540A.0105. ENROLLMENT AS MEDICAID PROVIDER BY CERTAIN MOTOR VEHICLE OPERATORS NOT REQUIRED . . . . . 551
Sec. 540A.0106. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS . . . . . 552
Sec. 540A.0107. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY . . . . . 552
SUBCHAPTER D. NONMEDICAL TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION
Sec. 540A.0151. DELIVERY OF NONMEDICAL TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION . . . . . 553
Sec. 540A.0152. RULES FOR NONMEDICAL TRANSPORTATION SERVICES . . . . . 555

Sec. 540A.0153. PERIODIC SCREENING OF TRANSPORTATION VENDOR OR MOTOR VEHICLE OPERATOR AUTHORIZED . . . . . 558
Sec. 540A.0154. ENROLLMENT AS MEDICAID PROVIDER BY, OR CREDENTIALING OF, MOTOR VEHICLE OPERATOR NOT REQUIRED . . . . . 559
Sec. 540A.0155. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS . . . . . 560
Sec. 540A.0156. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY . . . . . 561

CHAPTER 540A. MEDICAID MANAGED TRANSPORTATION SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 540A.0001. DEFINITIONS. In this chapter:

(1) Notwithstanding Section 521.0001(2), "commission" means the Health and Human Services Commission or an agency operating part of the Medicaid managed care program, as appropriate.

(2) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(3) "Managed transportation organization" means:

(A) a rural or urban transit district created under Chapter 458, Transportation Code;

(B) a public transportation provider as defined by Section 461.002, Transportation Code;

(C) a regional contracted broker as defined by Section 526.0351;

(D) a local private transportation provider the commission approves to provide Medicaid nonemergency medical transportation services; or

(E) any other entity the commission determines meets the requirements of Subchapter B.

(4) "Medical transportation program" has the meaning assigned by Section 526.0351.

(5) "Nonemergency transportation service" has the meaning assigned by Section 526.0351.

(6) "Nonmedical transportation service" means:

(A) curb-to-curb transportation to or from a medically necessary, nonemergency covered health care service in a standard passenger vehicle that is scheduled not more than 48 hours before the transportation occurs, that is provided to a recipient enrolled in a Medicaid managed care plan offered by a Medicaid managed care organization, and that the organization determines meets the level of care that is medically appropriate for the recipient, including transportation related to:

(i) discharging a recipient from a health care facility;

(ii) receiving urgent care; and

(iii) obtaining pharmacy services and prescription drugs; and

(B) any other transportation to or from a medically necessary, nonemergency covered health care service the commission considers appropriate to be provided by a transportation vendor, as determined by commission rule or policy.

(7) "Recipient" means a Medicaid recipient.

(8) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

(9) "Transportation vendor" means an entity, including a transportation network company, that contracts with a Medicaid managed care organization to provide nonmedical transportation services. (Gov. Code, Secs. 533.001(1), (5), (6),

533.00257(a)(1), (2), (2-a), 533.002571(a), 533.00258(a), 533.002581(a); New.)

Source Law

Sec. 533.001. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program, as appropriate.

(5) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(6) "Recipient" means a recipient of Medicaid.

Sec. 533.00257. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION ORGANIZATION. (a) In this section:

(1) "Managed transportation organization" means:

(A) a rural or urban transit district created under Chapter 458, Transportation Code;

(B) a public transportation provider defined by Section 461.002, Transportation Code;

(C) a regional contracted broker defined by Section 531.02414;

(D) a local private transportation provider approved by the commission to provide Medicaid nonemergency medical transportation services; or

(E) any other entity the commission determines meets the requirements of this section.

(2) "Medical transportation program" has the meaning assigned by Section 531.02414.

(2-a) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

Sec. 533.002571. DELIVERY OF NONEMERGENCY TRANSPORTATION SERVICES TO CERTAIN MEDICAID RECIPIENTS THROUGH MEDICAID MANAGED CARE ORGANIZATION. (a) In this section:

(1) "Nonemergency transportation service" has the meaning assigned by Section 531.02414.

(2) "Nonmedical transportation service" and "transportation network company" have the meanings assigned by Section 533.00258.

Sec. 533.00258. NONMEDICAL TRANSPORTATION SERVICES UNDER MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(1) "Nonmedical transportation service" means:

(A) curb-to-curb transportation to or from a medically necessary, nonemergency covered health care service in a standard passenger vehicle

that is scheduled not more than 48 hours before the transportation occurs, that is provided to a recipient enrolled in a managed care plan offered by a Medicaid managed care organization, and that the organization determines meets the level of care that is medically appropriate for the recipient, including transportation related to:

(i) discharge of a recipient from a health care facility;

(ii) receipt of urgent care; and

(iii) obtaining pharmacy services and prescription drugs; and

(B) any other transportation to or from a medically necessary, nonemergency covered health care service the commission considers appropriate to be provided by a transportation vendor, as determined by commission rule or policy.

(2) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

(3) "Transportation vendor" means an entity, including a transportation network company, that contracts with a Medicaid managed care organization to provide nonmedical transportation services.

Sec. 533.002581. DELIVERY OF NONMEDICAL TRANSPORTATION SERVICES UNDER MEDICAID MANAGED CARE PROGRAM. (a) In this section, "nonmedical transportation service" and "transportation vendor" have the meanings assigned by Section 533.00258.

Revisor's Note

(1) Section 533.001(1), Government Code, defines "commission" for purposes of Chapter 533, Government Code, as meaning the Health and Human Services Commission and certain other state agencies. That definition applies to the law revised in this chapter, which is derived from Chapter 533. Section 531.001(2), Government Code, which is revised as Section 521.0001(2) of this subtitle, defines "commission" for purposes of Subtitle I, Title 4, Government Code, to mean only the Health and Human Services Commission. The law revised in this chapter is derived from Subtitle I, and the definition provided by Section 531.001(2) would apply to this chapter in the absence of the definition provided by Section 533.001(1) that more specifically applies to the law revised in this chapter. The revised law defines "commission" to have the more expansive

meaning assigned by Section 533.001(1) for purposes of the law revised in this chapter and, for clarity and the convenience of the reader, adds that this definition is "[n]otwithstanding Section 521.0001(2)."

(2) Section 533.001(2), Government Code, defines "executive commissioner" for purposes of Chapter 533, Government Code. The law revised in this chapter is derived from Chapter 533, and the cited definition applies to the term as used in this chapter. However, the revised law omits the definition because the definition duplicates the definition for that term in Section 531.001, Government Code, which is revised in this subtitle as Section 521.0001 and applies to this subtitle, including to the law revised in this chapter. The omitted law reads:

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

(3) Sections 533.00257(a), 533.002571(a), 533.00258(a), and 533.002581(a), Government Code, provide definitions related to transportation services under the Medicaid managed care program that apply to the law in each respective section. The revised law applies the definitions to the entire chapter because each defined term is either not used in any provision other than a provision derived from the same source law section or, to the extent the term is used in other provisions, the source law definitions from which those provisions were derived define the term in a substantively identical manner.

(4) Section 533.00257(a)(1), Government Code, defines a "managed transportation organization" as, among other things, an "entity the commission determines meets the requirements of this section,"

meaning the substantive requirements of Section 533.00257, Government Code. The substantive requirements of that section are revised in this chapter as Subchapter B. The revised law is drafted accordingly.

(5) Section 533.00257(a)(3), Government Code, defines "transportation service area provider" for purposes of Section 533.00257, Government Code. That term was used only in Subsection (h) of Section 533.00257, but that subsection expired August 31, 2015, in accordance with former Subsection (k) of that section, which also expired August 31, 2015. The revised law omits the definition because the term is no longer used in the section. The omitted law reads:

> (3) "Transportation service area provider" means a for-profit or nonprofit entity or political subdivision of this state that provides demand response, curb-to-curb, nonemergency transportation under the medical transportation program.

SUBCHAPTER B. MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION DELIVERY MODEL

Revised Law

Sec. 540A.0051. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION ORGANIZATION. (a) The commission may provide medical transportation program services on a regional basis through a managed transportation delivery model using managed transportation organizations and providers, as appropriate, that:

(1) operate under a capitated rate system;

(2) assume financial responsibility under a full-risk model;

(3) operate a call center;

(4) use fixed routes when available and appropriate; and

(5) agree to provide data to the commission if the

commission determines that the data is required to receive federal matching funds.

(b) The commission shall procure managed transportation organizations under the medical transportation program through a competitive bidding process for each managed transportation region as determined by the commission.

(c) The commission may not delay providing medical transportation program services through a managed transportation delivery model in:

(1) a county with a population of 750,000 or more:

(A) in which all or part of a municipality with a population of one million or more is located; and

(B) that is located adjacent to a county with a population of two million or more; or

(2) a county with a population of at least 55,000 but not more than 65,000 that is located adjacent to a county with a population of at least 500,000 but not more than 1.5 million. (Gov. Code, Secs. 533.00257(b), (c), (j).)

Source Law

(b) The commission may provide medical transportation program services on a regional basis through a managed transportation delivery model using managed transportation organizations and providers, as appropriate, that:
(1) operate under a capitated rate system;
(2) assume financial responsibility under a full-risk model;
(3) operate a call center;
(4) use fixed routes when available and appropriate; and
(5) agree to provide data to the commission if the commission determines that the data is required to receive federal matching funds.
(c) The commission shall procure managed transportation organizations under the medical transportation program through a competitive bidding process for each managed transportation region as determined by the commission.

(j) Notwithstanding Subsection (i), the commission may not delay providing medical transportation program services through a managed transportation delivery model in:
(1) a county with a population of 750,000 or more:
(A) in which all or part of a municipality with a population of one million or more is located; and

(B) that is located adjacent to a county with a population of two million or more; or

(2) a county with a population of at least 55,000 but not more than 65,000 that is located adjacent to a county with a population of at least 500,000 but not more than 1.5 million.

Revisor's Note

Section 533.00257(j), Government Code, prohibits the Health and Human Services Commission from delaying the provision of medical transportation program services through a managed transportation delivery model in certain counties, "[n]otwithstanding Subsection (i)" of the same section. Section 533.00257(i), Government Code, was repealed by Chapter 1235 (H.B. 1576), Acts of the 86th Legislature, Regular Session, 2019, and the revised law therefore omits the quoted phrase.

Revised Law

Sec. 540A.0052. MINIMUM QUALITY AND EFFICIENCY MEASURES. Except as provided by Sections 540A.0054, 540A.0057, and 540A.0058, the commission shall require that managed transportation organizations and providers participating in the medical transportation program meet minimum quality and efficiency measures the commission determines. (Gov. Code, Sec. 533.00257(g).)

Source Law

(g) Except as provided by Subsections (k) and (m), the commission shall require that managed transportation organizations and providers participating in the medical transportation program meet minimum quality and efficiency measures as determined by the commission.

Revised Law

Sec. 540A.0053. MANAGED TRANSPORTATION ORGANIZATION: CONTRACT WITH MEDICAL TRANSPORTATION PROVIDER. Except as provided by Sections 540A.0054, 540A.0057, and 540A.0058, a managed transportation organization that participates in the medical transportation program must attempt to contract with medical transportation providers that:

(1) are significant traditional providers, as the executive commissioner defines by rule;

(2) meet the minimum quality and efficiency measures required under Section 540A.0052 and other requirements that the managed transportation organization may impose; and

(3) agree to accept the managed transportation organization's prevailing contract rate. (Gov. Code, Sec. 533.00257(d).)

Source Law

(d) Except as provided by Subsections (k) and (m), a managed transportation organization that participates in the medical transportation program must attempt to contract with medical transportation providers that:

(1) are considered significant traditional providers, as defined by rule by the executive commissioner;

(2) meet the minimum quality and efficiency measures required under Subsection (g) and other requirements that may be imposed by the managed transportation organization; and

(3) agree to accept the prevailing contract rate of the managed transportation organization.

Revised Law

Sec. 540A.0054. MANAGED TRANSPORTATION ORGANIZATION: SUBCONTRACT WITH TRANSPORTATION NETWORK COMPANY. A managed transportation organization may subcontract with a transportation network company to provide services under this subchapter. A rule or other requirement the executive commissioner adopts under this subchapter or Subchapter H, Chapter 526, does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. (Gov. Code, Sec. 533.00257(k) (part).)

Source Law

(k) A managed transportation organization may subcontract with a transportation network company to provide services under this section. A rule or other requirement adopted by the executive commissioner under this section or Section 531.02414 does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. . . .

Revisor's Note

(1) Section 533.00257(k), Government Code, refers to services provided and a rule or requirement adopted under "this section," meaning Section 533.00257, Government Code. The substantive provisions of Section 533.00257 relating to the provision of services and adoption of rules and requirements are revised as this subchapter. The revised law is drafted accordingly. Similar changes are made throughout this subchapter where the source law references services provided under Section 533.00257.

(2) Section 533.00257(k), Government Code, refers to a rule or requirement adopted under Section 531.02414, Government Code. The revised law substitutes "Subchapter H, Chapter 526" for "Section 531.02414" because Section 531.02414 is revised as part of Subchapter H, Chapter 526, Government Code. Although Section 531.0057, Government Code, is also revised as part of Subchapter H, Chapter 526, Section 531.0057 does not include any provision governing relevant rules or regulations.

Revised Law

Sec. 540A.0055. MANAGED TRANSPORTATION ORGANIZATION: VEHICLE FLEETS. (a) To the extent allowed under federal law, a managed transportation organization may own, operate, and maintain a fleet of vehicles or contract with an entity that owns, operates, and maintains a fleet of vehicles. The commission shall seek an appropriate federal waiver or other authorization to implement this subsection as necessary.

(b) The commission shall consider a managed transportation organization's ownership, operation, and maintenance of a fleet of vehicles to be a related-party transaction for purposes of applying experience rebates, administrative costs, and other administrative

controls the commission determines. (Gov. Code, Secs. 533.00257(e), (f).)

Source Law

(e) To the extent allowed under federal law, a managed transportation organization may own, operate, and maintain a fleet of vehicles or contract with an entity that owns, operates, and maintains a fleet of vehicles. The commission shall seek appropriate federal waivers or other authorizations to implement this subsection as necessary.

(f) The commission shall consider the ownership, operation, and maintenance of a fleet of vehicles by a managed transportation organization to be a related-party transaction for purposes of applying experience rebates, administrative costs, and other administrative controls determined by the commission.

Revised Law

Sec. 540A.0056. PERIODIC SCREENING OF TRANSPORTATION NETWORK COMPANY OR MOTOR VEHICLE OPERATOR AUTHORIZED. The commission or a managed transportation organization that subcontracts with a transportation network company under Section 540A.0054 may require the transportation network company or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and entities the Office of Inspector General of the United States Department of Health and Human Services maintains. (Gov. Code, Sec. 533.00257(l).)

Source Law

(l) The commission or a managed transportation organization that subcontracts with a transportation network company under Subsection (k) may require the transportation network company or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

Revisor's Note

Section 533.00257(l), Government Code, refers to a managed transportation organization that subcontracts with a transportation network company under Subsection (k), meaning Section 533.00257(k), Government Code. The portion of Section 533.00257(k)

that authorizes subcontracting with a transportation network company is revised in this chapter as Section 540A.0054. The revised law is drafted accordingly.

Revised Law

Sec. 540A.0057. ENROLLMENT AS MEDICAID PROVIDER BY CERTAIN MOTOR VEHICLE OPERATORS NOT REQUIRED. The commission or a managed transportation organization that subcontracts with a transportation network company under Section 540A.0054 may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this subchapter. (Gov. Code, Sec. 533.00257(k) (part).)

Source Law

> (k) [A managed transportation organization may subcontract with a transportation network company to provide services under this section.] . . . The commission or the managed transportation organization may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this section.

Revised Law

Sec. 540A.0058. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS. Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a managed transportation organization under Section 540A.0054 and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this subchapter. The commission and the managed transportation organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this subchapter. (Gov. Code, Sec. 533.00257(m).)

Source Law

> (m) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a managed transportation organization under Subsection (k) and who satisfies the driver requirements in Section 2402.107, Occupations Code, is

qualified to provide services under this section. The commission and the managed transportation organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this section.

Revisor's Note

Section 533.00257(m), Government Code, refers to a transportation network company that subcontracts with a managed transportation organization under Subsection (k), meaning Section 533.00257(k), Government Code. The revised law substitutes a reference to Section 540A.0054 of this chapter for the reference to Subsection (k) for the reason stated in the revisor's note to Section 540A.0056 of this chapter.

Revised Law

Sec. 540A.0059. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY. For purposes of this subchapter and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides a service under this subchapter may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting a passenger using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code. (Gov. Code, Sec. 533.00257(n).)

Source Law

(n) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

SUBCHAPTER C. NONEMERGENCY TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION

Revised Law

Sec. 540A.0101. DELIVERY OF NONEMERGENCY TRANSPORTATION

SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION. (a) The commission shall require each Medicaid managed care organization to arrange and provide nonemergency transportation services to a recipient enrolled in a Medicaid managed care plan offered by the organization using the most cost-effective and cost-efficient method of delivery, including by delivering nonmedical transportation services through a transportation network company or other transportation vendor as provided by Section 540A.0151, if available and medically appropriate. The commission shall supervise the provision of the services.

(b) The commission may temporarily waive the applicability of Subsection (a) to a Medicaid managed care organization as necessary based on the results of a review conducted under Sections 540.0207 and 540.0209 and until enrollment of recipients in a Medicaid managed care plan offered by the organization is permitted under that section. (Gov. Code, Secs. 533.002571(b), (h).)

Source Law

> (b) The commission shall require each Medicaid managed care organization to arrange and provide nonemergency transportation services to a recipient enrolled in a managed care plan offered by the organization using the most cost-effective and cost-efficient method of delivery, including by delivering nonmedical transportation services through a transportation network company or other transportation vendor as provided by Section 533.002581, if available and medically appropriate. The commission shall supervise the provision of the services.
>
> (h) The commission may temporarily waive the applicability of Subsection (b) to a Medicaid managed care organization as necessary based on the results of a review conducted under Section 533.007 and until enrollment of recipients in a managed care plan offered by the organization is permitted under that section.

Revisor's Note

(1) Section 533.002571(b), Government Code, requires the Health and Human Services Commission to require each Medicaid managed care organization to deliver nonmedical transportation services through a transportation network company or "other

transportation vendor as provided by Section 533.002581," Government Code. The portion of Section 533.002581 relating to a Medicaid managed care organization delivering nonmedical transportation services through a transportation vendor is revised in this chapter as Section 540A.0151. The revised law is drafted accordingly.

(2) Section 533.002571(h), Government Code, refers to a review of a managed care organization conducted under Section 533.007, Government Code. The relevant provisions of Section 533.007 relating to a review of a managed care organization are revised in this subtitle as Sections 540.0207 and 540.0209, and the revised law is drafted accordingly.

Revised Law

Sec. 540A.0102. RULES FOR NONEMERGENCY TRANSPORTATION SERVICES. Subject to Sections 540A.0103 and 540A.0105, the executive commissioner shall adopt rules as necessary to ensure the safe and efficient provision of nonemergency transportation services by a Medicaid managed care organization under this subchapter. (Gov. Code, Sec. 533.002571(c).)

Source Law

(c) Subject to Subsection (d), the executive commissioner shall adopt rules as necessary to ensure the safe and efficient provision of nonemergency transportation services by a Medicaid managed care organization under this section.

Revisor's Note

Section 533.002571(c), Government Code, refers to nonemergency transportation services provided by a Medicaid managed care organization under "this section," meaning Section 533.002571, Government Code. The substantive provisions of Section 533.002571 relating to the provision of those services by a Medicaid managed care organization are revised as this subchapter. The revised law is drafted

accordingly. Similar changes are made throughout this subchapter where the source law references services provided under Section 533.002571.

Revised Law

Sec. 540A.0103. MEDICAID MANAGED CARE ORGANIZATION: SUBCONTRACT WITH TRANSPORTATION NETWORK COMPANY. A Medicaid managed care organization may subcontract with a transportation network company to provide nonemergency transportation services under this subchapter. A rule or other requirement the executive commissioner adopts under Section 540A.0102 or Subchapter H, Chapter 526, does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. (Gov. Code, Sec. 533.002571(d) (part).)

Source Law

> (d) A Medicaid managed care organization may subcontract with a transportation network company to provide nonemergency transportation services under this section. A rule or other requirement adopted by the executive commissioner under Subsection (c) or Section 531.02414 does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. . . .

Revisor's Note

Section 533.002571(d), Government Code, refers to a rule or requirement adopted under Section 531.02414, Government Code. The revised law substitutes "Subchapter H, Chapter 526" for "Section 531.02414" for the reason stated in Revisor's Note (2) to Section 540A.0054.

Revised Law

Sec. 540A.0104. PERIODIC SCREENING OF TRANSPORTATION NETWORK COMPANY OR MOTOR VEHICLE OPERATOR AUTHORIZED. The commission or a Medicaid managed care organization that subcontracts with a transportation network company under Section 540A.0103 may require the transportation network company or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and

entities the Office of Inspector General of the United States Department of Health and Human Services maintains. (Gov. Code, Sec. 533.002571(e).)

Source Law

> (e) The commission or a Medicaid managed care organization that subcontracts with a transportation network company under Subsection (d) may require the transportation network company or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

Revisor's Note

Section 533.002571(e), Government Code, refers to a Medicaid managed care organization that subcontracts with a transportation network company under Subsection (d), meaning Section 533.002571(d), Government Code. The portion of Section 533.002571(d) that authorizes subcontracting with a transportation network company is revised in this chapter as Section 540A.0103. The revised law is drafted accordingly.

Revised Law

Sec. 540A.0105. ENROLLMENT AS MEDICAID PROVIDER BY CERTAIN MOTOR VEHICLE OPERATORS NOT REQUIRED. The commission or a Medicaid managed care organization that subcontracts with a transportation network company under Section 540A.0103 may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this subchapter. (Gov. Code, Sec. 533.002571(d) (part).)

Source Law

> (d) [A Medicaid managed care organization may subcontract with a transportation network company to provide nonemergency transportation services under this section.] . . . The commission or the Medicaid managed care organization may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this section.

Revised Law

Sec. 540A.0106. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS. Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a Medicaid managed care organization under Section 540A.0103 and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this subchapter. The commission and the Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this subchapter. (Gov. Code, Sec. 533.002571(f).)

Source Law

> (f) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a Medicaid managed care organization under Subsection (d) and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this section. The commission and the Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this section.

Revisor's Note

Section 533.002571(f), Government Code, refers to a transportation network company that subcontracts with a Medicaid managed care organization under Subsection (d), meaning Section 533.002571(d), Government Code. The revised law substitutes a reference to Section 540A.0103 of this chapter for the reference to Subsection (d) for the reason stated in the revisor's note to Section 540A.0104 of this chapter.

Revised Law

Sec. 540A.0107. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY. For purposes of this subchapter and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle

operator who provides a service under this subchapter may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting a passenger using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code. (Gov. Code, Sec. 533.002571(g).)

Source Law

> (g) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

SUBCHAPTER D. NONMEDICAL TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION

Revised Law

Sec. 540A.0151. DELIVERY OF NONMEDICAL TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION. (a) The commission shall require each Medicaid managed care organization to arrange for the provision of nonmedical transportation services to a recipient enrolled in a Medicaid managed care plan offered by the organization.

(b) A Medicaid managed care organization may contract with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services. If a Medicaid managed care organization contracts with a third party that is not a transportation vendor to arrange for the provision of nonmedical transportation services, the third party shall contract with a transportation vendor to deliver the nonmedical transportation services.

(c) A Medicaid managed care organization that contracts with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services shall ensure the effective sharing and integration of service coordination, service authorization, and utilization management data between the managed

care organization and the transportation vendor or third party.

(d) The commission may waive the applicability of Subsection (a) to a Medicaid managed care organization for not more than three months as necessary based on the results of a review conducted under Sections 540.0207 and 540.0209 and until enrollment of recipients in a Medicaid managed care plan offered by the organization is permitted under that section. (Gov. Code, Secs. 533.002581(c), (d), (e), (h).)

Source Law

(c) Beginning not later than September 1, 2020, the commission shall require each Medicaid managed care organization to arrange for the provision of nonmedical transportation services to recipients enrolled in a managed care plan offered by the organization.

(d) A Medicaid managed care organization may contract with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services. If a Medicaid managed care organization contracts with a third party that is not a transportation vendor to arrange for the provision of nonmedical transportation services, the third party shall contract with a transportation vendor to deliver the nonmedical transportation services.

(e) A Medicaid managed care organization that contracts with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services shall ensure the effective sharing and integration of service coordination, service authorization, and utilization management data between the managed care organization and the transportation vendor or third party.

(h) The commission may waive the applicability of Subsection (c) to a Medicaid managed care organization for not more than three months as necessary based on the results of a review conducted under Section 533.007 and until enrollment of recipients in a managed care plan offered by the organization is permitted under that section.

Revisor's Note

(1) Section 533.002581(c), Government Code, directs the Health and Human Services Commission, "[b]eginning not later than September 1, 2020," to require each Medicaid managed care organization to carry out certain duties. The revised law omits the quoted language as executed.

(2) Section 533.002581(h), Government Code, refers to a review of a managed care organization

conducted under Section 533.007, Government Code. The relevant provisions of Section 533.007 relating to a review of a managed care organization are revised in this subtitle as Sections 540.0207 and 540.0209, and the revised law is drafted accordingly.

Revised Law

Sec. 540A.0152. RULES FOR NONMEDICAL TRANSPORTATION SERVICES. (a) The executive commissioner shall adopt rules regarding the manner in which nonmedical transportation services may be arranged and provided.

(b) The rules must require a Medicaid managed care organization to create a process to:

(1) verify that a passenger is eligible to receive nonmedical transportation services;

(2) ensure that nonmedical transportation services are provided only to and from covered health care services in areas in which a transportation network company operates; and

(3) ensure the timely delivery of nonmedical transportation services to a recipient, including by setting reasonable service response goals.

(c) The rules must require a transportation vendor to, before permitting a motor vehicle operator to provide nonmedical transportation services:

(1) confirm that the operator:

(A) is at least 18 years of age;

(B) maintains a valid driver's license issued by this state, another state, or the District of Columbia; and

(C) possesses proof of registration and automobile financial responsibility for each motor vehicle to be used to provide nonmedical transportation services;

(2) conduct, or cause to be conducted, a local, state, and national criminal background check for the operator that includes the use of:

(A) a commercial multistate and

multijurisdiction criminal records locator or other similar commercial nationwide database; and

(B) the national sex offender public website the United States Department of Justice or a successor agency maintains;

(3) confirm that any vehicle to be used to provide nonmedical transportation services:

(A) meets the applicable requirements of Chapter 548, Transportation Code; and

(B) except as provided by Section 540A.0156, has at least four doors; and

(4) obtain and review the operator's driving record.

(d) The rules may not permit a motor vehicle operator to provide nonmedical transportation services if the operator:

(1) has been convicted in the three-year period preceding the issue date of the driving record obtained under Subsection (c)(4) of:

(A) more than three offenses the Department of Public Safety classifies as moving violations; or

(B) one or more of the following offenses:

(i) fleeing or attempting to elude a police officer under Section 545.421, Transportation Code;

(ii) reckless driving under Section 545.401, Transportation Code;

(iii) driving without a valid driver's license under Section 521.025, Transportation Code; or

(iv) driving with an invalid driver's license under Section 521.457, Transportation Code;

(2) has been convicted in the preceding seven-year period of any of the following:

(A) driving while intoxicated under Section 49.04 or 49.045, Penal Code;

(B) use of a motor vehicle to commit a felony;

(C) a felony crime involving property damage;

(D) fraud;

(E) theft;

(F) an act of violence; or

(G) an act of terrorism; or

(3) is found to be registered in the national sex offender public website the United States Department of Justice or a successor agency maintains. (Gov. Code, Secs. 533.00258(b), (c), (e), (f).)

Source Law

(b) The executive commissioner shall adopt rules regarding the manner in which nonmedical transportation services may be arranged and provided.

(c) The rules must require a Medicaid managed care organization to create a process to:

(1) verify that a passenger is eligible to receive nonmedical transportation services;

(2) ensure that nonmedical transportation services are provided only to and from covered health care services in areas in which a transportation network company operates; and

(3) ensure the timely delivery of nonmedical transportation services to a recipient, including by setting reasonable service response goals.

(e) The rules must require a transportation vendor to, before permitting a motor vehicle operator to provide nonmedical transportation services:

(1) confirm that the operator:

(A) is at least 18 years of age;

(B) maintains a valid driver's license issued by this state, another state, or the District of Columbia; and

(C) possesses proof of registration and automobile financial responsibility for each motor vehicle to be used to provide nonmedical transportation services;

(2) conduct, or cause to be conducted, a local, state, and national criminal background check for the operator that includes the use of:

(A) a commercial multistate and multijurisdiction criminal records locator or other similar commercial nationwide database; and

(B) the national sex offender public website maintained by the United States Department of Justice or a successor agency;

(3) confirm that any vehicle to be used to provide nonmedical transportation services:

(A) meets the applicable requirements of Chapter 548, Transportation Code; and

(B) except as provided by Subsection (j), has at least four doors; and

(4) obtain and review the operator's driving record.

(f) The rules may not permit a motor vehicle operator to provide nonmedical transportation services if the operator:

(1) has been convicted in the three-year

period preceding the issue date of the driving record obtained under Subsection (e)(4) of:

(A) more than three offenses classified by the Department of Public Safety as moving violations; or

(B) one or more of the following offenses:

(i) fleeing or attempting to elude a police officer under Section 545.421, Transportation Code;

(ii) reckless driving under Section 545.401, Transportation Code;

(iii) driving without a valid driver's license under Section 521.025, Transportation Code; or

(iv) driving with an invalid driver's license under Section 521.457, Transportation Code;

(2) has been convicted in the preceding seven-year period of any of the following:

(A) driving while intoxicated under Section 49.04 or 49.045, Penal Code;

(B) use of a motor vehicle to commit a felony;

(C) a felony crime involving property damage;

(D) fraud;

(E) theft;

(F) an act of violence; or

(G) an act of terrorism; or

(3) is found to be registered in the national sex offender public website maintained by the United States Department of Justice or a successor agency.

Revisor's Note

Section 533.00258(d), Government Code, prohibits certain rules the executive commissioner of the Health and Human Services Commission adopts from imposing penalties on certain Medicaid managed care organizations before September 1, 2020. The revised law omits that subsection as executed. The omitted law reads:

> (d) Before September 1, 2020, and subject to Section 533.002581(h), a rule adopted in accordance with Subsection (c)(3) may not impose a penalty on a Medicaid managed care organization that contracts with a transportation vendor under this section if the vendor is unable to provide nonmedical transportation services to a recipient after the Medicaid managed care organization has made a specific request for those services.

Revised Law

Sec. 540A.0153. PERIODIC SCREENING OF TRANSPORTATION VENDOR OR MOTOR VEHICLE OPERATOR AUTHORIZED. The commission or a

Medicaid managed care organization that contracts with a transportation vendor may require the transportation vendor or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and entities the Office of Inspector General of the United States Department of Health and Human Services maintains. (Gov. Code, Sec. 533.00258(h).)

Source Law

> (h) The commission or a Medicaid managed care organization that contracts with a transportation vendor may require the transportation vendor or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

Revisor's Note

Section 533.00258(h), Government Code, refers to the imposition of requirements on transportation vendors or motor vehicle operators who provide nonmedical transportation services under "this section," meaning Section 533.00258, Government Code. The substantive provisions of Section 533.00258 relating to the provision of nonmedical transportation services are revised in this subchapter. This subchapter also includes the revision of provisions derived from Section 533.002581, Government Code, which relates the same type of services. Because the entire subchapter relates to those services, the revised law substitutes a reference to the subchapter for the reference to Section 533.00258.

Revised Law

Sec. 540A.0154. ENROLLMENT AS MEDICAID PROVIDER BY, OR CREDENTIALING OF, MOTOR VEHICLE OPERATOR NOT REQUIRED. (a) The commission or a Medicaid managed care organization may not require a motor vehicle operator to enroll as a Medicaid provider to provide nonmedical transportation services.

(b) The commission may not require a Medicaid managed care organization to credential a motor vehicle operator to provide nonmedical transportation services, and the organization may not require the credentialing of a motor vehicle operator to provide those services. (Gov. Code, Secs. 533.00258(g), 533.002581(f).)

Source Law

[Sec. 533.00258]

(g) The commission may not require:

(1) a motor vehicle operator to enroll as a Medicaid provider to provide nonmedical transportation services; or

(2) a Medicaid managed care organization to credential a motor vehicle operator to provide nonmedical transportation services.

[Sec. 533.002581]

(f) A Medicaid managed care organization may not require:

(1) a motor vehicle operator to enroll as a Medicaid provider to provide nonmedical transportation services; or

(2) the credentialing of a motor vehicle operator to provide nonmedical transportation services.

Revised Law

Sec. 540A.0155. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS. Notwithstanding any other law, a motor vehicle operator who is part of a transportation network company's network and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide nonmedical transportation services. The commission and a Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide nonmedical transportation services. (Gov. Code, Sec. 533.00258(i).)

Source Law

(i) Notwithstanding any other law, a motor vehicle operator who is part of a transportation network company's network and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide nonmedical transportation services. The commission and a Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide nonmedical transportation services.

Revised Law

Sec. 540A.0156. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY. For purposes of this subchapter and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides a service under this subchapter may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting a passenger using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code. (Gov. Code, Secs. 533.00258(j), 533.002581(g).)

Source Law

[Sec. 533.00258]

(j) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

[Sec. 533.002581]

(g) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 542.0001. DEFINITIONS . . . . . 563

Sec. 542.0002. CONFLICT WITH OTHER LAW . . . . . 567

Sec. 542.0003. DELAYED IMPLEMENTATION AUTHORIZED . . . . . 567

SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM REDESIGN
Sec. 542.0051. REDESIGN OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY . . . . . 568
Sec. 542.0052. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE . . . . . 570
Sec. 542.0053. IMPLEMENTATION OF SYSTEM REDESIGN . . . . . 573
Sec. 542.0054. ANNUAL REPORT ON IMPLEMENTATION . . . . . 574
SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING SERVICE DELIVERY MODELS
Sec. 542.0101. DEFINITIONS . . . . . 576
Sec. 542.0102. PILOT PROGRAM TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION . . . . . 577
Sec. 542.0103. ALTERNATIVE PAYMENT RATE OR METHODOLOGY . . . 581
Sec. 542.0104. PILOT PROGRAM WORK GROUP . . . . . 583
Sec. 542.0105. STAKEHOLDER INPUT . . . . . 584
Sec. 542.0106. MEASURABLE GOALS . . . . . 584
Sec. 542.0107. MANAGED CARE ORGANIZATION SELECTION . . . . . 585
Sec. 542.0108. MANAGED CARE ORGANIZATION PARTICIPATION REQUIREMENTS . . . . . 586
Sec. 542.0109. REQUIRED BENEFITS . . . . . 587
Sec. 542.0110. PROVIDER PARTICIPATION . . . . . 591
Sec. 542.0111. CARE COORDINATION . . . . . 592
Sec. 542.0112. PERSON-CENTERED PLANNING . . . . . 593
Sec. 542.0113. USE OF INNOVATIVE TECHNOLOGY . . . . . 593
Sec. 542.0114. INFORMATIONAL MATERIALS . . . . . 596
Sec. 542.0115. IMPLEMENTATION, LOCATION, AND DURATION . . . 597
Sec. 542.0116. RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY . . . . . 598

Sec. 542.0117. PILOT PROGRAM INFORMATION COLLECTION AND ANALYSIS . . . . . 600
Sec. 542.0118. PILOT PROGRAM CONCLUSION; PUBLICATION OF CONTINUATION . . . . . 602
Sec. 542.0119. EVALUATIONS AND REPORTS . . . . . 603
Sec. 542.0120. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF CARE . . . . . 606
Sec. 542.0121. SERVICE TRANSITION REQUIREMENTS . . . . . 607
SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND CERTAIN OTHER SERVICES
Sec. 542.0151. DELIVERY OF ACUTE CARE SERVICES TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY . . . . . 609
Sec. 542.0152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR+PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM PROVIDERS . . . . . 611
SUBCHAPTER E. STAGE TWO: TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM
Sec. 542.0201. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM . . . . . 616
Sec. 542.0202. RECIPIENT CHOICE OF DELIVERY MODEL . . . . . 620
Sec. 542.0203. REQUIRED CONTRACT PROVISIONS . . . . . 621
Sec. 542.0204. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER . . . . . 623

CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 542.0001. DEFINITIONS. In this chapter:

(1) "Advisory committee" means the intellectual and developmental disability system redesign advisory committee established under Section 542.0052.

(2) "Basic attendant service" means a service provided to an individual to assist the individual with an activity of daily living, including an instrumental activity of daily living, because of a physical, cognitive, or behavioral limitation related to the individual's disability or chronic health condition.

(3) "Comprehensive long-term services and supports provider" means a provider of long-term services and supports under this chapter that ensures the coordinated, seamless delivery of the full range of services in a recipient's program plan. The term includes:

(A) an ICF-IID program provider; and

(B) a Medicaid waiver program provider.

(4) "Consumer direction model" has the meaning assigned by Section 546.0101.

(5) "Functional need" means the measurement of an individual's services and supports needs, including the individual's intellectual, psychiatric, medical, and physical support needs.

(6) "Habilitation service" includes a service provided to an individual to assist the individual with acquiring, retaining, or improving:

(A) a skill related to the activities of daily living; and

(B) the social and adaptive skills necessary for the individual to live and fully participate in the community.

(7) "ICF-IID" means the Medicaid program serving individuals with an intellectual or developmental disability who receive care in intermediate care facilities other than a state supported living center.

(8) "ICF-IID program" means a Medicaid program serving individuals with an intellectual or developmental disability who

reside in and receive care from:

(A) an intermediate care facility licensed under Chapter 252, Health and Safety Code; or

(B) a community-based intermediate care facility operated by a local intellectual and developmental disability authority.

(9) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(10) "Managed care organization" has the meaning assigned by Section 543A.0001.

(11) "Medicaid waiver program" means only the following programs that are authorized under Section 1915(c) of the Social Security Act (42 U.S.C. Section 1396n(c)) for the provision of services to individuals with an intellectual or developmental disability:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the home and community-based services (HCS) waiver program;

(C) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(12) "Potentially preventable event" has the meaning assigned by Section 543A.0001.

(13) "Residential service" means a service provided to an individual with an intellectual or developmental disability through a community-based ICF-IID, three- or four-person home or host home setting under the home and community-based services (HCS) waiver program, or a group home under the deaf-blind with multiple disabilities (DBMD) waiver program.

(14) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code. (Gov. Code, Sec. 534.001 (part).)

Source Law

Sec. 534.001. DEFINITIONS. In this chapter:

(1) "Advisory committee" means the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053.

(2) "Basic attendant services" means assistance with the activities of daily living, including instrumental activities of daily living, provided to an individual because of a physical, cognitive, or behavioral limitation related to the individual's disability or chronic health condition.

(3) "Comprehensive long-term services and supports provider" means a provider of long-term services and supports under this chapter that ensures the coordinated, seamless delivery of the full range of services in a recipient's program plan. The term includes:

(A) a provider under the ICF-IID program; and

(B) a provider under a Medicaid waiver program.

(3-a) "Consumer direction model" has the meaning assigned by Section 531.051.

(4) "Functional need" means the measurement of an individual's services and supports needs, including the individual's intellectual, psychiatric, medical, and physical support needs.

(5) "Habilitation services" includes assistance provided to an individual with acquiring, retaining, or improving:

(A) skills related to the activities of daily living; and

(B) the social and adaptive skills necessary to enable the individual to live and fully participate in the community.

(6) "ICF-IID" means the program under Medicaid serving individuals with an intellectual or developmental disability who receive care in intermediate care facilities other than a state supported living center.

(7) "ICF-IID program" means a program under Medicaid serving individuals with an intellectual or developmental disability who reside in and receive care from:

(A) intermediate care facilities licensed under Chapter 252, Health and Safety Code; or

(B) community-based intermediate care facilities operated by local intellectual and developmental disability authorities.

(8) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(9) "Managed care organization," . . . and "potentially preventable event" have the meanings assigned under Section 536.001.

(11) "Medicaid waiver program" means only the following programs that are authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for the provision of services to persons with an intellectual or developmental disability:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the home and community-based services (HCS) waiver program;

(C) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(11-a) "Residential services" means services provided to an individual with an intellectual or developmental disability through a community-based ICF-IID, three- or four-person home or host home setting under the home and community-based services (HCS) waiver program, or a group home under the deaf-blind with multiple disabilities (DBMD) waiver program.

(12) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

Revisor's Note

Section 534.001(9), Government Code, defines "managed care plan" for purposes of Chapter 534, Government Code, which is revised as this chapter. The revised law omits the definition as unnecessary because the term is not used elsewhere in Chapter 534. The omitted law reads:

(9) ["Managed care organization,"] "managed care plan," [and potentially preventable event" have the meanings assigned under Section 536.001.]

Revised Law

Sec. 542.0002. CONFLICT WITH OTHER LAW. To the extent of a conflict between a provision of this chapter and another state law, the provision of this chapter controls. (Gov. Code, Sec. 534.002.)

Source Law

Sec. 534.002. CONFLICT WITH OTHER LAW. To the extent of a conflict between a provision of this chapter and another state law, the provision of this chapter controls.

Revised Law

Sec. 542.0003. DELAYED IMPLEMENTATION AUTHORIZED. Notwithstanding any other law, the commission may delay implementing a provision of this chapter without additional investigation, adjustment, or legislative action if the commission determines implementing the provision would adversely affect the system of services and supports to persons and programs to which this chapter applies. (Gov. Code, Sec. 534.251.)

Source Law

Sec. 534.251. DELAYED IMPLEMENTATION AUTHORIZED. Notwithstanding any other law, the commission may delay implementation of a provision of this chapter without further investigation, adjustments, or legislative action if the commission determines the provision adversely affects the system of services and supports to persons and programs to which this chapter applies.

SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM REDESIGN

Revised Law

Sec. 542.0051. REDESIGN OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. The commission shall design and implement an acute care services and long-term services and supports system for individuals with an intellectual or developmental disability that supports the following goals:

(1) provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to an individual's needs and preferences in the most integrated and least restrictive setting;

(2) improve access to services and supports by ensuring that an individual receives information about all available programs and services, including employment and least restrictive housing assistance, and the manner of applying for the programs and services;

(3) improve the assessment of an individual's needs and available supports, including the assessment of an individual's functional needs;

(4) promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;

(5) promote individualized budgeting based on an assessment of an individual's needs and person-centered planning;

(6) promote integrated service coordination of acute care services and long-term services and supports;

(7) improve acute care and long-term services and supports outcomes, including reducing unnecessary institutionalization and potentially preventable events;

(8) promote high-quality care;

(9) provide fair hearing and appeals processes in accordance with federal law;

(10) ensure the availability of a local safety net provider and local safety net services;

(11) promote independent service coordination and independent ombudsmen services; and

(12) ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent the inappropriate institutionalization of an individual. (Gov. Code, Sec. 534.051.)

Source Law

> Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. In accordance with this chapter, the commission shall design and implement an acute care services and long-term services and supports system for individuals with an intellectual or developmental disability that supports the following goals:
>
> (1) provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs and preferences in the most integrated and least restrictive setting;
>
> (2) improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services;
>
> (3) improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs;
>
> (4) promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;
>
> (5) promote individualized budgeting based on an assessment of an individual's needs and person-centered planning;
>
> (6) promote integrated service coordination of acute care services and long-term services and supports;
>
> (7) improve acute care and long-term services and supports outcomes, including reducing unnecessary institutionalization and potentially preventable events;
>
> (8) promote high-quality care;

(9) provide fair hearing and appeals processes in accordance with applicable federal law;

(10) ensure the availability of a local safety net provider and local safety net services;

(11) promote independent service coordination and independent ombudsmen services; and

(12) ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.

Revised Law

Sec. 542.0052. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The intellectual and developmental disability system redesign advisory committee shall advise the commission on implementing the acute care services and long-term services and supports system redesign under this chapter.

(b) The executive commissioner shall appoint stakeholders from the intellectual and developmental disabilities community to serve as advisory committee members, including:

(1) individuals with an intellectual or developmental disability who receive services under a Medicaid waiver program;

(2) individuals with an intellectual or developmental disability who receive services under an ICF-IID program;

(3) representatives who are advocates for individuals described by Subdivisions (1) and (2), including at least three representatives from intellectual and developmental disability advocacy organizations;

(4) representatives of Medicaid managed care and nonmanaged care health care providers, including:

(A) physicians who are primary care providers;

(B) physicians who are specialty care providers;

(C) nonphysician mental health professionals; and

(D) long-term services and supports providers, including direct service workers;

(5) representatives of entities with responsibilities for delivering Medicaid long-term services and supports or for other Medicaid service delivery, including:

(A) representatives of aging and disability

resource centers established under the Aging and Disability Resource Center initiative funded in part by the Administration on Aging and the Centers for Medicare and Medicaid Services;

(B) representatives of community mental health and intellectual disability centers;

(C) representatives of and service coordinators or case managers from private and public home and community-based services providers that serve individuals with an intellectual or developmental disability; and

(D) representatives of private and public ICF-IID providers; and

(6) representatives of managed care organizations that contract with this state to provide services to individuals with an intellectual or developmental disability.

(c) To the greatest extent possible, the executive commissioner shall appoint members to the advisory committee who reflect the geographic diversity of this state and include members who represent rural Medicaid recipients.

(d) The executive commissioner shall appoint the presiding officer of the advisory committee.

(e) The advisory committee must meet at least quarterly or more frequently if the presiding officer determines that more frequent meetings are necessary to address planning and development needs related to implementation of the acute care services and long-term services and supports system. The advisory committee may establish work groups that meet at other times to study and make recommendations on issues the advisory committee considers appropriate.

(f) An advisory committee member serves without compensation. An advisory committee member who is a Medicaid recipient or the relative of a Medicaid recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

(g) Chapter 551 applies to the advisory committee.

(h) On the second anniversary of the date the commission completes implementation of the transition required under Section 542.0201:

(1) the advisory committee is abolished; and

(2) this section expires. (Gov. Code, Sec. 534.053.)

Source Law

Sec. 534.053. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The Intellectual and Developmental Disability System Redesign Advisory Committee shall advise the commission on the implementation of the acute care services and long-term services and supports system redesign under this chapter. Subject to Subsection (b), the executive commissioner shall appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including:

(1) individuals with an intellectual or developmental disability who are recipients of services under the Medicaid waiver programs, individuals with an intellectual or developmental disability who are recipients of services under the ICF-IID program, and individuals who are advocates of those recipients, including at least three representatives from intellectual and developmental disability advocacy organizations;

(2) representatives of Medicaid managed care and nonmanaged care health care providers, including:

(A) physicians who are primary care providers and physicians who are specialty care providers;

(B) nonphysician mental health professionals; and

(C) providers of long-term services and supports, including direct service workers;

(3) representatives of entities with responsibilities for the delivery of Medicaid long-term services and supports or other Medicaid service delivery, including:

(A) representatives of aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(B) representatives of community mental health and intellectual disability centers;

(C) representatives of and service coordinators or case managers from private and public home and community-based services providers that serve individuals with an intellectual or developmental disability; and

(D) representatives of private and public ICF-IID providers; and

(4) representatives of managed care organizations contracting with the state to provide services to individuals with an intellectual or developmental disability.

(b) To the greatest extent possible, the executive commissioner shall appoint members of the advisory committee who reflect the geographic

diversity of the state and include members who represent rural Medicaid recipients.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) The advisory committee must meet at least quarterly or more frequently if the presiding officer determines that it is necessary to address planning and development needs related to implementation of the acute care services and long-term services and supports system.

(e) A member of the advisory committee serves without compensation. A member of the advisory committee who is a Medicaid recipient or the relative of a Medicaid recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

(e-1) The advisory committee may establish work groups that meet at other times for purposes of studying and making recommendations on issues the committee considers appropriate.

(f) The advisory committee is subject to the requirements of Chapter 551.

(g) On the second anniversary of the date the commission completes implementation of the transition required under Section 534.202:

(1) the advisory committee is abolished; and

(2) this section expires.

Revisor's Note

(1) Section 534.053(a), Government Code, requires the executive commissioner of the Health and Human Services Commission to appoint members of the intellectual and developmental disability system redesign advisory committee "[s]ubject to Subsection (b)" of Section 534.053, Government Code. The revised law omits the quoted phrase as unnecessary because the requirements of Subsection (b), which is revised as Subsection (c) of this section, apply by their own terms.

(2) Section 534.053(g), Government Code, refers to the transition required under Section 534.202, Government Code. The provisions of Section 534.202 requiring the implementation of a transition are revised in this chapter as Section 542.0201, and the revised law is drafted accordingly.

Revised Law

Sec. 542.0053. IMPLEMENTATION OF SYSTEM REDESIGN. The commission shall, in collaboration with the advisory committee,

implement the acute care services and long-term services and supports system for individuals with an intellectual or developmental disability in the manner and in the stages described by this chapter. (Gov. Code, Sec. 534.052.)

Source Law

> Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. The commission shall, in consultation and collaboration with the advisory committee, implement the acute care services and long-term services and supports system for individuals with an intellectual or developmental disability in the manner and in the stages described in this chapter.

Revisor's Note

Section 534.052, Government Code, provides that the Health and Human Services Commission shall take certain action in "consultation and collaboration" with an advisory committee. Throughout this chapter, the revised law omits "consultation" in this context as redundant because "consultation" is included within the meaning of "collaboration."

Revised Law

Sec. 542.0054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in collaboration with the advisory committee, shall prepare and submit to the legislature a report that includes:

(1) an assessment of the implementation of the system required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with an intellectual or developmental disability under Medicaid;

(2) recommendations regarding implementation of and improvements to the system redesign, including recommendations regarding appropriate statutory changes to facilitate the implementation; and

(3) an assessment of the effect of the system on:

(A) access to long-term services and supports;

(B) the quality of acute care services and

long-term services and supports;

(C) meaningful outcomes for Medicaid recipients using person-centered planning, individualized budgeting, and self-determination, including an individual's inclusion in the community;

(D) the integration of service coordination of acute care services and long-term services and supports;

(E) the efficiency and use of funding;

(F) the placement of individuals in housing that is the least restrictive setting appropriate to an individual's needs;

(G) employment assistance and customized, integrated, competitive employment options; and

(H) the number and types of fair hearing and appeals processes in accordance with federal law.

(b) This section expires on the second anniversary of the date the commission completes implementation of the transition required under Section 542.0201. (Gov. Code, Sec. 534.054.)

Source Law

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in consultation and collaboration with the advisory committee, shall prepare and submit a report to the legislature that must include:

(1) an assessment of the implementation of the system required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with an intellectual or developmental disability under Medicaid as described by this chapter;

(2) recommendations regarding implementation of and improvements to the system redesign, including recommendations regarding appropriate statutory changes to facilitate the implementation; and

(3) an assessment of the effect of the system on the following:

(A) access to long-term services and supports;

(B) the quality of acute care services and long-term services and supports;

(C) meaningful outcomes for Medicaid recipients using person-centered planning, individualized budgeting, and self-determination, including a person's inclusion in the community;

(D) the integration of service coordination of acute care services and long-term

services and supports;

(E) the efficiency and use of funding;

(F) the placement of individuals in housing that is the least restrictive setting appropriate to an individual's needs;

(G) employment assistance and customized, integrated, competitive employment options; and

(H) the number and types of fair hearing and appeals processes in accordance with applicable federal law.

(b) This section expires on the second anniversary of the date the commission completes implementation of the transition required under Section 534.202.

Revisor's Note

Section 534.054(b), Government Code, refers to the transition required under Section 534.202, Government Code. The revised law substitutes a reference to Section 542.0201 of this chapter for the reason stated in Revisor's Note (2) to Section 542.0052 of this chapter.

SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING SERVICE DELIVERY MODELS

Revised Law

Sec. 542.0101. DEFINITIONS. In this subchapter:

(1) "Capitation" means a method of compensating a provider on a monthly basis for providing or coordinating the provision of a defined set of services and supports that is based on a predetermined payment per services recipient.

(2) "Pilot program" means the pilot program established under this subchapter.

(3) "Pilot program participant" means an individual who is enrolled in and receives services through the pilot program.

(4) "Pilot program work group" means the pilot program work group established under Section 542.0104. (Gov. Code, Sec. 534.101; New.)

Source Law

Sec. 534.101. DEFINITIONS. In this subchapter:

(1) "Capitation" means a method of compensating a provider on a monthly basis for providing or coordinating the provision of a defined set of services and supports that is based on a

predetermined payment per services recipient.

(2) "Pilot program" means the pilot program established under this subchapter.

(3) "Pilot program workgroup" means the pilot program workgroup established under Section 534.1015.

Revisor's Note

(1) Section 534.101, Government Code, defines terms for purposes of "this subchapter," meaning Subchapter C, Chapter 534. The provisions of Subchapter C, Chapter 534, are revised in this subchapter. This subchapter of the revised law also includes the revision of Section 534.252, Government Code, which is a provision of Subchapter F, Chapter 534, Government Code. The revised law retains the reference to "this subchapter" and applies the definitions included in this section of the revised law to the revision of Section 534.252, Government Code, because, to the extent those terms are used in the revision of Section 534.252, the terms have the same meanings as defined by this section.

(2) The revised law adds a definition of "pilot program participant" for drafting convenience and to avoid frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 542.0102. PILOT PROGRAM TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall develop and implement a pilot program to test the delivery of long-term services and supports to pilot program participants through the STAR+PLUS Medicaid managed care program.

(b) A managed care organization participating in the pilot program shall provide Medicaid long-term services and supports to individuals with an intellectual or developmental disability and individuals with similar functional needs to test the

organization's managed care strategy based on capitation.

(c) The pilot program must be designed to:

(1) increase access to long-term services and supports;

(2) improve the quality of acute care services and long-term services and supports;

(3) promote:

(A) informed choice and meaningful outcomes by using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination; and

(B) community inclusion and engagement;

(4) promote integrated service coordination of acute care services and long-term services and supports;

(5) promote efficiency and best funding use based on a pilot program participant's needs and preferences;

(6) promote, through housing supports and navigation services, stability in housing that is the most integrated and least restrictive based on a pilot program participant's needs and preferences;

(7) promote employment assistance and customized, integrated, competitive employment;

(8) provide fair hearing and appeals processes in accordance with federal and state law;

(9) promote the use of innovative technologies and benefits, including telemedicine, telemonitoring, the testing of remote monitoring, transportation services, and other innovations that support community integration;

(10) ensure a provider network that is adequate and includes comprehensive long-term services and supports providers and ensure that pilot program participants have a choice among those providers;

(11) ensure the timely initiation and consistent provision of long-term services and supports in accordance with a pilot program participant's person-centered plan;

(12) ensure that pilot program participants with complex behavioral, medical, and physical needs are assessed and receive appropriate services in the most integrated and least restrictive setting based on the participants' needs and preferences;

(13) increase access to, expand flexibility of, and promote the use of the consumer direction model;

(14) promote independence, self-determination, the use of the consumer direction model, and decision making by pilot program participants by using alternatives to guardianship, including a supported decision-making agreement as defined by Section 1357.002, Estates Code; and

(15) promote sufficient flexibility to achieve, through the pilot program, the goals listed in:

(A) this subsection;

(B) Subsection (b); and

(C) Sections 542.0103, 542.0110(a), 542.0113, and 542.0116(c). (Gov. Code, Secs. 534.102, 534.104(a), (h).)

Source Law

Sec. 534.102. PILOT PROGRAM TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop and implement a pilot program in accordance with this subchapter to test, through the STAR+PLUS Medicaid managed care program, the delivery of long-term services and supports to individuals participating in the pilot program.

Sec. 534.104. PILOT PROGRAM DESIGN. (a) The pilot program must be designed to:

(1) increase access to long-term services and supports;

(2) improve quality of acute care services and long-term services and supports;

(3) promote:

(A) informed choice and meaningful outcomes by using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination; and

(B) community inclusion and engagement;

(4) promote integrated service coordination of acute care services and long-term services and supports;

(5) promote efficiency and the best use of funding based on an individual's needs and

preferences;

(6) promote through housing supports and navigation services stability in housing that is the most integrated and least restrictive based on the individual's needs and preferences;

(7) promote employment assistance and customized, integrated, and competitive employment;

(8) provide fair hearing and appeals processes in accordance with applicable federal and state law;

(9) promote sufficient flexibility to achieve the goals listed in this section through the pilot program;

(10) promote the use of innovative technologies and benefits, including telemedicine, telemonitoring, the testing of remote monitoring, transportation services, and other innovations that support community integration;

(11) ensure an adequate provider network that includes comprehensive long-term services and supports providers and ensure that pilot program participants have a choice among those providers;

(12) ensure the timely initiation and consistent provision of long-term services and supports in accordance with an individual's person-centered plan;

(13) ensure that individuals with complex behavioral, medical, and physical needs are assessed and receive appropriate services in the most integrated and least restrictive setting based on the individuals' needs and preferences;

(14) increase access to, expand flexibility of, and promote the use of the consumer direction model; and

(15) promote independence, self-determination, the use of the consumer direction model, and decision making by individuals participating in the pilot program by using alternatives to guardianship, including a supported decision-making agreement as defined by Section 1357.002, Estates Code.

(h) Under the pilot program, a participating managed care organization shall provide long-term services and supports under Medicaid to persons with an intellectual or developmental disability and persons with similar functional needs to test its managed care strategy based on capitation.

Revisor's Note

(1) Sections 534.102 and 534.104(a)(15), Government Code, refer to "individuals participating in the pilot program," meaning the pilot program implemented under Subchapter C, Chapter 534, Government Code, which is revised in this subchapter. Sections 534.104(a)(5), (6), (12), and (13), Government Code, specify certain goals of the pilot program in relation to individuals. Section 542.0101 of this chapter defines "pilot program participant"

for purposes of the subchapter, and the substance of that definition is synonymous with an "individual participating in the pilot program." Additionally, the pilot program goals relate only to individuals who receive services through the pilot program, and those individuals are pilot program participants. For clarity and consistency of terminology, the revised law substitutes "pilot program participant" or "pilot program participants," as appropriate, for the references to "individuals participating in the pilot program" or to an individual with respect to whom the pilot program is designed to achieve the specified goals. Similar changes are made throughout this subchapter where the context makes clear that a referenced individual is necessarily a pilot program participant.

(2) Section 534.104(a)(9), Government Code, refers to goals listed in "this section," meaning Section 534.104, Government Code. The relevant provisions of Section 534.104 are revised in this section as Subsections (b) and (c) and elsewhere in this chapter as Sections 542.0103, 542.0110(a), 542.0113, and 542.0116(c). The revised law is drafted accordingly.

Revised Law

Sec. 542.0103. ALTERNATIVE PAYMENT RATE OR METHODOLOGY. (a) The pilot program must be designed to test the use of innovative payment rates and methodologies for the provision of long-term services and supports to achieve the goals of the pilot program. The payment methodologies must include:

(1) the payment of a bundled amount without downside risk to a comprehensive long-term services and supports provider for some or all services delivered as part of a comprehensive array of long-term services and supports;

(2) enhanced incentive payments to comprehensive long-term services and supports providers based on the completion of predetermined outcomes or quality metrics; and

(3) any other payment model the commission approves.

(b) An alternative payment rate or methodology may be used for a managed care organization and comprehensive long-term services and supports provider only if the organization and provider agree in advance and in writing to use the rate or methodology.

(c) In developing an alternative payment rate or methodology, the commission, managed care organizations, and comprehensive long-term services and supports providers shall consider:

(1) the historical costs of long-term services and supports, including Medicaid fee-for-service rates;

(2) reasonable cost estimates for new services under the pilot program; and

(3) whether an alternative payment rate or methodology is sufficient to promote quality outcomes and ensure a provider's continued participation in the pilot program.

(d) An alternative payment rate or methodology may not reduce the minimum payment a provider receives for delivering long-term services and supports under the pilot program to an amount that is less than the fee-for-service reimbursement rate the provider received for delivering those services before participating in the pilot program. (Gov. Code, Secs. 534.104(c), (d), (e), (f).)

Source Law

> (c) The pilot program must be designed to test innovative payment rates and methodologies for the provision of long-term services and supports to achieve the goals of the pilot program by using payment methodologies that include:
>
> (1) the payment of a bundled amount without downside risk to a comprehensive long-term services and supports provider for some or all services delivered as part of a comprehensive array of long-term services and supports;
>
> (2) enhanced incentive payments to

comprehensive long-term services and supports providers based on the completion of predetermined outcomes or quality metrics; and

(3) any other payment models approved by the commission.

(d) An alternative payment rate or methodology described by Subsection (c) may be used for a managed care organization and comprehensive long-term services and supports provider only if the organization and provider agree in advance and in writing to use the rate or methodology.

(e) In developing an alternative payment rate or methodology described by Subsection (c), the commission, managed care organizations, and comprehensive long-term services and supports providers shall consider:

(1) the historical costs of long-term services and supports, including Medicaid fee-for-service rates;

(2) reasonable cost estimates for new services under the pilot program; and

(3) whether an alternative payment rate or methodology is sufficient to promote quality outcomes and ensure a provider's continued participation in the pilot program.

(f) An alternative payment rate or methodology described by Subsection (c) may not reduce the minimum payment received by a provider for the delivery of long-term services and supports under the pilot program below the fee-for-service reimbursement rate received by the provider for the delivery of those services before participating in the pilot program.

Revised Law

Sec. 542.0104. PILOT PROGRAM WORK GROUP. (a) The executive commissioner, in consultation with the advisory committee, shall establish a pilot program work group to assist in developing and provide advice on the operation of the pilot program.

(b) The pilot program work group is composed of:

(1) representatives of the advisory committee;

(2) stakeholders representing individuals with an intellectual or developmental disability;

(3) stakeholders representing individuals with similar functional needs as the individuals described by Subdivision (2); and

(4) representatives of managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program.

(c) Chapter 2110 applies to the pilot program work group. (Gov. Code, Sec. 534.1015.)

Source Law

Sec. 534.1015. PILOT PROGRAM WORKGROUP. (a) The executive commissioner, in consultation with the advisory committee, shall establish a pilot program workgroup to provide assistance in developing and advice concerning the operation of the pilot program.

(b) The pilot program workgroup is composed of:

(1) representatives of the advisory committee;

(2) stakeholders representing individuals with an intellectual or developmental disability;

(3) stakeholders representing individuals with similar functional needs as those individuals described by Subdivision (2); and

(4) representatives of managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program.

(c) Chapter 2110 applies to the pilot program workgroup.

Revised Law

Sec. 542.0105. STAKEHOLDER INPUT. As part of developing and implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop a process to receive and evaluate:

(1) input from:

(A) statewide stakeholders; and

(B) stakeholders from a STAR+PLUS Medicaid managed care service area in which the pilot program will be implemented; and

(2) other evaluations and data. (Gov. Code, Sec. 534.103.)

Source Law

Sec. 534.103. STAKEHOLDER INPUT. As part of developing and implementing the pilot program, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop a process to receive and evaluate:

(1) input from statewide stakeholders and stakeholders from a STAR+PLUS Medicaid managed care service area in which the pilot program will be implemented; and

(2) other evaluations and data.

Revised Law

Sec. 542.0106. MEASURABLE GOALS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall:

(1) identify, using national core indicators, the National Quality Forum long-term services and supports measures, and other appropriate Consumer Assessment of Healthcare Providers and Systems measures, measurable goals the pilot program is to achieve;

(2) develop specific strategies and performance measures for achieving the identified goals; and

(3) ensure that mechanisms to report, track, and assess specific strategies and performance measures for achieving the identified goals are established before implementing the pilot program.

(b) A strategy proposed under Subsection (a)(2) may be evidence-based if an evidence-based strategy is available for meeting the identified goals. (Gov. Code, Sec. 534.105.)

Source Law

> Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup and using national core indicators, the National Quality Forum long-term services and supports measures, and other appropriate Consumer Assessment of Healthcare Providers and Systems measures, shall identify measurable goals to be achieved by the pilot program.
>
> (b) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop specific strategies and performance measures for achieving the identified goals. A proposed strategy may be evidence-based if there is an evidence-based strategy available for meeting the pilot program's goals.
>
> (c) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall ensure that mechanisms to report, track, and assess specific strategies and performance measures for achieving the identified goals are established before implementing the pilot program.

Revised Law

Sec. 542.0107. MANAGED CARE ORGANIZATION SELECTION. The commission shall:

(1) in collaboration with the advisory committee and pilot program work group, develop criteria regarding the selection of a managed care organization to participate in the pilot program; and

(2) select and contract with not more than two managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program to participate in the pilot program. (Gov. Code, Sec. 534.1035.)

Source Law

> Sec. 534.1035. MANAGED CARE ORGANIZATION SELECTION. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop criteria regarding the selection of a managed care organization to participate in the pilot program.
>
> (b) The commission shall select and contract with not more than two managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program to participate in the pilot program.

Revised Law

Sec. 542.0108. MANAGED CARE ORGANIZATION PARTICIPATION REQUIREMENTS. The commission shall require that a managed care organization participating in the pilot program:

(1) ensures that pilot program participants have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model;

(2) demonstrates to the commission's satisfaction that the organization's network of acute care, long-term services and supports, and comprehensive long-term services and supports providers have experience and expertise in providing services for individuals with an intellectual or developmental disability and individuals with similar functional needs;

(3) has a process for preventing the inappropriate institutionalization of pilot program participants; and

(4) ensures the timely initiation and consistent provision of services in accordance with a pilot program participant's person-centered plan. (Gov. Code, Sec. 534.107(a).)

Source Law

> Sec. 534.107. COMMISSION RESPONSIBILITIES. (a) The commission shall require that a managed care organization participating in the pilot program:
>
> (1) ensures that individuals participating in the pilot program have a choice among

acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model;

(2) demonstrates to the commission's satisfaction that the organization's network of acute care, long-term services and supports, and comprehensive long-term services and supports providers have experience and expertise in providing services for individuals with an intellectual or developmental disability and individuals with similar functional needs;

(3) has a process for preventing inappropriate institutionalizations of individuals; and

(4) ensures the timely initiation and consistent provision of services in accordance with an individual's person-centered plan.

Revised Law

Sec. 542.0109. REQUIRED BENEFITS. (a) The commission shall ensure that a managed care organization participating in the pilot program provides:

(1) all Medicaid state plan acute care benefits available under the STAR+PLUS Medicaid managed care program;

(2) long-term services and supports under the Medicaid state plan, including:

(A) Community First Choice services;

(B) personal assistance services;

(C) day activity health services; and

(D) habilitation services;

(3) long-term services and supports under the STAR+PLUS home and community-based services (HCBS) waiver program, including:

(A) assisted living services;

(B) personal assistance services;

(C) employment assistance;

(D) supported employment;

(E) adult foster care;

(F) dental care;

(G) nursing care;

(H) respite care;

(I) home-delivered meals;

(J) cognitive rehabilitative therapy;

(K) physical therapy;

(L) occupational therapy;

(M) speech-language pathology;

(N) medical supplies;

(O) minor home modifications; and

(P) adaptive aids;

(4) the following long-term services and supports under a Medicaid waiver program:

(A) enhanced behavioral health services;

(B) behavioral supports;

(C) day habilitation; and

(D) community support transportation;

(5) the following additional long-term services and supports:

(A) housing supports;

(B) behavioral health crisis intervention services; and

(C) high medical needs services;

(6) other nonresidential long-term services and supports that the commission, in collaboration with the advisory committee and pilot program work group, determines are appropriate and consistent with requirements governing the Medicaid waiver programs, person-centered approaches, home and community-based setting requirements, and achievement of the most integrated and least restrictive setting based on an individual's needs and preferences; and

(7) dental services benefits in accordance with Subsection (b).

(b) In developing the pilot program, the commission shall:

(1) evaluate dental services benefits provided through Medicaid waiver programs and dental services benefits provided as a value-added service under the Medicaid managed care delivery model;

(2) determine which dental services benefits are the

most cost-effective in reducing emergency room and inpatient hospital admissions resulting from poor oral health; and

(3) based on the determination made under Subdivision (2), provide the most cost-effective dental services benefits to pilot program participants.

(c) Before implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall:

(1) for pilot program purposes only, develop recommendations to modify adult foster care and supported employment and employment assistance benefits to increase access to and availability of those services; and

(2) as necessary, define services listed under Subsections (a)(4) and (5) and any other services the commission determines to be appropriate under Subsection (a)(6). (Gov. Code, Secs. 534.1045(a), (a-1), (f).)

Source Law

Sec. 534.1045. PILOT PROGRAM BENEFITS AND PROVIDER QUALIFICATIONS. (a) Subject to Subsection (b), the commission shall ensure that a managed care organization participating in the pilot program provides:

(1) all Medicaid state plan acute care benefits available under the STAR+PLUS Medicaid managed care program;

(2) long-term services and supports under the Medicaid state plan, including:

(A) Community First Choice services;

(B) personal assistance services;

(C) day activity health services; and

(D) habilitation services;

(3) long-term services and supports under the STAR+PLUS home and community-based services (HCBS) waiver program, including:

(A) assisted living services;

(B) personal assistance services;

(C) employment assistance;

(D) supported employment;

(E) adult foster care;

(F) dental care;

(G) nursing care;

(H) respite care;

(I) home-delivered meals;

(J) cognitive rehabilitative therapy;

(K) physical therapy;

(L) occupational therapy;

(M) speech-language pathology;

(N) medical supplies;

(O) minor home modifications; and

(P) adaptive aids;

(4) the following long-term services and supports under a Medicaid waiver program:

(A) enhanced behavioral health services;

(B) behavioral supports;

(C) day habilitation; and

(D) community support transportation;

(5) the following additional long-term services and supports:

(A) housing supports;

(B) behavioral health crisis intervention services; and

(C) high medical needs services;

(6) other nonresidential long-term services and supports that the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, determines are appropriate and consistent with applicable requirements governing the Medicaid waiver programs, person-centered approaches, home and community-based setting requirements, and achieving the most integrated and least restrictive setting based on an individual's needs and preferences; and

(7) dental services benefits in accordance with Subsection (a-1).

(a-1) In developing the pilot program, the commission shall:

(1) evaluate dental services benefits provided through Medicaid waiver programs and dental services benefits provided as a value-added service under the Medicaid managed care delivery model;

(2) determine which dental services benefits are the most cost-effective in reducing emergency room and inpatient hospital admissions due to poor oral health; and

(3) based on the determination made under Subdivision (2), provide the most cost-effective dental services benefits to pilot program participants.

(f) Before implementing the pilot program, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall:

(1) for purposes of the pilot program only, develop recommendations to modify adult foster care and supported employment and employment assistance benefits to increase access to and availability of those services; and

(2) as necessary, define services listed under Subsections (a)(4) and (5) and any other services determined to be appropriate under Subsection (a)(6).

Revisor's Note

Section 534.1045(a), Government Code, provides that "[s]ubject to Subsection (b)" of Section 534.1045, Government Code, the Health and Human Services Commission shall ensure that a managed care organization provides certain benefits and services under the pilot program implemented under Subchapter

C, Chapter 534, Government Code, which is revised in this subchapter. The revised law omits the quoted language because the provisions of Subsection (b), revised in this chapter as Section 542.0110(c), apply by their own terms, and an additional statement to that effect is unnecessary.

Revised Law

Sec. 542.0110. PROVIDER PARTICIPATION. (a) The pilot program must allow a comprehensive long-term services and supports provider for individuals with an intellectual or developmental disability or similar functional needs that contracts with the commission to provide Medicaid services before the date the pilot program is implemented to voluntarily participate in the pilot program. A provider's choice not to participate in the pilot program does not affect the provider's status as a significant traditional provider.

(b) For the duration of the pilot program, the commission shall ensure that comprehensive long-term services and supports providers are:

(1) considered significant traditional providers; and

(2) included in the provider network of a managed care organization participating in the pilot program.

(c) A comprehensive long-term services and supports provider may deliver services listed under the following provisions only if the provider also delivers the services under a Medicaid waiver program:

(1) Sections 542.0109(a)(2)(A) and (D);

(2) Sections 542.0109(a)(3)(B), (C), (D), (G), (H), (J), (K), (L), and (M); and

(3) Section 542.0109(a)(4).

(d) A comprehensive long-term services and supports provider may deliver services listed under Sections 542.0109(a)(5) and (6) only if the managed care organization in the network of which the provider participates agrees, in a contract with the

provider, to the provision of those services.

(e) Day habilitation services listed under Section 542.0109(a)(4)(C) may be delivered by a provider who contracts or subcontracts with the commission to provide day habilitation services under the home and community-based services (HCS) waiver program or the ICF-IID program. (Gov. Code, Secs. 534.104(g), 534.1045(b), (c), (d), 534.107(b).)

Source Law

[Sec. 534.104]

(g) The pilot program must allow a comprehensive long-term services and supports provider for individuals with an intellectual or developmental disability or similar functional needs that contracts with the commission to provide services under Medicaid before the implementation date of the pilot program to voluntarily participate in the pilot program. A provider's choice not to participate in the pilot program does not affect the provider's status as a significant traditional provider.

[Sec. 534.1045]

(b) A comprehensive long-term services and supports provider may deliver services listed under the following provisions only if the provider also delivers the services under a Medicaid waiver program:

(1) Subsections (a)(2)(A) and (D);

(2) Subsections (a)(3)(B), (C), (D), (G), (H), (J), (K), (L), and (M); and

(3) Subsection (a)(4).

(c) A comprehensive long-term services and supports provider may deliver services listed under Subsections (a)(5) and (6) only if the managed care organization in the network of which the provider participates agrees to, in a contract with the provider, the provision of those services.

(d) Day habilitation services listed under Subsection (a)(4)(C) may be delivered by a provider who contracts or subcontracts with the commission to provide day habilitation services under the home and community-based services (HCS) waiver program or the ICF-IID program.

[Sec. 534.107]

(b) For the duration of the pilot program, the commission shall ensure that comprehensive long-term services and supports providers are considered significant traditional providers and included in the provider network of a managed care organization participating in the pilot program.

Revised Law

Sec. 542.0111. CARE COORDINATION. (a) A comprehensive long-term services and supports provider participating in the pilot program shall work in coordination with the care coordinators of a managed care organization participating in the pilot program to

ensure the seamless daily delivery of acute care and long-term services and supports in accordance with a pilot program participant's plan of care.

(b) A managed care organization may reimburse a comprehensive long-term services and supports provider for coordinating with care coordinators under this section. (Gov. Code, Sec. 534.1045(e).)

Source Law

> (e) A comprehensive long-term services and supports provider participating in the pilot program shall work in coordination with the care coordinators of a managed care organization participating in the pilot program to ensure the seamless delivery of acute care and long-term services and supports on a daily basis in accordance with an individual's plan of care. A comprehensive long-term services and supports provider may be reimbursed by a managed care organization for coordinating with care coordinators under this subsection.

Revised Law

Sec. 542.0112. PERSON-CENTERED PLANNING. The commission, in collaboration with the advisory committee and pilot program work group, shall ensure that each pilot program participant or the participant's legally authorized representative has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the participant and drives the development of the individualized budget. The consumer direction model must be an available option for a participant to achieve self-determination, choice, and control. (Gov. Code, Sec. 534.109.)

Source Law

> Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall ensure that each individual who receives services and supports under Medicaid through the pilot program, or the individual's legally authorized representative, has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the individual and drives the development of the individualized budget. The consumer direction model must be an available option for individuals to achieve self-determination, choice, and control.

Revised Law

Sec. 542.0113. USE OF INNOVATIVE TECHNOLOGY. A pilot

program participant is not required to use an innovative technology described by Section 542.0102(c)(9). If a participant chooses to use an innovative technology described by that subdivision, the commission shall ensure that:

(1) services associated with the technology are delivered in a manner that:

(A) ensures the participant's privacy, health, and well-being;

(B) provides access to housing in the most integrated and least restrictive environment;

(C) assesses individual needs and preferences to promote autonomy, self-determination, the use of the consumer direction model, and privacy;

(D) increases personal independence;

(E) specifies the extent to which the innovative technology will be used, including:

(i) the times of day during which the technology will be used;

(ii) the place in which the technology is authorized to be used;

(iii) the types of telemonitoring or remote monitoring that will be used; and

(iv) the purposes for which the technology will be used; and

(F) is consistent with and agreed on during the person-centered planning process;

(2) staff overseeing the use of the innovative technology:

(A) review the person-centered and implementation plans for each participant before overseeing the use of the innovative technology; and

(B) demonstrate competency regarding the support needs of each participant using the innovative technology;

(3) a participant using the innovative technology is

able to request the removal of equipment associated with the technology and, on receipt of a request for the removal, the equipment is immediately removed; and

(4) a participant is not required to use telemedicine at any point during the pilot program and, if the participant refuses to use telemedicine, the managed care organization providing pilot program health care services to the participant arranges for services that do not include telemedicine. (Gov. Code, Sec. 534.104(b).)

Source Law

(b) An individual is not required to use an innovative technology described by Subsection (a)(10). If an individual chooses to use an innovative technology described by that subdivision, the commission shall ensure that services associated with the technology are delivered in a manner that:

(1) ensures the individual's privacy, health, and well-being;

(2) provides access to housing in the most integrated and least restrictive environment;

(3) assesses individual needs and preferences to promote autonomy, self-determination, the use of the consumer direction model, and privacy;

(4) increases personal independence;

(5) specifies the extent to which the innovative technology will be used, including:

(A) the times of day during which the technology will be used;

(B) the place in which the technology may be used;

(C) the types of telemonitoring or remote monitoring that will be used; and

(D) for what purposes the technology will be used;

(6) is consistent with and agreed on during the person-centered planning process;

(7) ensures that staff overseeing the use of an innovative technology:

(A) review the person-centered and implementation plans for each individual before overseeing the use of the innovative technology; and

(B) demonstrate competency regarding the support needs of each individual using the innovative technology;

(8) ensures that an individual using an innovative technology is able to request the removal of equipment relating to the technology and, on receipt of a request for the removal, the equipment is immediately removed; and

(9) ensures that an individual is not required to use telemedicine at any point during the pilot program and, in the event the individual refuses to use telemedicine, the managed care organization providing health care services to the individual under the pilot program arranges for services that do not include telemedicine.

Revised Law

Sec. 542.0114. INFORMATIONAL MATERIALS. (a) To ensure that prospective pilot program participants are able to make an informed decision on whether to participate in the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop and distribute informational materials that describe the pilot program's benefits and impact on current services and other related information.

(b) The commission shall establish a timeline and process for developing and distributing the informational materials and ensure that:

(1) the materials are developed and distributed to individuals eligible to participate in the pilot program with sufficient time to educate the individuals, their families, and other persons actively involved in their lives regarding the pilot program;

(2) individuals eligible to participate in the pilot program, including individuals enrolled in the STAR+PLUS Medicaid managed care program, their families, and other persons actively involved in their lives receive the materials and oral information on the pilot program;

(3) the materials contain clear, simple language presented in a manner that is easy to understand; and

(4) at a minimum, the materials explain that:

(A) on the pilot program's conclusion, each pilot program participant will be asked to provide feedback on the participant's experience, including feedback on whether the pilot program was able to meet the participant's unique support needs;

(B) participation in the pilot program does not remove an individual from any Medicaid waiver program interest list;

(C) a pilot program participant who, during the pilot program's operation, is offered enrollment in a Medicaid waiver program may accept the enrollment, transition, or diversion

offer; and

(D) a pilot program participant has a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model and comprehensive services model. (Gov. Code, Sec. 534.1065(b).)

Source Law

(b) To ensure prospective pilot program participants are able to make an informed decision on whether to participate in the pilot program, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop and distribute informational materials on the pilot program that describe the pilot program's benefits, the pilot program's impact on current services, and other related information. The commission shall establish a timeline and process for the development and distribution of the materials and shall ensure:

(1) the materials are developed and distributed to individuals eligible to participate in the pilot program with sufficient time to educate the individuals, their families, and other persons actively involved in their lives regarding the pilot program;

(2) individuals eligible to participate in the pilot program, including individuals enrolled in the STAR+PLUS Medicaid managed care program, their families, and other persons actively involved in their lives, receive the materials and oral information on the pilot program;

(3) the materials contain clear, simple language presented in a manner that is easy to understand; and

(4) the materials explain, at a minimum, that:

(A) on conclusion of the pilot program, pilot program participants will be asked to provide feedback on their experience, including feedback on whether the pilot program was able to meet their unique support needs;

(B) participation in the pilot program does not remove individuals from any Medicaid waiver program interest list;

(C) individuals who choose to participate in the pilot program and who, during the pilot program's operation, are offered enrollment in a Medicaid waiver program may accept the enrollment, transition, or diversion offer; and

(D) pilot program participants have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model and comprehensive services model.

Revised Law

Sec. 542.0115. IMPLEMENTATION, LOCATION, AND DURATION. The commission shall:

(1) implement the pilot program on September 1, 2023;

(2) conduct the pilot program in a STAR+PLUS Medicaid managed care service area the commission selects; and

(3) operate the pilot program for at least 24 months. (Gov. Code, Sec. 534.106.)

Source Law

> Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION. (a) The commission shall implement the pilot program on September 1, 2023.
>
> (b) The pilot program shall operate for at least 24 months.
>
> (c) The pilot program shall be conducted in a STAR+PLUS Medicaid managed care service area selected by the commission.

Revised Law

Sec. 542.0116. RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall develop pilot program participant eligibility criteria. The criteria must ensure that pilot program participants:

(1) include individuals with an intellectual or developmental disability or a cognitive disability, including:

(A) individuals with autism;

(B) individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program;

(C) individuals enrolled in the STAR+PLUS Medicaid managed care program who:

(i) are on a Medicaid waiver program interest list;

(ii) meet the criteria for an intellectual or developmental disability; or

(iii) have a traumatic brain injury that occurred after the age of 21; and

(D) other individuals with disabilities who have similar functional needs without regard to the age of onset or

diagnosis; and

(2) do not include individuals who are receiving only acute care services under the STAR+PLUS Medicaid managed care program and are enrolled in the community-based ICF-IID program or another Medicaid waiver program.

(b) An individual who is eligible to participate in the pilot program will be enrolled automatically. The decision to opt out of participating may be made only by the individual or the individual's legally authorized representative.

(c) Before implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop and implement a process to ensure that pilot program participants remain eligible for Medicaid for 12 consecutive months during the pilot program. (Gov. Code, Secs. 534.104(k), 534.1065(a), (c).)

Source Law

[Sec. 534.104]

(k) Before implementing the pilot program, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop and implement a process to ensure pilot program participants remain eligible for Medicaid benefits for 12 consecutive months during the pilot program.

Sec. 534.1065. RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY. (a) An individual who is eligible for the pilot program will be enrolled automatically, and the decision whether to opt out of participation in the pilot program and not receive long-term services and supports under the pilot program may be made only by the individual or the individual's legally authorized representative.

(c) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall develop pilot program participant eligibility criteria. The criteria must ensure pilot program participants:

(1) include individuals with an intellectual or developmental disability or a cognitive disability, including:

(A) individuals with autism;

(B) individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program;

(C) individuals enrolled in the STAR+PLUS Medicaid managed care program who:

(i) are on a Medicaid waiver program interest list;

(ii) meet the criteria for an intellectual or developmental disability; or

(iii) have a traumatic brain injury that occurred after the age of 21; and

(D) other individuals with disabilities who have similar functional needs without regard to the age of onset or diagnosis; and

(2) do not include individuals who are receiving only acute care services under the STAR+PLUS Medicaid managed care program and are enrolled in the community-based ICF-IID program or another Medicaid waiver program.

Revised Law

Sec. 542.0117. PILOT PROGRAM INFORMATION COLLECTION AND ANALYSIS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall determine the information to collect from a managed care organization participating in the pilot program for use in conducting the evaluation and preparing the report under Section 542.0119.

(b) For the duration of the pilot program, a managed care organization participating in the pilot program shall submit to the commission and the advisory committee quarterly reports on the services provided to each pilot program participant. The reports must include information on:

(1) the level of each requested service and the authorization and utilization rates for those services;

(2) timelines of:

(A) the authorization of each requested service;

(B) the initiation of each requested service;

(C) the delivery of each requested service; and

(D) each unplanned break in the delivery of requested services and the duration of the break;

(3) the number of pilot program participants using employment assistance and supported employment services;

(4) the number of service denials and fair hearings and the dispositions of the fair hearings;

(5) the number of complaints and inquiries the managed care organization received and the outcome of each complaint; and

(6) the number of pilot program participants who choose the consumer direction model and the reasons other

participants did not choose the consumer direction model.

(c) The commission shall ensure that the mechanisms to report and track the information and data required by Subsections (a) and (b) are established before implementing the pilot program.

(d) For purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules, the commission, in collaboration with the advisory committee and pilot program work group, shall analyze:

(1) information provided by managed care organizations participating in the pilot program; and

(2) any information the commission collects during the operation of the pilot program.

(e) The analysis under Subsection (d) must include an assessment of the effect of the managed care strategies implemented in the pilot program on the goals described by Sections 542.0102(b) and (c), 542.0103, 542.0110(a), 542.0113, and 542.0116(c). (Gov. Code, Secs. 534.104(i), (j), 534.108.)

Source Law

[Sec. 534.104]

(i) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall analyze information provided by the managed care organizations participating in the pilot program and any information collected by the commission during the operation of the pilot program for purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules.

(j) The analysis under Subsection (i) must include an assessment of the effect of the managed care strategies implemented in the pilot program on the goals described by this section.

Sec. 534.108. PILOT PROGRAM INFORMATION. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall determine which information will be collected from a managed care organization participating in the pilot program to use in conducting the evaluation and preparing the report under Section 534.112.

(b) For the duration of the pilot program, a managed care organization participating in the pilot program shall submit to the commission and the advisory committee quarterly reports on the services provided to each pilot program participant that include information on:

(1) the level of each requested service and the authorization and utilization rates for those services;

(2) timelines of:

(A) the delivery of each requested service;

(B) authorization of each requested service;

(C) the initiation of each requested service; and

(D) each unplanned break in the delivery of requested services and the duration of the break;

(3) the number of pilot program participants using employment assistance and supported employment services;

(4) the number of service denials and fair hearings and the dispositions of fair hearings;

(5) the number of complaints and inquiries received by the managed care organization and the outcome of each complaint; and

(6) the number of pilot program participants who choose the consumer direction model and the reasons why other participants did not choose the consumer direction model.

(c) The commission shall ensure that the mechanisms to report and track the information and data required by this section are established before implementing the pilot program.

Revisor's Note

Section 534.104(j), Government Code, refers to goals described by "this section," meaning Section 534.104, Government Code. The relevant provisions of Section 534.104 are revised in this chapter as Sections 542.0102(b) and (c), 542.0103, 542.0110(a), 542.0113, and 542.0116(c). The revised law is drafted accordingly.

Revised Law

Sec. 542.0118. PILOT PROGRAM CONCLUSION; PUBLICATION OF CONTINUATION. On September 1, 2025, the pilot program is concluded unless the commission continues the pilot program under Section 542.0120. If the commission continues the pilot program, the commission shall publish notice of that continuation in the Texas Register not later than September 1, 2025. (Gov. Code, Sec. 534.111.)

Source Law

Sec. 534.111. CONCLUSION OF PILOT PROGRAM. (a) On September 1, 2025, the pilot program is concluded unless the commission continues the pilot program under Section 534.110.

(b) If the commission continues the pilot program under Section 534.110, the commission shall publish notice of the pilot program's continuance in

the Texas Register not later than September 1, 2025.

Revised Law

Sec. 542.0119. EVALUATIONS AND REPORTS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall review and evaluate the progress and outcomes of the pilot program and submit, as part of the annual report required under Section 542.0054, a report on the pilot program's status that includes recommendations for improving the pilot program.

(b) Not later than September 1, 2026, the commission, in collaboration with the advisory committee and pilot program work group, shall prepare and submit to the legislature a written report that evaluates the pilot program based on a comprehensive analysis. The analysis must:

(1) assess the effect of the pilot program on:

(A) access to and quality of long-term services and supports;

(B) informed choice and meaningful outcomes using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination, including a pilot program participant's inclusion in the community;

(C) the integration of service coordination of acute care services and long-term services and supports;

(D) employment assistance and customized, integrated, competitive employment options;

(E) the number, types, and dispositions of fair hearings and appeals in accordance with federal and state law;

(F) increasing the use and flexibility of the consumer direction model;

(G) increasing the use of alternatives to guardianship, including supported decision-making agreements as defined by Section 1357.002, Estates Code;

(H) achieving the best and most cost-effective funding use based on a pilot program participant's needs and

preferences; and

(I) attendant recruitment and retention;

(2) analyze the experiences and outcomes of the following systems changes:

(A) the comprehensive assessment instrument described by Section 533A.0335, Health and Safety Code;

(B) the 21st Century Cures Act (Pub. L. No. 114-255);

(C) implementation of the federal rule adopted by the Centers for Medicare and Medicaid Services and published at 79 Fed. Reg. 2948 (January 16, 2014) related to the provision of long-term services and supports through a home and community-based services (HCS) waiver program under Section 1915(c), 1915(i), or 1915(k) of the Social Security Act (42 U.S.C. Section 1396n(c), (i), or (k));

(D) the provision of basic attendant and habilitation services under Section 542.0152; and

(E) the benefits of providing STAR+PLUS Medicaid managed care services to individuals based on functional needs;

(3) include feedback on the pilot program based on the personal experiences of:

(A) individuals with an intellectual or developmental disability and individuals with similar functional needs who were pilot program participants;

(B) families of and other persons actively involved in the lives of individuals described by Paragraph (A); and

(C) comprehensive long-term services and supports providers who delivered services under the pilot program;

(4) be incorporated in the annual report required under Section 542.0054; and

(5) include recommendations on:

(A) a system of programs and services for the legislature's consideration;

(B) necessary statutory changes; and

(C) whether to implement the pilot program statewide under the STAR+PLUS Medicaid managed care program for eligible individuals. (Gov. Code, Sec. 534.112.)

Source Law

Sec. 534.112. PILOT PROGRAM EVALUATIONS AND REPORTS. (a) The commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall review and evaluate the progress and outcomes of the pilot program and submit, as part of the annual report required under Section 534.054, a report on the pilot program's status that includes recommendations for improving the program.

(b) Not later than September 1, 2026, the commission, in consultation and collaboration with the advisory committee and pilot program workgroup, shall prepare and submit to the legislature a written report that evaluates the pilot program based on a comprehensive analysis. The analysis must:

(1) assess the effect of the pilot program on:

(A) access to and quality of long-term services and supports;

(B) informed choice and meaningful outcomes using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination, including a pilot program participant's inclusion in the community;

(C) the integration of service coordination of acute care services and long-term services and supports;

(D) employment assistance and customized, integrated, competitive employment options;

(E) the number, types, and dispositions of fair hearings and appeals in accordance with applicable federal and state law;

(F) increasing the use and flexibility of the consumer direction model;

(G) increasing the use of alternatives to guardianship, including supported decision-making agreements as defined by Section 1357.002, Estates Code;

(H) achieving the best and most cost-effective use of funding based on a pilot program participant's needs and preferences; and

(I) attendant recruitment and retention;

(2) analyze the experiences and outcomes of the following systems changes:

(A) the comprehensive assessment instrument described by Section 533A.0335, Health and Safety Code;

(B) the 21st Century Cures Act (Pub. L. No. 114-255);

(C) implementation of the federal rule adopted by the Centers for Medicare and Medicaid Services and published at 79 Fed. Reg. 2948 (January 16, 2014) related to the provision of long-term services and supports through a home and community-based services (HCS) waiver program under Section 1915(c), 1915(i), or 1915(k) of the federal

Social Security Act (42 U.S.C. Section 1396n(c), (i), or (k));

(D) the provision of basic attendant and habilitation services under Section 534.152; and

(E) the benefits of providing STAR+PLUS Medicaid managed care services to persons based on functional needs;

(3) include feedback on the pilot program based on the personal experiences of:

(A) individuals with an intellectual or developmental disability and individuals with similar functional needs who participated in the pilot program;

(B) families of and other persons actively involved in the lives of individuals described by Paragraph (A); and

(C) comprehensive long-term services and supports providers who delivered services under the pilot program;

(4) be incorporated in the annual report required under Section 534.054; and

(5) include recommendations on:

(A) a system of programs and services for consideration by the legislature;

(B) necessary statutory changes; and

(C) whether to implement the pilot program statewide under the STAR+PLUS Medicaid managed care program for eligible individuals.

Revised Law

Sec. 542.0120. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF CARE. (a) During the evaluation of the pilot program required under Section 542.0119, the commission may continue the pilot program to ensure continuity of care for pilot program participants. If, following the evaluation, the commission does not continue the pilot program, the commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits for pilot program participants to the benefits provided before participation in the pilot program.

(b) A transition plan under Subsection (a) shall be developed in collaboration with the advisory committee and pilot program work group and with stakeholder input as described by Section 542.0105. (Gov. Code, Sec. 534.110.)

Source Law

Sec. 534.110. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF SERVICES. (a) During the evaluation of the pilot program required under Section 534.112, the commission may continue the pilot program to ensure continuity of care for pilot program participants. If the commission does not continue the pilot program following the evaluation, the commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits for pilot program

participants to the benefits provided before participating in the pilot program.

(b) A transition plan under Subsection (a) shall be developed in consultation and collaboration with the advisory committee and pilot program workgroup and with stakeholder input as described by Section 534.103.

Revised Law

Sec. 542.0121. SERVICE TRANSITION REQUIREMENTS. (a) For purposes of implementing the pilot program and transitioning the provision of services provided to recipients under certain Medicaid waiver programs to a Medicaid managed care delivery model following completion of the pilot program, the commission shall:

(1) implement and maintain a certification process for and maintain regulatory oversight over providers under the Texas home living (TxHmL) and home and community-based services (HCS) waiver programs; and

(2) require managed care organizations to include in the organizations' provider networks providers who are certified in accordance with the certification process described by Subdivision (1).

(b) For purposes of implementing the pilot program and transitioning the provision of services described by Section 542.0201 to the STAR+PLUS Medicaid managed care program, a comprehensive long-term services and supports provider:

(1) must report to the managed care organization in the network of which the provider participates each encounter of any directly contracted service;

(2) must provide to the managed care organization quarterly reports on:

(A) coordinated services and time frames for the delivery of those services; and

(B) the goals and objectives outlined in an individual's person-centered plan and progress made toward meeting those goals and objectives; and

(3) may not be held accountable for the provision of services specified in an individual's service plan that are not

authorized or are subsequently denied by the managed care organization.

(c) On transitioning services under a Medicaid waiver program to a Medicaid managed care delivery model, the commission shall ensure that individuals do not lose benefits the individuals receive under the Medicaid waiver program. (Gov. Code, Sec. 534.252.)

Source Law

Sec. 534.252. REQUIREMENTS REGARDING TRANSITION OF SERVICES. (a) For purposes of implementing the pilot program under Subchapter C and transitioning the provision of services provided to recipients under certain Medicaid waiver programs to a Medicaid managed care delivery model following completion of the pilot program, the commission shall:

(1) implement and maintain a certification process for and maintain regulatory oversight over providers under the Texas home living (TxHmL) and home and community-based services (HCS) waiver programs; and

(2) require managed care organizations to include in the organizations' provider networks providers who are certified in accordance with the certification process described by Subdivision (1).

(b) For purposes of implementing the pilot program under Subchapter C and transitioning the provision of services described by Section 534.202 to the STAR+PLUS Medicaid managed care program, a comprehensive long-term services and supports provider:

(1) must report to the managed care organization in the network of which the provider participates each encounter of any directly contracted service;

(2) must provide to the managed care organization quarterly reports on:

(A) coordinated services and time frames for the delivery of those services; and

(B) the goals and objectives outlined in an individual's person-centered plan and progress made toward meeting those goals and objectives; and

(3) may not be held accountable for the provision of services specified in an individual's service plan that are not authorized or subsequently denied by the managed care organization.

(c) On transitioning services under a Medicaid waiver program to a Medicaid managed care delivery model, the commission shall ensure that individuals do not lose benefits they receive under the Medicaid waiver program.

Revisor's Note

Section 534.252(b), Government Code, refers to "services described by Section 534.202," Government Code. The relevant provisions of Section 534.202 are

revised in this chapter as Section 542.0201. The revised law is drafted accordingly.

SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND CERTAIN OTHER SERVICES

Revised Law

Sec. 542.0151. DELIVERY OF ACUTE CARE SERVICES TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a) Subject to Sections 540.0701 and 540.0753, the commission shall:

(1) provide acute care Medicaid benefits to individuals with an intellectual or developmental disability through the STAR+PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model; and

(2) monitor the provision of those benefits.

(b) The commission, in collaboration with the advisory committee, shall analyze the outcomes of providing acute care Medicaid benefits to individuals with an intellectual or developmental disability under a model described by Subsection (a). The analysis must:

(1) include an assessment of the effects of the delivery model on:

(A) access to and quality of acute care services; and

(B) the number and types of fair hearing and appeals processes in accordance with federal law;

(2) be incorporated into the annual report to the legislature required under Section 542.0054; and

(3) include recommendations for delivery model improvements and implementation for the legislature's consideration, including recommendations for needed statutory changes. (Gov. Code, Sec. 534.151.)

Source Law

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a) Subject to Section 533.0025, the

commission shall provide acute care Medicaid benefits to individuals with an intellectual or developmental disability through the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model and monitor the provision of those benefits.

(b) The commission and the department, in consultation and collaboration with the advisory committee, shall analyze the outcomes of providing acute care Medicaid benefits to individuals with an intellectual or developmental disability under a model specified in Subsection (a). The analysis must:

(1) include an assessment of the effects on:

(A) access to and quality of acute care services; and

(B) the number and types of fair hearing and appeals processes in accordance with applicable federal law;

(2) be incorporated into the annual report to the legislature required under Section 534.054; and

(3) include recommendations for delivery model improvements and implementation for consideration by the legislature, including recommendations for needed statutory changes.

Revisor's Note

(1) Section 534.151(a), Government Code, refers to the provision of acute care Medicaid benefits, "[s]ubject to Section 533.0025," Government Code. The relevant provisions of Section 533.0025 requiring delivering Medicaid services through the most cost-effective model of managed care are revised in this chapter as Sections 540.0701 and 540.0753. The revised law is drafted accordingly.

(2) Section 534.151(b), Government Code, refers to the Health and Human Services Commission and "the department." Former Section 534.001(3), Government Code, defined "department" for purposes of the chapter from which this chapter of revised law is derived to mean the Department of Aging and Disability Services. That definition was repealed in 2019 by Chapter 1330 (H.B. 4533), Acts of the 86th Legislature, Regular Session. The Department of Aging and Disability Services was abolished effective September 1, 2017, in accordance with Section 531.0202(b), Government Code, which is executed law that expired September 1, 2023,

and the powers and duties of that department were transferred to the commission. Section 531.0011, Government Code, which is revised in this subtitle as Section 521.0002, provides that a reference to the department means the commission or the appropriate division of the commission. Because the department no longer exists and the commission has assumed the powers and duties of the department, the revised law omits "department."

Revised Law

Sec. 542.0152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR+PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM PROVIDERS. (a) The commission shall:

(1) implement the option for the delivery of basic attendant and habilitation services to individuals with an intellectual or developmental disability under the STAR+PLUS Medicaid managed care program that:

(A) is the most cost-effective; and

(B) maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR+PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss a personal attendant providing basic attendant and habilitation services under the program.

(b) The commission shall require each managed care organization that contracts with the commission to provide basic attendant and habilitation services under the STAR+PLUS Medicaid managed care program in accordance with this section to:

(1) include in the organization's provider network for the provision of those services:

(A) home and community support services agencies licensed under Chapter 142, Health and Safety Code, with which the commission has a contract to provide services under the community

living assistance and support services (CLASS) waiver program; and

(B) persons exempted from licensing under Section 142.003(a)(19), Health and Safety Code, with which the commission has a contract to provide services under:

(i) the home and community-based services (HCS) waiver program; or

(ii) the Texas home living (TxHmL) waiver program;

(2) review and consider any assessment conducted by a local intellectual and developmental disability authority providing intellectual and developmental disability service coordination under Subsection (c); and

(3) enter into a written agreement with each local intellectual and developmental disability authority in the service area regarding the processes the organization and the authority will use to coordinate the services provided to individuals with an intellectual or developmental disability.

(c) The commission shall contract with and make contract payments to local intellectual and developmental disability authorities to:

(1) provide intellectual and developmental disability service coordination to individuals with an intellectual or developmental disability under the STAR+PLUS Medicaid managed care program by assisting individuals who are eligible to receive services in a community-based setting, including individuals transitioning to a community-based setting;

(2) provide to the appropriate managed care organization, based on the functional need, risk factors, and desired outcomes of an individual with an intellectual or developmental disability, an assessment of whether the individual needs attendant or habilitation services;

(3) assist individuals with an intellectual or developmental disability with developing the individuals' plans of care under the STAR+PLUS Medicaid managed care program, including

with making any changes resulting from periodic reassessments of the plans;

(4) provide to the appropriate managed care organization and the commission information regarding the recommended plans of care with which the authorities provide assistance as provided by Subdivision (3), including documentation necessary to demonstrate the need for care described by a plan; and

(5) annually provide to the appropriate managed care organization and the commission a description of outcomes based on an individual's plan of care.

(d) Local intellectual and developmental disability authorities providing service coordination under this section may not also provide attendant and habilitation services under this section.

(e) A local intellectual and developmental disability authority with which the commission contracts under Subsection (c) may subcontract with an eligible person, including a nonprofit entity, to coordinate the delivery of services to individuals with an intellectual or developmental disability under this section. The executive commissioner by rule shall establish minimum qualifications a person must meet to be considered an eligible person under this subsection.

(f) The commission may contract with providers participating in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, the community living assistance and support services (CLASS) waiver program, or the deaf-blind with multiple disabilities (DBMD) waiver program for the delivery of basic attendant and habilitation services to individuals as described by Subsection (a). The commission has regulatory and oversight authority over the providers with which the commission contracts for the delivery of those services. (Gov. Code, Secs. 534.152(a), (b), (c), (d), (f), (g).)

Source Law

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM PROVIDERS. (a) The commission shall:

(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with an intellectual or developmental disability under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.

(b) The commission shall require that each managed care organization that contracts with the commission for the provision of basic attendant and habilitation services under the STAR + PLUS Medicaid managed care program in accordance with this section:

(1) include in the organization's provider network for the provision of those services:

(A) home and community support services agencies licensed under Chapter 142, Health and Safety Code, with which the department has a contract to provide services under the community living assistance and support services (CLASS) waiver program; and

(B) persons exempted from licensing under Section 142.003(a)(19), Health and Safety Code, with which the department has a contract to provide services under:

(i) the home and community-based services (HCS) waiver program; or

(ii) the Texas home living (TxHmL) waiver program;

(2) review and consider any assessment conducted by a local intellectual and developmental disability authority providing intellectual and developmental disability service coordination under Subsection (c); and

(3) enter into a written agreement with each local intellectual and developmental disability authority in the service area regarding the processes the organization and the authority will use to coordinate the services of individuals with an intellectual or developmental disability.

(c) The department shall contract with and make contract payments to local intellectual and developmental disability authorities to conduct the following activities under this section:

(1) provide intellectual and developmental disability service coordination to individuals with an intellectual or developmental disability under the STAR + PLUS Medicaid managed care program by assisting those individuals who are eligible to receive services in a community-based setting, including individuals transitioning to a community-based setting;

(2) provide an assessment to the appropriate managed care organization regarding whether an individual with an intellectual or

developmental disability needs attendant or habilitation services, based on the individual's functional need, risk factors, and desired outcomes;

(3) assist individuals with an intellectual or developmental disability with developing the individuals' plans of care under the STAR + PLUS Medicaid managed care program, including with making any changes resulting from periodic reassessments of the plans;

(4) provide to the appropriate managed care organization and the department information regarding the recommended plans of care with which the authorities provide assistance as provided by Subdivision (3), including documentation necessary to demonstrate the need for care described by a plan; and

(5) on an annual basis, provide to the appropriate managed care organization and the department a description of outcomes based on an individual's plan of care.

(d) Local intellectual and developmental disability authorities providing service coordination under this section may not also provide attendant and habilitation services under this section.

(f) A local intellectual and developmental disability authority with which the department contracts under Subsection (c) may subcontract with an eligible person, including a nonprofit entity, to coordinate the services of individuals with an intellectual or developmental disability under this section. The executive commissioner by rule shall establish minimum qualifications a person must meet to be considered an "eligible person" under this subsection.

(g) The department may contract with providers participating in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, the community living assistance and support services (CLASS) waiver program, or the deaf-blind with multiple disabilities (DBMD) waiver program for the delivery of basic attendant and habilitation services described in Subsection (a) for individuals to which that subsection applies. The department has regulatory and oversight authority over the providers with which the department contracts for the delivery of those services.

Revisor's Note

(1) Sections 534.152(b), (c), (f), and (g), Government Code, refer to "the department," meaning the Department of Aging and Disability Services as explained in Revisor's Note (2) to Section 542.0151 of this chapter. The revised law substitutes "commission" for "department" for the reason stated in that revisor's note.

(2) Section 534.152(e), Government Code, requires that certain service providers be considered significant traditional providers during the first

three years that basic attendant and habilitation services are provided to certain individuals under the STAR+PLUS Medicaid managed care program. The Health and Human Services Commission began providing the services through that program in 2015. Therefore, the revised law omits that provision as executed. The omitted law reads:

> (e) During the first three years basic attendant and habilitation services are provided to individuals with an intellectual or developmental disability under the STAR + PLUS Medicaid managed care program in accordance with this section, providers eligible to participate in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, or the community living assistance and support services (CLASS) waiver program on September 1, 2013, are considered significant traditional providers.

SUBCHAPTER E. STAGE TWO: TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM

Revised Law

Sec. 542.0201. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) This section applies to individuals with an intellectual or developmental disability who are receiving long-term services and supports under:

(1) a Medicaid waiver program; or

(2) an ICF-IID program.

(b) After implementing the pilot program under Subchapter C and completing the evaluations required by Section 542.0119, the commission, in collaboration with the advisory committee, shall develop a plan for transitioning all or a portion of the services provided through a Medicaid waiver program or an ICF-IID program to a Medicaid managed care model. The plan must include:

(1) a process for transitioning the services in the following phases:

(A) beginning September 1, 2027, the Texas home living (TxHmL) waiver program services;

(B) beginning September 1, 2029, the community living assistance and support services (CLASS) waiver program services;

(C) beginning September 1, 2031, nonresidential services provided under the home and community-based services (HCS) waiver program and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) subject to Subdivision (2), the residential services provided under an ICF-IID program, the home and community-based services (HCS) waiver program, and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(2) a process for evaluating and determining the feasibility and cost efficiency of transitioning residential services described by Subdivision (1)(D) to a Medicaid managed care model based on an evaluation of a separate pilot program the commission, in collaboration with the advisory committee, conducts that operates after the transition process described by Subdivision (1).

(c) Before implementing the transition plan, the commission shall determine whether to:

(1) continue operating the Medicaid waiver programs or ICF-IID program only for purposes of providing, if applicable:

(A) supplemental long-term services and supports not available under the managed care program delivery model the commission selects; or

(B) long-term services and supports to Medicaid waiver program recipients who choose to continue receiving benefits under the waiver programs as provided by Section 542.0202(a); or

(2) provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs or ICF-IID program through the managed care program delivery model the commission selects.

(d) In implementing the transition plan, the commission shall develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input the advisory committee provides.

(e) The commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits under this section that protects the continuity of care provided to individuals to whom this section applies and ensures that individuals have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model.

(f) Before transitioning the provision of Medicaid benefits for children under this section, a managed care organization providing services under the managed care program delivery model the commission selects must demonstrate to the commission's satisfaction that the providers in the organization's provider network have experience and expertise in providing services to children with an intellectual or developmental disability.

(g) Before transitioning the provision of Medicaid benefits for adults under this section, a managed care organization providing services under the managed care program delivery model the commission selects must demonstrate to the commission's satisfaction that the providers in the organization's provider network have experience and expertise in providing services to adults with an intellectual or developmental disability. (Gov. Code, Secs. 534.202(a), (b), (c), (d), (e), (f).)

Source Law

Sec. 534.202. DETERMINATION TO TRANSITION ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) This section applies to individuals with an intellectual or developmental disability who are receiving long-term services and supports under:

(1) a Medicaid waiver program; or

(2) an ICF-IID program.

(b) Subject to Subsection (g), after implementing the pilot program under Subchapter C and completing the evaluation under Section 534.112, the commission, in consultation and collaboration with the advisory committee, shall develop a plan for the

transition of all or a portion of the services provided through an ICF-IID program or a Medicaid waiver program to a Medicaid managed care model. The plan must include:

(1) a process for transitioning the services in phases as follows:

(A) beginning September 1, 2027, the Texas home living (TxHmL) waiver program services;

(B) beginning September 1, 2029, the community living assistance and support services (CLASS) waiver program services;

(C) beginning September 1, 2031, nonresidential services provided under the home and community-based services (HCS) waiver program and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) subject to Subdivision (2), the residential services provided under an ICF-IID program, the home and community-based services (HCS) waiver program, and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(2) a process for evaluating and determining the feasibility and cost efficiency of transitioning residential services described by Subdivision (1)(D) to a Medicaid managed care model that is based on an evaluation of a separate pilot program conducted by the commission, in consultation and collaboration with the advisory committee, that operates after the transition process described by Subdivision (1).

(c) Before implementing the transition described by Subsection (b), the commission shall, subject to Subsection (g), determine whether to:

(1) continue operation of the Medicaid waiver programs or ICF-IID program only for purposes of providing, if applicable:

(A) supplemental long-term services and supports not available under the managed care program delivery model selected by the commission; or

(B) long-term services and supports to Medicaid waiver program recipients who choose to continue receiving benefits under the waiver programs as provided by Subsection (g); or

(2) provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs or ICF-IID program through the managed care program delivery model selected by the commission.

(d) In implementing the transition described by Subsection (b), the commission shall develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input provided by the advisory committee.

(e) The commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits under this section that protects the continuity of care provided to individuals to whom this section applies and ensures individuals have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model.

(f) Before transitioning the provision of Medicaid benefits for children under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the

provision of services to children with an intellectual or developmental disability. Before transitioning the provision of Medicaid benefits for adults with an intellectual or developmental disability under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to adults with an intellectual or developmental disability.

Revisor's Note

Sections 534.202(b) and (c), Government Code, provide that "[s]ubject to Subsection (g)" of Section 534.202, Government Code, the Health and Human Services Commission shall carry out certain duties. The revised law omits the quoted phrase because the requirements of Subsection (g), which is revised in this chapter as Section 542.0202(a), apply by their own terms, and a separate statement to that effect is unnecessary.

Revised Law

Sec. 542.0202. RECIPIENT CHOICE OF DELIVERY MODEL. (a) If the commission determines under Section 542.0201(c)(2) that all or a portion of the long-term services and supports previously available under Medicaid waiver programs should be provided through a managed care program delivery model, the commission shall, at the time of the transition, allow each recipient receiving long-term services and supports under a Medicaid waiver program the option of:

(1) continuing to receive the services and supports under the Medicaid waiver program; or

(2) receiving the services and supports through the managed care program delivery model the commission selects.

(b) A recipient who chooses under Subsection (a) to receive long-term services and supports through a managed care program delivery model may not subsequently choose to receive the services and supports under a Medicaid waiver program. (Gov. Code, Secs. 534.202(g), (h).)

Source Law

(g) If the commission determines that all or a portion of the long-term services and supports previously available under the Medicaid waiver programs should be provided through a managed care program delivery model under Subsection (c)(2), the commission shall, at the time of the transition, allow each recipient receiving long-term services and supports under a Medicaid waiver program the option of:

(1) continuing to receive the services and supports under the Medicaid waiver program; or

(2) receiving the services and supports through the managed care program delivery model selected by the commission.

(h) A recipient who chooses to receive long-term services and supports through a managed care program delivery model under Subsection (g) may not, at a later time, choose to receive the services and supports under a Medicaid waiver program.

Revised Law

Sec. 542.0203. REQUIRED CONTRACT PROVISIONS. In addition to the requirements of Subchapter F, Chapter 540, a contract between a managed care organization and the commission for the organization to provide Medicaid benefits under Section 542.0201 must contain a requirement that the organization implement a process for individuals with an intellectual or developmental disability that:

(1) ensures that the individuals have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model;

(2) to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including through the use of single-case agreements with out-of-network providers; and

(3) provides access to a member services telephone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary and specialty services and other long-term services and supports. (Gov. Code, Sec. 534.202(i).)

Source Law

(i) In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization to provide Medicaid benefits under this section must contain a requirement that the organization implement a process for individuals with an intellectual or developmental disability that:

(1) ensures that the individuals have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model;

(2) to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including the use of single-case agreements with out-of-network providers; and

(3) provides access to a member services phone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary, specialty, and other long-term services and supports.

Revisor's Note

(1) Section 534.202(i), Government Code, refers to the "requirements of Section 533.005," Government Code, meaning the required provisions in a contract between a Medicaid managed care organization and the Health and Human Services Commission for the organization to provide health care services to Medicaid recipients. The required contract provisions of Section 533.005 are revised in this subtitle as Subchapter F, Chapter 540. Accordingly, the revised law throughout this subchapter substitutes a reference to the "requirements of Subchapter F" for the quoted phrase.

(2) Section 534.202(i), Government Code, refers to a contract for a managed care organization to provide Medicaid benefits under "this section," meaning Section 534.202, Government Code. The provisions of Section 534.202 relating to the provision of Medicaid benefits by a managed care organization are revised in this chapter as Section 542.0201, and the revised law is drafted accordingly.

Revised Law

Sec. 542.0204. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure, on making a determination to transition services under Section 542.0201:

(1) that the commission is responsible for setting the minimum reimbursement rate paid to an ICF-IID services or group home provider under the integrated managed care system, including the staff rate enhancement paid to an ICF-IID services or group home provider;

(2) that an ICF-IID services or group home provider is paid not later than the 10th day after the date the provider submits a clean claim in accordance with the criteria the commission uses to reimburse an ICF-IID services or group home provider, as applicable;

(3) the establishment of an electronic portal through which an ICF-IID services or group home provider participating in the STAR+PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as appropriate, may submit long-term services and supports claims to any participating managed care organization; and

(4) that the consumer direction model is an available option for each individual with an intellectual or developmental disability who receives Medicaid benefits in accordance with this subchapter to achieve self-determination, choice, and control and that the individual or the individual's legally authorized representative has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the individual. (Gov. Code, Sec. 534.203.)

Source Law

> Sec. 534.203. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure, on making a determination to transition services under Section 534.202:
>
> (1) that the commission is responsible for setting the minimum reimbursement rate paid to a provider of ICF-IID services or a group home provider

under the integrated managed care system, including the staff rate enhancement paid to a provider of ICF-IID services or a group home provider;

(2) that an ICF-IID service provider or a group home provider is paid not later than the 10th day after the date the provider submits a clean claim in accordance with the criteria used by the commission for the reimbursement of ICF-IID service providers or a group home provider, as applicable;

(3) the establishment of an electronic portal through which a provider of ICF-IID services or a group home provider participating in the STAR+PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as appropriate, may submit long-term services and supports claims to any participating managed care organization; and

(4) that the consumer direction model is an available option for each individual with an intellectual or developmental disability who receives Medicaid benefits in accordance with this subchapter to achieve self-determination, choice, and control, and that the individual or the individual's legally authorized representative has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the individual.

Revisor's Note

Section 534.203, Government Code, refers to the Health and Human Services Commission making a determination to transition services under "Section 534.202," Government Code. The provisions of Section 534.202 relating to making a determination to transition services are revised as Section 542.0201 of this chapter, and the revised law is drafted accordingly.

CHAPTER 543. CLINICAL INITIATIVES TO IMPROVE MEDICAID QUALITY OF CARE AND COST-EFFECTIVENESS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 543.0001. EFFECT OF CHAPTER ON COMMISSION'S AUTHORITY . . . . . 625
Sec. 543.0002. RULES . . . . . 626
Sec. 543.0003. INTERNET WEBSITE . . . . . 626

SUBCHAPTER B. ASSESSMENT OF CLINICAL INITIATIVES

Sec. 543.0051. MEDICAID QUALITY IMPROVEMENT PROCESS . . . . 627
Sec. 543.0052. SOLICITATION OF SUGGESTIONS FOR CLINICAL INITIATIVES . . . . . 627
Sec. 543.0053. CLINICAL INITIATIVE EVALUATION PROCESS . . . 630

Sec. 543.0054. ANALYSIS OF CLINICAL INITIATIVES . . . . . 632
Sec. 543.0055. FINAL REPORT ON CLINICAL INITIATIVE . . . . . 633
Sec. 543.0056. COMMISSION ACTION ON CLINICAL INITIATIVE . . . . . 634

# CHAPTER 543. CLINICAL INITIATIVES TO IMPROVE MEDICAID QUALITY OF CARE AND COST-EFFECTIVENESS

## SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 543.0001. EFFECT OF CHAPTER ON COMMISSION'S AUTHORITY. This chapter does not affect the commission's authority, or give the commission additional authority, to:

(1) affect any individual health care treatment decision for a Medicaid recipient;

(2) replace or affect:

(A) the process of determining Medicaid benefits, including the approval process for receiving benefits for durable medical equipment; or

(B) any applicable approval process required for reimbursement for services or other equipment under Medicaid;

(3) implement a clinical initiative or associated rule or program policy that is otherwise prohibited under state or federal law; or

(4) implement any initiative that would expand eligibility for Medicaid benefits. (Gov. Code, Sec. 538.002.)

Source Law

Sec. 538.002. EFFECT OF CHAPTER; AUTHORITY OF COMMISSION. This chapter does not affect or give the commission additional authority to:

(1) affect any individual health care treatment decision for a Medicaid recipient;

(2) replace or affect the process of determining Medicaid benefits, including the approval process for receiving benefits for durable medical equipment, or any applicable approval process required for reimbursement for services or other equipment under Medicaid;

(3) implement a clinical initiative or associated rule or program policy that is otherwise prohibited under state or federal law; or

(4) implement any initiative that would expand eligibility for benefits under Medicaid.

Revised Law

Sec. 543.0002. RULES. The executive commissioner shall adopt rules necessary to implement this chapter. (Gov. Code, Sec. 538.003.)

Source Law

> Sec. 538.003. RULES. The executive commissioner shall adopt rules necessary to implement this chapter.

Revised Law

Sec. 543.0003. INTERNET WEBSITE. The commission shall maintain an Internet website related to the quality improvement process required under this chapter. The website must include:

(1) an explanation of the process for submission, preliminary review, analysis, and approval of a clinical initiative under this chapter;

(2) an explanation of how members of the public may submit comments or research related to an initiative;

(3) a copy of each initiative selected for analysis under Section 543.0054;

(4) the status of each initiative in the approval process; and

(5) a copy of each final report prepared under this chapter. (Gov. Code, Sec. 538.056.)

Source Law

> Sec. 538.056. INTERNET WEBSITE. The commission shall maintain an Internet website related to the quality improvement process required under this chapter. The website must include:
>
> (1) an explanation of the process for submission, preliminary review, analysis, and approval of clinical initiatives under this chapter;
>
> (2) an explanation of how members of the public may submit comments or research related to an initiative;
>
> (3) a copy of each initiative selected for analysis under Section 538.054;
>
> (4) the status of each initiative in the approval process; and
>
> (5) a copy of each final report prepared under this chapter.

SUBCHAPTER B. ASSESSMENT OF CLINICAL INITIATIVES

Revised Law

Sec. 543.0051. MEDICAID QUALITY IMPROVEMENT PROCESS. The commission shall, in accordance with this chapter, develop and implement a quality improvement process by which the commission:

(1) receives suggestions for clinical initiatives designed to improve:

(A) the quality of care provided under Medicaid; and

(B) the cost-effectiveness of Medicaid;

(2) conducts a preliminary review under Section 543.0053(2) of each suggestion received under Section 543.0052 to determine whether the suggestion warrants further consideration and analysis; and

(3) conducts an analysis under Section 543.0054 of each suggestion that is selected for analysis in accordance with Subdivision (2). (Gov. Code, Sec. 538.051.)

Source Law

> Sec. 538.051. MEDICAID QUALITY IMPROVEMENT PROCESS. The commission shall, according to the provisions of this chapter, develop and implement a quality improvement process by which the commission:
> (1) receives suggestions for clinical initiatives designed to improve:
> (A) the quality of care provided under Medicaid; and
> (B) the cost-effectiveness of Medicaid;
> (2) conducts a preliminary review under Section 538.053(4) of each suggestion received under Section 538.052 to determine whether the suggestion warrants further consideration and analysis; and
> (3) conducts an analysis under Section 538.054 of clinical initiative suggestions that are selected for analysis under Subdivision (2).

Revised Law

Sec. 543.0052. SOLICITATION OF SUGGESTIONS FOR CLINICAL INITIATIVES. (a) Subject to Subsection (b), the commission shall solicit and accept written or electronic suggestions for clinical initiatives from:

(1) a member of the legislature;

(2) the executive commissioner;

(3) the commissioner of state health services;

(4) the commissioner of the Department of Family and Protective Services; and

(5) the medical care advisory committee appointed under Section 32.022, Human Resources Code.

(b) The commission may not accept a suggestion for a clinical initiative that:

(1) is undergoing clinical trials; or

(2) expands a health care provider's scope of practice beyond the law governing the provider's practice. (Gov. Code, Sec. 538.052.)

Source Law

Sec. 538.052. SOLICITATION OF SUGGESTIONS FOR CLINICAL INITIATIVES. (a) Subject to Subsection (b), the commission shall solicit and accept suggestions for clinical initiatives, in either written or electronic form, from:

(1) a member of the state legislature;

(2) the executive commissioner;

(3) the commissioner of aging and disability services;

(4) the commissioner of state health services;

(5) the commissioner of the Department of Family and Protective Services;

(6) the commissioner of assistive and rehabilitative services;

(7) the medical care advisory committee established under Section 32.022, Human Resources Code; and

(8) the physician payment advisory committee created under Section 32.022(d), Human Resources Code.

(b) The commission may not accept suggestions under this section for an initiative that:

(1) is undergoing clinical trials; or

(2) expands a health care provider's scope of practice beyond the law governing the provider's practice.

Revisor's Note

(1) Section 538.052(a), Government Code, refers to soliciting and accepting suggestions for clinical initiatives from "the commissioner of aging and disability services" and "the commissioner of assistive and rehabilitative services." The commissioner of aging and disability services was the chief administrative officer of the Department of Aging and Disability Services, and the commissioner of

assistive and rehabilitative services was the chief administrative officer of the Department of Assistive and Rehabilitative Services. The Department of Aging and Disability Services was abolished September 1, 2017, in accordance with Section 531.0202(b), Government Code, which is executed law that expired September 1, 2023. The Department of Assistive and Rehabilitative Services was abolished September 1, 2016, in accordance with Section 531.0202(a), Government Code, which is also executed law that expired September 1, 2023. Because those agencies have been abolished, no individuals serve as the chief administrative officers of the agencies who would make suggestions for clinical initiatives. The revised law therefore omits the quoted references as obsolete.

(2) Section 538.052(a)(8), Government Code, refers to "the physician payment advisory committee created under Section 32.022(d), Human Resources Code." The referenced advisory committee, which functioned as a subcommittee of the medical care advisory committee established under Section 32.022, Human Resources Code, was to be automatically abolished August 31, 2017. See 39 Tex. Reg. 340 (2014).

In 2015, Section 2.02, Chapter 946 (S.B. 277), Acts of the 84th Legislature, Regular Session, 2015, amended Section 531.012(a), Government Code, to require the executive commissioner of the Health and Human Services Commission to establish and maintain advisory committees to consider and solicit public input on certain health and human services-related issues. Section 2.39 of that Act required the executive commissioner to, not later than November 1, 2015, publish in the Texas Register a list of new

advisory committees to be established under Section 531.012(a), Government Code, as amended by the Act, and a list that identified advisory committees whose functions would be assumed by newly established advisory committees. In October 2015, under authority of that section, the executive commissioner identified the physician payment advisory committee as a committee to be discontinued. See 40 Tex. Reg. 7726 (2015). The committee was subsequently discontinued before its automatic abolition date of August 31, 2017. Accordingly, the revised law omits the quoted reference to the advisory committee as obsolete.

Revised Law

Sec. 543.0053. CLINICAL INITIATIVE EVALUATION PROCESS. The commission shall establish and implement an evaluation process for the submission, preliminary review, analysis, and approval of a clinical initiative. The process must:

(1) require that a suggestion for a clinical initiative be submitted to the state Medicaid director;

(2) allow the commission to conduct, with the assistance of an appropriate advisory committee or similar group as determined by the commission, a preliminary review of each suggested clinical initiative to determine whether the initiative warrants further consideration and analysis under Section 543.0054;

(3) require the commission to publish on the Internet website maintained in accordance with Section 543.0003 the criteria the commission uses in the preliminary review under Subdivision (2) to determine whether an initiative warrants analysis under Section 543.0054;

(4) limit the number of suggestions analyzed under Section 543.0054;

(5) require that a suggestion for a clinical initiative selected for analysis under Section 543.0054 be

published on the Internet website maintained in accordance with Section 543.0003 not later than the 30th day after the date the state Medicaid director receives the suggestion;

(6) provide for a formal public comment period that lasts at least 30 days during which the public may submit comments and research relating to a suggested clinical initiative;

(7) require commission employees to analyze, in accordance with Section 543.0054, each suggested clinical initiative selected for analysis; and

(8) require the development and publication of a final report in accordance with Section 543.0055 on each clinical initiative selected for analysis under Section 543.0054 not later than the 180th day after the date the state Medicaid director receives the suggestion. (Gov. Code, Sec. 538.053.)

Source Law

Sec. 538.053. CLINICAL INITIATIVE EVALUATION PROCESS. The commission shall establish and implement an evaluation process for the submission, preliminary review, analysis, and approval of a clinical initiative. The process must:

(1) require that a suggestion for a clinical initiative be submitted to the state Medicaid director;

(2) require that a suggestion for a clinical initiative selected for analysis under Section 538.054 be published on the Internet website created under Section 538.056 not later than the 30th day after the date on which the state Medicaid director receives the suggestion;

(3) provide for a formal public comment period that lasts at least 30 days during which the public may submit comments and research relating to a suggested clinical initiative;

(4) allow the commission to conduct with the assistance of appropriate advisory committees or similar groups as determined by the commission a preliminary review of each suggested clinical initiative to determine whether the initiative warrants further consideration and analysis under Section 538.054;

(5) limit the number of suggestions that receive analysis under Section 538.054;

(6) require the commission to publish on the Internet website created under Section 538.056 the criteria the commission uses in the preliminary review under Subdivision (4) to determine whether an initiative warrants analysis under Section 538.054;

(7) require commission employees to perform an analysis of each suggested clinical initiative selected for analysis in accordance with Section 538.054; and

(8) require the development and

publication of a final report in accordance with Section 538.055 on each clinical initiative selected for analysis under Section 538.054 not later than the 180th day after the date on which the state Medicaid director receives the suggestion.

Revised Law

Sec. 543.0054. ANALYSIS OF CLINICAL INITIATIVES. After conducting a preliminary review of a clinical initiative under Section 543.0053(2), the commission shall analyze the clinical initiative if the commission selects the initiative for analysis. The analysis must include a review of:

(1) any public comments and submitted research relating to the initiative;

(2) the available clinical research and historical utilization information relating to the initiative;

(3) published medical literature relating to the initiative;

(4) any adoption of the initiative by a medical society or other clinical group;

(5) whether the initiative has been implemented under:

(A) the Medicare program;

(B) another state medical assistance program; or

(C) a state-operated health care program, including the child health plan program;

(6) the results of reports, research, pilot programs, or clinical studies relating to the initiative conducted by:

(A) institutions of higher education, including related medical schools;

(B) governmental entities and agencies; and

(C) private and nonprofit think tanks and research groups;

(7) the impact the initiative would have on Medicaid if the initiative were implemented in this state, including:

(A) an estimate of the number of Medicaid recipients that would be impacted by implementing the initiative; and

(B) a description of any potential cost savings to the state that would result from implementing the initiative; and

(8) any statutory barriers to implementing the initiative. (Gov. Code, Sec. 538.054.)

Source Law

Sec. 538.054. ANALYSIS OF CLINICAL INITIATIVES. The commission shall conduct an analysis of each clinical initiative selected by the commission after having conducted the commission's preliminary review under Section 538.053(4). The analysis required under this section must include a review of:

(1) any public comments and submitted research relating to the initiative;

(2) the available clinical research and historical utilization information relating to the initiative;

(3) published medical literature relating to the initiative;

(4) any adoption of the initiative by medical societies or other clinical groups;

(5) whether the initiative has been implemented under:

(A) the Medicare program;

(B) another state medical assistance program; or

(C) a state-operated health care program, including the child health plan program;

(6) the results of reports, research, pilot programs, or clinical studies relating to the initiative conducted by:

(A) institutions of higher education, including related medical schools;

(B) governmental entities and agencies; and

(C) private and nonprofit think tanks and research groups;

(7) the impact that the initiative would have on Medicaid if the initiative were implemented in this state, including:

(A) an estimate of the number of recipients under Medicaid that would be impacted by implementation of the initiative; and

(B) a description of any potential cost savings to the state that would result from implementation of the initiative; and

(8) any statutory barriers to implementation of the initiative.

Revised Law

Sec. 543.0055. FINAL REPORT ON CLINICAL INITIATIVE. The commission shall prepare a final report based on the analysis of a clinical initiative conducted under Section 543.0054. The final report must include:

(1) a final determination of:

(A) the feasibility of implementing the initiative;

(B) the likely impact implementing the initiative would have on the quality of care provided under Medicaid; and

(C) the anticipated cost savings to the state that would result from implementing the initiative;

(2) a summary of the public comments, including a description of any opposition to the initiative;

(3) an identification of any statutory barriers to implementing the initiative; and

(4) if the initiative is not implemented, an explanation of that decision. (Gov. Code, Sec. 538.055.)

Source Law

> Sec. 538.055. FINAL REPORT ON CLINICAL INITIATIVE. The commission shall prepare a final report based on the commission's analysis of a clinical initiative under Section 538.054. The final report must include:
>
> (1) a final determination of:
>
> (A) the feasibility of implementing the initiative;
>
> (B) the likely impact implementing the initiative would have on the quality of care provided under Medicaid; and
>
> (C) the anticipated cost savings to the state that would result from implementing the initiative;
>
> (2) a summary of the public comments, including a description of any opposition to the initiative;
>
> (3) an identification of any statutory barriers to implementation of the initiative; and
>
> (4) if the initiative is not implemented, an explanation of the decision not to implement the initiative.

Revised Law

Sec. 543.0056. COMMISSION ACTION ON CLINICAL INITIATIVE. After the commission analyzes a clinical initiative under Section 543.0054:

(1) if the commission determined that the initiative is cost-effective and will improve the quality of care under Medicaid, the commission may:

(A) implement the initiative if implementing the

initiative is not otherwise prohibited by law; or

(B) if implementation requires a change in law, submit a copy of the final report together with recommendations relating to the initiative's implementation to the standing committees of the senate and house of representatives with jurisdiction over Medicaid; and

(2) if the commission determined that the initiative is not cost-effective or will not improve quality of care under Medicaid, the commission may not implement the initiative. (Gov. Code, Sec. 538.057.)

Source Law

> Sec. 538.057. ACTION ON CLINICAL INITIATIVE BY COMMISSION. After the commission conducts an analysis of a clinical initiative under Section 538.054:
>
> (1) if the commission has determined that the initiative is cost-effective and will improve the quality of care under Medicaid, the commission may:
>
> (A) implement the initiative if implementation of the initiative is not otherwise prohibited by law; or
>
> (B) if implementation requires a change in law, submit a copy of the final report together with recommendations relating to the initiative's implementation to the standing committees of the senate and house of representatives having jurisdiction over Medicaid; and
>
> (2) if the commission has determined that the initiative is not cost-effective or will not improve quality of care under Medicaid, the commission may not implement the initiative.

CHAPTER 543A. QUALITY-BASED OUTCOMES AND PAYMENTS UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS


Sec. 543A.0001. DEFINITIONS . . . . . 637

Sec. 543A.0002. DEVELOPMENT OF OUTCOME AND PROCESS MEASURES; CORRELATION WITH INCREASED REIMBURSEMENT RATES . . . . . 643

Sec. 543A.0003. USE OF QUALITY-BASED OUTCOME MEASURE FOR ENROLLEES OR RECIPIENTS WITH HIV INFECTION . . . . . 647

Sec. 543A.0004. DEVELOPMENT OF QUALITY-BASED PAYMENT SYSTEMS . . . . . 647

Sec. 543A.0005. PAYMENT METHODOLOGY CONVERSION . . . . . 650

Sec. 543A.0006. TRANSPARENCY; CONSIDERATIONS . . . . . 651
Sec. 543A.0007. PERIODIC EVALUATION . . . . . 653
Sec. 543A.0008. ANNUAL REPORT . . . . . 653
SUBCHAPTER B. QUALITY-BASED PAYMENTS RELATING TO MANAGED CARE ORGANIZATIONS
Sec. 543A.0051. QUALITY-BASED PREMIUM PAYMENTS; PERFORMANCE REPORTING . . . . . 655
Sec. 543A.0052. FINANCIAL INCENTIVES AND CONTRACT AWARD PREFERENCES . . . . . 656
SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS
Sec. 543A.0101. DEFINITION . . . . . 658
Sec. 543A.0102. QUALITY-BASED HEALTH HOME PAYMENTS . . . . . 659
Sec. 543A.0103. HEALTH HOME ELIGIBILITY . . . . . 660
SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM
Sec. 543A.0151. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN HOSPITALS . . . . . 661
Sec. 543A.0152. REIMBURSEMENT ADJUSTMENTS . . . . . 662
SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES
Sec. 543A.0201. PAYMENT INITIATIVES; DETERMINATION OF BENEFIT TO STATE . . . . . 663
Sec. 543A.0202. PAYMENT INITIATIVE ADMINISTRATION . . . . . 665
Sec. 543A.0203. QUALITY-OF-CARE AND COST-EFFICIENCY BENCHMARKS AND GOALS; EFFICIENCY PERFORMANCE STANDARDS . . . . . 666
Sec. 543A.0204. PAYMENT RATES UNDER PAYMENT INITIATIVES . . . . . 667
SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENT SYSTEMS
Sec. 543A.0251. QUALITY-BASED PAYMENT SYSTEMS FOR LONG-TERM SERVICES AND SUPPORTS . . . . . 668
Sec. 543A.0252. DATA SET EVALUATION . . . . . 669
Sec. 543A.0253. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN PROVIDERS . . . . . 670

CHAPTER 543A. QUALITY-BASED OUTCOMES AND PAYMENTS UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 543A.0001. DEFINITIONS. In this chapter:

(1) "Alternative payment system" includes:

(A) a global payment system;

(B) an episode-based bundled payment system; and

(C) a blended payment system.

(2) "Blended payment system" means a system for compensating a physician or other health care provider that:

(A) includes at least one feature of a global payment system and an episode-based bundled payment system; and

(B) may include a system under which a portion of the compensation paid to a physician or other health care provider is based on a fee-for-service payment arrangement.

(3) "Enrollee" means an individual enrolled in the child health plan program.

(4) "Episode-based bundled payment system" means a system for compensating a physician or other health care provider for providing or arranging for health care services to an enrollee or recipient that is based on a flat payment for all services provided in connection with a single episode of medical care.

(5) "Exclusive provider benefit plan" means a managed care plan subject to 28 T.A.C. Part 1, Chapter 3, Subchapter KK.

(6) "Freestanding emergency medical care facility" means a facility licensed under Chapter 254, Health and Safety Code.

(7) "Global payment system" means a system for compensating a physician or other health care provider for providing or arranging for a defined set of covered health care services to an enrollee or recipient for a specified period that is based on a predetermined payment per enrollee or recipient for the specified period, without regard to the quantity of services

actually provided.

(8) "Health care provider" means a person, facility, or institution licensed, certified, registered, or chartered by this state to provide health care. The term includes an employee, independent contractor, or agent of a health care provider acting in the course and scope of the employment or contractual relationship.

(9) "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

(10) "Hospital" means an institution licensed under Chapter 241 or 577, Health and Safety Code, including a general or special hospital as defined by Section 241.003 of that code.

(11) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan. The term includes a health maintenance organization and an exclusive provider organization.

(12) "Managed care plan" means a plan, including an exclusive provider benefit plan, under which a person undertakes to provide, arrange or pay for, or reimburse any part of the cost of health care services. The plan must include arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(13) "Physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(14) "Potentially preventable admission" means an individual's admission to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

(15) "Potentially preventable ancillary service" means a health care service that:

(A) a physician or other health care provider provides or orders to supplement or support evaluating or treating a patient, including a diagnostic test, laboratory test, therapy service, or radiology service; and

(B) might not be reasonably necessary to provide quality health care or treatment.

(16) "Potentially preventable complication" means a harmful event or negative outcome with respect to an individual, including an infection or surgical complication, that:

(A) occurs after the individual's admission to a hospital or long-term care facility; and

(B) may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

(17) "Potentially preventable emergency room visit" means an individual's treatment in a hospital emergency room or freestanding emergency medical care facility for a condition that might not require emergency medical attention because the condition could be treated, or could have been prevented, by a physician or other health care provider in a nonemergency setting.

(18) "Potentially preventable event" means a:

(A) potentially preventable admission;

(B) potentially preventable ancillary service;

(C) potentially preventable complication;

(D) potentially preventable emergency room visit;

(E) potentially preventable readmission; or

(F) combination of those events.

(19) "Potentially preventable readmission" means an individual's return hospitalization within a period the commission specifies that may have resulted from deficiencies in the individual's care or treatment provided during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The

term does not include a hospital readmission necessitated by the occurrence of unrelated events after the individual's discharge. The term includes an individual's readmission to a hospital for:

(A) the same condition or procedure for which the individual was previously admitted;

(B) an infection or other complication resulting from care previously provided;

(C) a condition or procedure indicating that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or

(D) another condition or procedure of a similar nature that the executive commissioner determines.

(20) "Quality-based payment system" means a system, including an alternative payment system, for compensating a physician or other health care provider that:

(A) provides incentives to the physician or other health care provider to provide high-quality, cost-effective care; and

(B) bases some portion of the payment made to the physician or other health care provider on quality-of-care outcomes, which may include the extent to which the physician or other health care provider reduces potentially preventable events.

(21) "Recipient" means a Medicaid recipient. (Gov. Code, Secs. 536.001, 536.003(h); New.)

Source Law

Sec. 536.001. DEFINITIONS. In this chapter:

(2) "Alternative payment system" includes:

(A) a global payment system;

(B) an episode-based bundled payment system; and

(C) a blended payment system.

(3) "Blended payment system" means a system for compensating a physician or other health care provider that includes at least one or more features of a global payment system and an episode-based bundled payment system, but that may also include a system under which a portion of the compensation paid to a physician or other health care provider is based on a fee-for-service payment arrangement.

(5) "Episode-based bundled payment

system" means a system for compensating a physician or other health care provider for arranging for or providing health care services to child health plan program enrollees or Medicaid recipients that is based on a flat payment for all services provided in connection with a single episode of medical care.

(6) "Exclusive provider benefit plan" means a managed care plan subject to 28 T.A.C. Part 1, Chapter 3, Subchapter KK.

(7) "Freestanding emergency medical care facility" means a facility licensed under Chapter 254, Health and Safety Code.

(8) "Global payment system" means a system for compensating a physician or other health care provider for arranging for or providing a defined set of covered health care services to child health plan program enrollees or Medicaid recipients for a specified period that is based on a predetermined payment per enrollee or recipient, as applicable, for the specified period, without regard to the quantity of services actually provided.

(9) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution licensed, certified, registered, or chartered by this state to provide health care. The term includes an employee, independent contractor, or agent of a health care provider acting in the course and scope of the employment or contractual relationship.

(10) "Hospital" means a public or private institution licensed under Chapter 241 or 577, Health and Safety Code, including a general or special hospital as defined by Section 241.003, Health and Safety Code.

(11) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan. The term includes health maintenance organizations and exclusive provider organizations.

(12) "Managed care plan" means a plan, including an exclusive provider benefit plan, under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(14) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(15) "Potentially preventable admission" means an admission of a person to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

(16) "Potentially preventable ancillary service" means a health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory test, therapy service, or radiology service, that may not be reasonably necessary for the provision of quality health care or treatment.

(17) "Potentially preventable complication" means a harmful event or negative

outcome with respect to a person, including an infection or surgical complication, that:

(A) occurs after the person's admission to a hospital or long-term care facility; and

(B) may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

(18) "Potentially preventable event" means a potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency room visit, a potentially preventable readmission, or a combination of those events.

(19) "Potentially preventable emergency room visit" means treatment of a person in a hospital emergency room or freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be, or could have been, treated or prevented by a physician or other health care provider in a nonemergency setting.

(20) "Potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

(A) the same condition or procedure for which the person was previously admitted;

(B) an infection or other complication resulting from care previously provided;

(C) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or

(D) another condition or procedure of a similar nature, as determined by the executive commissioner.

(21) "Quality-based payment system" means a system for compensating a physician or other health care provider, including an alternative payment system, that provides incentives to the physician or other health care provider for providing high-quality, cost-effective care and bases some portion of the payment made to the physician or other health care provider on quality of care outcomes, which may include the extent to which the physician or other health care provider reduces potentially preventable events.

[Sec. 536.003]

(h) In this section, "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

Revisor's Note

(1) The revised law adds definitions of "enrollee" and "recipient" for drafting convenience and to avoid frequent, unnecessary repetition of the

substance of the definitions.

(2) Section 536.001(9), Government Code, refers to "any person, partnership, professional association, corporation, facility, or institution." The revised law omits the references to "partnership," "professional association," and "corporation" as unnecessary because the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to the revised law, expressly includes those terms.

(3) Section 536.001(10), Government Code, refers to a "public or private institution." The revised law omits "public or private" because an institution is necessarily either public or private.

(4) Section 536.001(14), Government Code, refers to a "person" licensed to practice medicine, and Sections 536.001(15), (17), (19), and (20), Government Code, refer to a "person" who receives health care services. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to the revised law.

Revised Law

Sec. 543A.0002. DEVELOPMENT OF OUTCOME AND PROCESS MEASURES; CORRELATION WITH INCREASED REIMBURSEMENT RATES. (a) The commission shall develop quality-based outcome and process measures that:

(1) promote the provision of efficient, quality health care; and

(2) can be used in the child health plan program and Medicaid to implement quality-based payments for acute care

services and long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems.

(b) The commission, in coordination with the Department of State Health Services, shall develop and implement a quality-based outcome measure for the child health plan program and Medicaid to annually measure the percentage of enrollees or recipients with HIV infection, regardless of age, whose most recent viral load test indicates a viral load of less than 200 copies per milliliter of blood.

(c) To the extent feasible, the commission shall develop outcome and process measures:

(1) consistently across all child health plan program and Medicaid delivery models and payment systems;

(2) in a manner that takes into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness;

(3) that will have the greatest effect on improving quality of care and the efficient use of services, including acute care services and long-term services and supports;

(4) that are similar to outcome and process measures used in the private sector, as appropriate;

(5) that reflect effective coordination of acute care services and long-term services and supports;

(6) that can be tied to expenditures; and

(7) that reduce preventable health care utilization and costs.

(d) In developing the outcome and process measures, the commission must include measures that are based on potentially preventable events and advance quality improvement and innovation. The outcome measures based on potentially preventable events must:

(1) allow for a rate-based determination of health care provider performance compared to statewide norms; and

(2) be risk-adjusted to account for the severity of

the illnesses of patients a provider serves.

(e) The commission may modify the outcome and process measures to:

(1) promote continuous system reform, improved quality, and reduced costs; and

(2) account for managed care organizations added to a service area.

(f) To the extent feasible, the commission shall align the outcome and process measures with measures required or recommended under reporting guidelines established by:

(1) the Centers for Medicare and Medicaid Services;

(2) the Agency for Healthcare Research and Quality; or

(3) another federal agency.

(g) The executive commissioner by rule may require physicians, other health care providers, and managed care organizations participating in the child health plan program and Medicaid to report information necessary to develop the outcome and process measures to the commission in a format the executive commissioner specifies.

(h) If the commission increases physician and other health care provider reimbursement rates under the child health plan program or Medicaid as a result of an increase in the amounts appropriated for those programs for a state fiscal biennium as compared to the preceding state fiscal biennium, the commission shall, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, correlate the increased reimbursement rates with the quality-based outcome and process measures. (Gov. Code, Secs. 536.003(a), (a-1), (b), (c), (d), (e), (f).)

Source Law

> Sec. 536.003. DEVELOPMENT OF QUALITY-BASED OUTCOME AND PROCESS MEASURES. (a) The commission shall develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan program and Medicaid to implement quality-based payments for acute care services and

long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems. Subject to Subsection (a-1), the commission, in developing outcome and process measures under this section, must include measures that are based on potentially preventable events and that advance quality improvement and innovation. The commission may change measures developed:

(1) to promote continuous system reform, improved quality, and reduced costs; and

(2) to account for managed care organizations added to a service area.

(a-1) The outcome measures based on potentially preventable events must:

(1) allow for rate-based determination of health care provider performance compared to statewide norms; and

(2) be risk-adjusted to account for the severity of the illnesses of patients served by the provider.

(b) To the extent feasible, the commission shall develop outcome and process measures:

(1) consistently across all child health plan program and Medicaid delivery models and payment systems;

(2) in a manner that takes into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness;

(3) that will have the greatest effect on improving quality of care and the efficient use of services, including acute care services and long-term services and supports;

(4) that are similar to outcome and process measures used in the private sector, as appropriate;

(5) that reflect effective coordination of acute care services and long-term services and supports;

(6) that can be tied to expenditures; and

(7) that reduce preventable health care utilization and costs.

(c) The commission shall, to the extent feasible, align outcome and process measures developed under this section with measures required or recommended under reporting guidelines established by the federal Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency.

(d) The executive commissioner by rule may require managed care organizations and physicians and other health care providers participating in the child health plan program and Medicaid to report to the commission in a format specified by the executive commissioner information necessary to develop outcome and process measures under this section.

(e) If the commission increases physician and other health care provider reimbursement rates under the child health plan program or Medicaid as a result of an increase in the amounts appropriated for the programs for a state fiscal biennium as compared to the preceding state fiscal biennium, the commission shall, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, correlate the increased reimbursement rates with the quality-based outcome and process measures developed under this section.

(f) The commission, in coordination with the Department of State Health Services, shall develop and implement a quality-based outcome measure for the child health plan program and Medicaid to annually measure the percentage of child health plan program enrollees or Medicaid recipients with HIV infection, regardless of age, whose most recent viral load test indicates a viral load of less than 200 copies per milliliter of blood.

Revised Law

Sec. 543A.0003. USE OF QUALITY-BASED OUTCOME MEASURE FOR ENROLLEES OR RECIPIENTS WITH HIV INFECTION. (a) The commission shall include aggregate, nonidentifying data collected using the quality-based outcome measure described by Section 543A.0002(b) in the annual report required by Section 543A.0008. The commission may include the data in any other report required by this chapter.

(b) The commission shall determine the appropriateness of including the quality-based outcome measure described by Section 543A.0002(b) in the quality-based payments and payment systems developed under Sections 543A.0004 and 543A.0051. (Gov. Code, Sec. 536.003(g).)

Source Law

(g) The commission shall include aggregate, nonidentifying data collected using the quality-based outcome measure described by Subsection (f) in the annual report required by Section 536.008 and may include the data in any other report required by this chapter. The commission shall determine the appropriateness of including the quality-based outcome measure described by Subsection (f) in the quality-based payments and payment systems developed under Sections 536.004 and 536.051.

Revised Law

Sec. 543A.0004. DEVELOPMENT OF QUALITY-BASED PAYMENT SYSTEMS. (a) Using the quality-based outcome and process measures developed under Section 543A.0002 and after consulting with appropriate stakeholders with an interest in the provision of acute care and long-term services and supports under the child health plan program and Medicaid, the commission shall develop and require managed care organizations to develop quality-based payment systems for compensating a physician or other health care provider participating in the child health plan program or Medicaid that:

(1) align payment incentives with high-quality,

cost-effective health care;

(2) reward the use of evidence-based best practices;

(3) promote health care coordination;

(4) encourage appropriate physician and other health care provider collaboration;

(5) promote effective health care delivery models; and

(6) take into account the specific needs of the enrollee and recipient populations.

(b) The commission shall develop the quality-based payment systems in the manner specified by this chapter. To the extent necessary to maximize the receipt of federal funds or reduce administrative burdens, the commission shall coordinate the timeline for developing and implementing a payment system with the implementation of other initiatives such as:

(1) the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations;

(2) the ICD-10 code sets initiative; or

(3) the ongoing Enterprise Data Warehouse (EDW) planning process.

(c) In developing the quality-based payment systems, the commission shall examine and consider implementing:

(1) an alternative payment system;

(2) an existing performance-based payment system used under the Medicare program that meets the requirements of this chapter, modified as necessary to account for programmatic differences, if implementing the system would:

(A) reduce unnecessary administrative burdens; and

(B) align quality-based payment incentives for physicians and other health care providers with the Medicare program; and

(3) alternative payment methodologies within a system that are used in the Medicare program, modified as necessary to account for programmatic differences, and that will achieve cost

savings and improve quality of care in the child health plan program and Medicaid.

(d) In developing the quality-based payment systems, the commission shall ensure that a system will not reward a physician, other health care provider, or managed care organization for withholding or delaying medically necessary care.

(e) The commission may modify a quality-based payment system to account for:

(1) programmatic differences between the child health plan program and Medicaid; and

(2) delivery systems under those programs. (Gov. Code, Sec. 536.004.)

Source Law

Sec. 536.004. DEVELOPMENT OF QUALITY-BASED PAYMENT SYSTEMS. (a) Using quality-based outcome and process measures developed under Section 536.003 and subject to this section, the commission, after consulting with appropriate stakeholders with an interest in the provision of acute care and long-term services and supports under the child health plan program and Medicaid, shall develop quality-based payment systems, and require managed care organizations to develop quality-based payment systems, for compensating a physician or other health care provider participating in the child health plan program or Medicaid that:

(1) align payment incentives with high-quality, cost-effective health care;

(2) reward the use of evidence-based best practices;

(3) promote the coordination of health care;

(4) encourage appropriate physician and other health care provider collaboration;

(5) promote effective health care delivery models; and

(6) take into account the specific needs of the child health plan program enrollee and Medicaid recipient populations.

(b) The commission shall develop quality-based payment systems in the manner specified by this chapter. To the extent necessary, the commission shall coordinate the timeline for the development and implementation of a payment system with the implementation of other initiatives such as the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations, the ICD-10 code sets initiative, or the ongoing Enterprise Data Warehouse (EDW) planning process in order to maximize the receipt of federal funds or reduce any administrative burden.

(c) In developing quality-based payment systems under this chapter, the commission shall examine and consider implementing:

(1) an alternative payment system;

(2) any existing performance-based payment system used under the Medicare program that meets the requirements of this chapter, modified as necessary to account for programmatic differences, if implementing the system would:

(A) reduce unnecessary administrative burdens; and

(B) align quality-based payment incentives for physicians and other health care providers with the Medicare program; and

(3) alternative payment methodologies within the system that are used in the Medicare program, modified as necessary to account for programmatic differences, and that will achieve cost savings and improve quality of care in the child health plan program and Medicaid.

(d) In developing quality-based payment systems under this chapter, the commission shall ensure that a managed care organization or physician or other health care provider will not be rewarded by the system for withholding or delaying the provision of medically necessary care.

(e) The commission may modify a quality-based payment system developed under this chapter to account for programmatic differences between the child health plan program and Medicaid and delivery systems under those programs.

Revisor's Note

Section 536.004(a), Government Code, provides that "subject to this section," meaning Section 536.004, Government Code, the Health and Human Services Commission shall develop certain payment systems. The revised law omits the quoted language as unnecessary because the requirements of that section, which is revised as this section, apply by their own terms.

Revised Law

Sec. 543A.0005. PAYMENT METHODOLOGY CONVERSION. (a) To the extent possible, the commission shall convert hospital reimbursement systems under the child health plan program and Medicaid to a diagnosis-related groups (DRG) methodology that will allow the commission to more accurately classify specific patient populations and account for the severity of patient illness and mortality risk.

(b) Subsection (a) does not authorize the commission to direct a managed care organization to compensate a physician or other health care provider providing services under the

organization's managed care plan based on a diagnosis-related groups (DRG) methodology.

(c) Notwithstanding Subsection (a) and to the extent possible, the commission shall convert outpatient hospital reimbursement systems under the child health plan program and Medicaid to an appropriate prospective payment system that will allow the commission to:

(1) more accurately classify the full range of outpatient service episodes;

(2) more accurately account for the intensity of services provided; and

(3) motivate outpatient service providers to increase efficiency and effectiveness. (Gov. Code, Sec. 536.005.)

Source Law

> Sec. 536.005. CONVERSION OF PAYMENT METHODOLOGY. (a) To the extent possible, the commission shall convert hospital reimbursement systems under the child health plan program and Medicaid to a diagnosis-related groups (DRG) methodology that will allow the commission to more accurately classify specific patient populations and account for severity of patient illness and mortality risk.
>
> (b) Subsection (a) does not authorize the commission to direct a managed care organization to compensate physicians and other health care providers providing services under the organization's managed care plan based on a diagnosis-related groups (DRG) methodology.
>
> (c) Notwithstanding Subsection (a) and to the extent possible, the commission shall convert outpatient hospital reimbursement systems under the child health plan program and Medicaid to an appropriate prospective payment system that will allow the commission to:
>
> (1) more accurately classify the full range of outpatient service episodes;
>
> (2) more accurately account for the intensity of services provided; and
>
> (3) motivate outpatient service providers to increase efficiency and effectiveness.

Revised Law

Sec. 543A.0006. TRANSPARENCY; CONSIDERATIONS. (a) The commission shall:

(1) ensure transparency in developing and establishing:

(A) quality-based payment and reimbursement

systems under Section 543A.0004 and Subchapters B, C, and D, including in developing outcome and process measures under Section 543A.0002; and

(B) quality-based payment initiatives under Subchapter E, including developing quality-of-care and cost-efficiency benchmarks under Section 543A.0203(a) and approving efficiency performance standards under Section 543A.0203(b); and

(2) for developing and establishing the quality-based payment and reimbursement systems and initiatives described by Subdivision (1), develop guidelines that establish procedures to provide notice and information to and receive input from managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate.

(b) In developing and establishing the quality-based payment and reimbursement systems and initiatives described by Subsection (a)(1), the commission shall consider that there will be a diminishing rate of improved performance over time as the performance of a physician, other health care provider, or managed care organization improves with respect to an outcome or process measure, quality-of-care and cost-efficiency benchmark, or efficiency performance standard, as applicable.

(c) The commission shall develop web-based capability that:

(1) provides health care providers and managed care organizations with data on their clinical and utilization performance, including comparisons to peer organizations and providers located in this state and in the provider's respective region; and

(2) supports the requirements of the electronic health information exchange system under Sections 525.0206, 525.0207, and 525.0208. (Gov. Code, Sec. 536.006.)

Source Law

Sec. 536.006. TRANSPARENCY. (a) The commission

shall:

(1) ensure transparency in the development and establishment of:

(A) quality-based payment and reimbursement systems under Section 536.004 and Subchapters B, C, and D, including the development of outcome and process measures under Section 536.003; and

(B) quality-based payment initiatives under Subchapter E, including the development of quality of care and cost-efficiency benchmarks under Section 536.204(a) and efficiency performance standards under Section 536.204(b);

(2) develop guidelines establishing procedures for providing notice and information to, and receiving input from, managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate, for purposes of developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1);

(3) in developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1), consider that as the performance of a managed care organization or physician or other health care provider improves with respect to an outcome or process measure, quality of care and cost-efficiency benchmark, or efficiency performance standard, as applicable, there will be a diminishing rate of improved performance over time; and

(4) develop web-based capability to provide managed care organizations and health care providers with data on their clinical and utilization performance, including comparisons to peer organizations and providers located in this state and in the provider's respective region.

(b) The web-based capability required by Subsection (a)(4) must support the requirements of the electronic health information exchange system under Sections 531.907 through 531.909.

Revised Law

Sec. 543A.0007. PERIODIC EVALUATION. At least once each two-year period, the commission shall evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under this chapter. (Gov. Code, Sec. 536.007.)

Source Law

Sec. 536.007. PERIODIC EVALUATION. (a) At least once each two-year period, the commission shall evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under this chapter.

Revised Law

Sec. 543A.0008. ANNUAL REPORT. (a) The commission shall submit to the legislature and make available to the public an annual

report on:

(1) the quality-based outcome and process measures developed under Section 543A.0002, including measures based on each potentially preventable event; and

(2) the progress of implementing quality-based payment systems and other payment initiatives under this chapter.

(b) The commission shall, as appropriate, report outcome and process measures under Subsection (a)(1) by:

(1) geographic location, which may require reporting by county, health care service region, or another appropriately defined geographic area;

(2) enrollee or recipient population or eligibility group served;

(3) type of health care provider, such as acute care or long-term care provider;

(4) number of enrollees and recipients who relocated to a community-based setting from a less integrated setting;

(5) quality-based payment system; and

(6) service delivery model.

(c) The report may not identify a specific health care provider. (Gov. Code, Sec. 536.008.)

Source Law

Sec. 536.008. ANNUAL REPORT. (a) The commission shall submit to the legislature and make available to the public an annual report regarding:

(1) the quality-based outcome and process measures developed under Section 536.003, including measures based on each potentially preventable event; and

(2) the progress of the implementation of quality-based payment systems and other payment initiatives implemented under this chapter.

(b) As appropriate, the commission shall report outcome and process measures under Subsection (a)(1) by:

(1) geographic location, which may require reporting by county, health care service region, or other appropriately defined geographic area;

(2) recipient population or eligibility group served;

(3) type of health care provider, such as acute care or long-term care provider;

(4) number of recipients who relocated to a community-based setting from a less integrated setting;

(5) quality-based payment system; and

(6) service delivery model.

(c) The report required under this section may not identify specific health care providers.

Revisor's Note

Sections 536.008(b)(2) and (4), Government Code, refer to "recipient population" and "recipients," respectively, to whom certain outcome and process measures relate. The revised law in Section 543A.0001 of this chapter adds a definition of "recipient" to mean a Medicaid recipient. That revised law also adds a definition of "enrollee" to mean an individual enrolled in the child health plan program. Because the outcome and process measures to which Section 536.008, Government Code, refers relate to both the child health plan program and Medicaid, the term "recipient" as used in Sections 536.008(b)(2) and (4) is clearly intended to mean both Medicaid recipients and child health plan program enrollees, rather than the more restrictive definition of "recipient" as added in the revised law. Therefore, the revised law substitutes "enrollee or recipient population" and "enrollees and recipients" for the references to "recipient population" and "recipients," respectively.

SUBCHAPTER B. QUALITY-BASED PAYMENTS RELATING TO MANAGED CARE ORGANIZATIONS

Revised Law

Sec. 543A.0051. QUALITY-BASED PREMIUM PAYMENTS; PERFORMANCE REPORTING. (a) Subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other federal law, the commission shall base a percentage of the premiums paid to a managed care organization participating in the child health plan program or Medicaid on the organization's performance with respect to outcome and process measures developed under Section 543A.0002 that address potentially preventable events. The percentage may increase each year.

(b) The commission shall make available information relating to a managed care organization's performance with respect to outcome and process measures under this subchapter to an enrollee or recipient before the enrollee or recipient chooses a managed care plan. (Gov. Code, Sec. 536.051.)

Source Law

> Sec. 536.051. DEVELOPMENT OF QUALITY-BASED PREMIUM PAYMENTS; PERFORMANCE REPORTING. (a) Subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal law, the commission shall base a percentage of the premiums paid to a managed care organization participating in the child health plan program or Medicaid on the organization's performance with respect to outcome and process measures developed under Section 536.003 that address potentially preventable events. The percentage of the premiums paid may increase each year.
>
> (b) The commission shall make available information relating to the performance of a managed care organization with respect to outcome and process measures under this subchapter to child health plan program enrollees and Medicaid recipients before those enrollees and recipients choose their managed care plans.

Revised Law

Sec. 543A.0052. FINANCIAL INCENTIVES AND CONTRACT AWARD PREFERENCES. (a) The commission may allow a managed care organization participating in the child health plan program or Medicaid increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, to:

(1) achieve high-quality, cost-effective health care;

(2) increase the use of high-quality, cost-effective delivery models;

(3) reduce the incidence of unnecessary institutionalization and potentially preventable events; and

(4) in collaboration with physicians and other health care providers, increase the use of alternative payment systems, including shared savings models.

(b) The commission shall develop quality-of-care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to:

(1) reducing potentially preventable events; and

(2) containing the growth rate of health care costs.

(c) The commission may include in a contract between a managed care organization and the commission financial incentives that are based on the organization's successful implementation of quality initiatives under Subsection (a) or success in achieving quality-of-care and cost-efficiency benchmarks under Subsection (b). The commission may implement the financial incentives only if implementing the incentives would be cost-effective.

(d) In awarding contracts to managed care organizations under the child health plan program and Medicaid, the commission shall, in addition to considerations under Section 540.0204 of this code and Section 62.155, Health and Safety Code, give preference to an organization that offers a managed care plan that:

(1) successfully implements quality initiatives under Subsection (a) as the commission determines based on data or other evidence the organization provides; or

(2) meets quality-of-care and cost-efficiency benchmarks under Subsection (b). (Gov. Code, Sec. 536.052.)

Source Law

Sec. 536.052. PAYMENT AND CONTRACT AWARD INCENTIVES FOR MANAGED CARE ORGANIZATIONS. (a) The commission may allow a managed care organization participating in the child health plan program or Medicaid increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to:

(1) achieve high-quality, cost-effective health care;

(2) increase the use of high-quality, cost-effective delivery models;

(3) reduce the incidence of unnecessary institutionalization and potentially preventable events; and

(4) increase the use of alternative payment systems, including shared savings models, in collaboration with physicians and other health care providers.

(b) The commission shall develop quality of care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.

(c) The commission may include in a contract between a managed care organization and the commission

financial incentives that are based on the organization's successful implementation of quality initiatives under Subsection (a) or success in achieving quality of care and cost-efficiency benchmarks under Subsection (b).

(d) In awarding contracts to managed care organizations under the child health plan program and Medicaid, the commission shall, in addition to considerations under Section 533.003 of this code and Section 62.155, Health and Safety Code, give preference to an organization that offers a managed care plan that successfully implements quality initiatives under Subsection (a) as determined by the commission based on data or other evidence provided by the organization or meets quality of care and cost-efficiency benchmarks under Subsection (b).

(e) The commission may implement financial incentives under this section only if implementing the incentives would be cost-effective.

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

Revised Law

Sec. 543A.0101. DEFINITION. In this subchapter, "health home" means a primary care provider practice or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under the child health plan program and Medicaid. (Gov. Code, Sec. 536.101(1).)

Source Law

Sec. 536.101. DEFINITIONS. In this subchapter:

(1) "Health home" means a primary care provider practice or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under the child health plan program and Medicaid.

Revisor's Note

Section 536.101(2), Government Code, defines "participating enrollee" for purposes of Subchapter C, Chapter 536, Government Code, which is revised as this subchapter. For clarity, the revised law incorporates the substance of the definition into the revised law in each place the term appears and omits the definition. The omitted law reads:

(2) "Participating enrollee" means a child health plan program enrollee or Medicaid recipient who has a health home.

Revised Law

Sec. 543A.0102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) The commission may develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. A quality-based payment system must:

(1) base payments made to an enrollee's or recipient's health home on quality and efficiency measures that may include measurable wellness and prevention criteria and the use of evidence-based best practices, sharing a portion of any realized cost savings the health home achieves, and ensuring quality of care outcomes, including a reduction in potentially preventable events; and

(2) allow for the examination of measurable wellness and prevention criteria, use of evidence-based best practices, and quality-of-care outcomes based on the type of primary or specialty care provider practice.

(b) The commission may develop a quality-based payment system for health homes only if implementing the system would be feasible and cost-effective. (Gov. Code, Sec. 536.102.)

Source Law

Sec. 536.102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) Subject to this subchapter, the commission may develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. A quality-based payment system developed under this section must:

(1) base payments made to a participating enrollee's health home on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the health home, and ensuring quality of care outcomes, including a reduction in potentially preventable events; and

(2) allow for the examination of measurable wellness and prevention criteria, use of evidence-based best practices, and quality of care outcomes based on the type of primary or specialty care provider practice.

(b) The commission may develop a quality-based payment system for health homes under this subchapter

only if implementing the system would be feasible and cost-effective.

Revisor's Note

Section 536.102(a), Government Code, provides that "[s]ubject to this subchapter," meaning Subchapter C, Chapter 536, Government Code, the Health and Human Services Commission may develop and implement certain payment systems. The revised law omits the quoted language for the reason stated in the revisor's note to Section 543A.0004 of this chapter.

Revised Law

Sec. 543A.0103. HEALTH HOME ELIGIBILITY. To be eligible to receive reimbursement under a quality-based payment system under this subchapter, a health home must:

(1) directly or indirectly provide enrollees or recipients who have a health home with access to health care services outside of regular business hours;

(2) educate those enrollees and recipients about the availability of health care services outside of regular business hours; and

(3) provide evidence satisfactory to the commission that the health home meets the requirement of Subdivision (1). (Gov. Code, Sec. 536.103.)

Source Law

Sec. 536.103. PROVIDER ELIGIBILITY. To be eligible to receive reimbursement under a quality-based payment system under this subchapter, a health home provider must:

(1) provide participating enrollees, directly or indirectly, with access to health care services outside of regular business hours;

(2) educate participating enrollees about the availability of health care services outside of regular business hours; and

(3) provide evidence satisfactory to the commission that the provider meets the requirement of Subdivision (1).

Revisor's Note

Section 536.103, Government Code, refers to a "health home provider." The revised law substitutes "health home" for "health home provider" because

"health home" is the defined term under Section 536.101(1), Government Code, revised in this subchapter as Section 543A.0101, and a health home is defined as a type of provider.

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Revised Law

Sec. 543A.0151. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN HOSPITALS. (a) The executive commissioner shall adopt rules for identifying:

(1) potentially preventable admissions and readmissions of enrollees and recipients, including preventable admissions to long-term care facilities;

(2) potentially preventable ancillary services provided to or ordered for enrollees and recipients;

(3) potentially preventable emergency room visits by enrollees and recipients; and

(4) potentially preventable complications experienced by enrollees and recipients.

(b) The commission shall collect data from hospitals on present-on-admission indicators for purposes of this section.

(c) The commission shall establish a program to provide to each hospital in this state that participates in the child health plan program or Medicaid a report regarding the hospital's performance with respect to each potentially preventable event described by Subsection (a). To the extent possible, the report should include all potentially preventable events across all child health plan program and Medicaid payment systems. A hospital shall distribute the information in the report to physicians and other health care providers providing services at the hospital.

(d) Except as provided by Subsection (e), a report provided to a hospital under Subsection (c) is confidential and not subject to Chapter 552.

(e) The commission may release information in a report described by Subsection (c):

(1) not earlier than one year after the date the report is provided to the hospital; and

(2) only after deleting any data that relates to a hospital's performance with respect to a particular diagnosis-related group or an individual patient. (Gov. Code, Sec. 536.151.)

Source Law

Sec. 536.151. COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) The executive commissioner shall adopt rules for identifying:

(1) potentially preventable admissions and readmissions of child health plan program enrollees and Medicaid recipients, including preventable admissions to long-term care facilities;

(2) potentially preventable ancillary services provided to or ordered for child health plan program enrollees and Medicaid recipients;

(3) potentially preventable emergency room visits by child health plan program enrollees and Medicaid recipients; and

(4) potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients.

(a-1) The commission shall collect data from hospitals on present-on-admission indicators for purposes of this section.

(b) The commission shall establish a program to provide a confidential report to each hospital in this state that participates in the child health plan program or Medicaid regarding the hospital's performance with respect to each potentially preventable event described under Subsection (a). To the extent possible, a report provided under this section should include all potentially preventable events across all child health plan program and Medicaid payment systems. A hospital shall distribute the information contained in the report to physicians and other health care providers providing services at the hospital.

(c) Except as provided by Subsection (d), a report provided to a hospital under this section is confidential and is not subject to Chapter 552.

(d) The commission may release the information in the report described by Subsection (b):

(1) not earlier than one year after the date the report is submitted to the hospital; and

(2) only after deleting any data that relates to a hospital's performance with respect to particular diagnosis-related groups or individual patients.

Revised Law

Sec. 543A.0152. REIMBURSEMENT ADJUSTMENTS. (a) The commission shall use the data collected under Section 543A.0151 and the diagnosis-related groups (DRG) methodology implemented under Section 543A.0005, if applicable, to adjust, to the extent

feasible, child health plan program and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs. The commission shall base an adjustment for a hospital on the hospital's performance with respect to exceeding or failing to achieve outcome and process measures developed under Section 543A.0002 that address the rates of potentially preventable readmissions and potentially preventable complications.

(b) The commission must provide the report required by Section 543A.0151(c) to a hospital at least one year before adjusting child health plan program and Medicaid reimbursements to the hospital under this section. (Gov. Code, Sec. 536.152.)

Source Law

Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a) Subject to Subsection (b), using the data collected under Section 536.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005, if applicable, the commission shall to the extent feasible adjust child health plan and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, based on the hospital's performance with respect to exceeding, or failing to achieve, outcome and process measures developed under Section 536.003 that address the rates of potentially preventable readmissions and potentially preventable complications.

(b) The commission must provide the report required under Section 536.151(b) to a hospital at least one year before the commission adjusts child health plan and Medicaid reimbursements to the hospital under this section.

Revisor's Note

Section 536.152(a), Government Code, provides that "[s]ubject to Subsection (b)," meaning Section 536.152(b), Government Code, the Health and Human Services Commission shall adjust certain hospital reimbursements. The revised law omits the quoted language for the reason stated in the revisor's note to Section 543A.0004 of this chapter.

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

Revised Law

Sec. 543A.0201. PAYMENT INITIATIVES; DETERMINATION OF

BENEFIT TO STATE. (a) The commission shall establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care providers to develop health care interventions for enrollees or recipients that will:

(1) improve the quality of health care provided to the enrollees or recipients;

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

(4) increase the use of evidence-based best practices;

(5) increase appropriate physician and other health care provider collaboration;

(6) contain costs; and

(7) improve integration of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports.

(b) The commission shall:

(1) establish a process through which a physician, other health care provider, or managed care organization may submit a proposal for a payment initiative; and

(2) determine whether implementing one or more proposed payment initiatives is feasible and cost-effective.

(c) If the commission determines that implementing one or more payment initiatives is feasible and cost-effective for this state, the commission shall establish one or more payment initiatives as provided by this subchapter. (Gov. Code, Secs. 536.202, 536.203(a).)

Source Law

Sec. 536.202. PAYMENT INITIATIVES; DETERMINATION OF BENEFIT TO STATE. (a) The commission shall establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care

providers to develop health care interventions for child health plan program enrollees or Medicaid recipients, or both, that will:

(1) improve the quality of health care provided to the enrollees or recipients;

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

(4) increase the use of evidence-based best practices;

(5) increase appropriate physician and other health care provider collaboration;

(6) contain costs; and

(7) improve integration of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports.

(b) The commission shall:

(1) establish a process by which managed care organizations and physicians and other health care providers may submit proposals for payment initiatives described by Subsection (a); and

(2) determine whether it is feasible and cost-effective to implement one or more of the proposed payment initiatives.

Sec. 536.203. PURPOSE AND IMPLEMENTATION OF PAYMENT INITIATIVES. (a) If the commission determines under Section 536.202 that implementation of one or more payment initiatives is feasible and cost-effective for this state, the commission shall establish one or more payment initiatives as provided by this subchapter.

Revisor's Note

Section 536.202(a), Government Code, provides that the Health and Human Services Commission "shall" establish payment initiatives to test certain payment systems, payment methodologies, and health care delivery models. In contrast, Section 536.203(a), Government Code, requires the commission to establish one or more of those payment initiatives if the commission determines that implementing the initiatives is feasible and cost-effective. The requirements imposed on the commission by the two provisions appear to conflict, and the revised law preserves the ambiguity.

Revised Law

Sec. 543A.0202. PAYMENT INITIATIVE ADMINISTRATION. (a) The commission shall administer any payment initiative the commission establishes under this subchapter. The executive commissioner may adopt rules, plans, and procedures and enter into

contracts and other agreements as the executive commissioner considers appropriate and necessary to administer this subchapter.

(b) The commission may limit a payment initiative to:

(1) one or more regions in this state;

(2) one or more organized networks of physicians and other health care providers; or

(3) specified types of services provided under the child health plan program or Medicaid, or specified types of enrollees or recipients.

(c) An implemented payment initiative must be operated for at least one calendar year. (Gov. Code, Secs. 536.203(b), (c), (d).)

Source Law

> (b) The commission shall administer any payment initiative established under this subchapter. The executive commissioner may adopt rules, plans, and procedures and enter into contracts and other agreements as the executive commissioner considers appropriate and necessary to administer this subchapter.
>
> (c) The commission may limit a payment initiative to:
>
> (1) one or more regions in this state;
>
> (2) one or more organized networks of physicians and other health care providers; or
>
> (3) specified types of services provided under the child health plan program or Medicaid, or specified types of enrollees or recipients under those programs.
>
> (d) A payment initiative implemented under this subchapter must be operated for at least one calendar year.

Revised Law

Sec. 543A.0203. QUALITY-OF-CARE AND COST-EFFICIENCY BENCHMARKS AND GOALS; EFFICIENCY PERFORMANCE STANDARDS. (a) The executive commissioner shall develop quality-of-care and cost-efficiency benchmarks and measurable goals that a payment initiative must meet to ensure high-quality and cost-effective health care services and healthy outcomes.

(b) In addition to the benchmarks and goals described by Subsection (a), the executive commissioner may approve efficiency performance standards that may include the sharing of realized cost savings with physicians and other health care providers who provide

health care services that exceed the standards. The standards may not create a financial incentive for or involve making a payment to a physician or other health care provider that directly or indirectly induces limiting medically necessary services. (Gov. Code, Sec. 536.204.)

Source Law

> Sec. 536.204. STANDARDS; PROTOCOLS. (a) The executive commissioner shall develop quality of care and cost-efficiency benchmarks and measurable goals that a payment initiative must meet to ensure high-quality and cost-effective health care services and healthy outcomes.
>
> (b) In addition to the benchmarks and goals under Subsection (a), the executive commissioner may approve efficiency performance standards that may include the sharing of realized cost savings with physicians and other health care providers who provide health care services that exceed the efficiency performance standards. The efficiency performance standards may not create any financial incentive for or involve making a payment to a physician or other health care provider that directly or indirectly induces the limitation of medically necessary services.

Revised Law

Sec. 543A.0204. PAYMENT RATES UNDER PAYMENT INITIATIVES. The executive commissioner may contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for an implemented payment initiative. (Gov. Code, Sec. 536.205.)

Source Law

> Sec. 536.205. PAYMENT RATES UNDER PAYMENT INITIATIVES. The executive commissioner may contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for a payment initiative implemented under this subchapter.

Revisor's Note
(End of Subchapter)

Section 536.201, Government Code, defines "payment initiative" for purposes of Subchapter E, Chapter 536, Government Code, as "a quality-based payment initiative established under" that subchapter.

The revised law omits the definition in part

because it is misleading and therefore does not add to the clear meaning of the law. Throughout the subchapter, the term is not consistently used in the manner in which it is defined. For example, Section 536.202(b)(1), Government Code, which is revised in this subchapter as Section 543A.0201(b)(1), authorizes certain persons to submit "proposals for payment initiatives," and Section 536.202(b)(2), Government Code, which is revised in this subchapter as Section 543A.0201(b)(2), refers to "proposed payment initiatives." A proposed payment initiative is not an initiative that necessarily has been or will be "established" as specified by the definition in Section 536.201.

The revised law also omits the definition as unnecessary. In each occurrence of the term, the meaning is clear from the context in which it is used. The omitted law reads:

> Sec. 536.201. DEFINITION. In this subchapter, "payment initiative" means a quality-based payment initiative established under this subchapter.

SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENT SYSTEMS

Revised Law

Sec. 543A.0251. QUALITY-BASED PAYMENT SYSTEMS FOR LONG-TERM SERVICES AND SUPPORTS. (a) The commission, after consulting with appropriate stakeholders representing nursing facility providers with an interest in providing long-term services and supports, may develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. A quality-based payment system must base payments made to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and the use

of evidence-based best practices, sharing a portion of any realized cost savings the provider achieves, and ensuring quality of care outcomes, including a reduction in potentially preventable events.

(b) The commission may develop a quality-based payment system for Medicaid long-term services and supports providers only if implementing the system would be feasible and cost-effective. (Gov. Code, Sec. 536.251.)

Source Law

> Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with appropriate stakeholders representing nursing facility providers with an interest in the provision of long-term services and supports, may develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. A quality-based payment system developed under this section must base payments to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the provider, and ensuring quality of care outcomes, including a reduction in potentially preventable events.
>
> (b) The commission may develop a quality-based payment system for Medicaid long-term services and supports providers under this subchapter only if implementing the system would be feasible and cost-effective.

Revisor's Note

Section 536.251(a), Government Code, provides that "[s]ubject to this subchapter," meaning Subchapter F, Chapter 536, Government Code, the Health and Human Services Commission may develop and implement certain payment systems. The revised law omits the quoted language for the reason stated in the revisor's note to Section 543A.0004 of this chapter.

Revised Law

Sec. 543A.0252. DATA SET EVALUATION. To ensure that the commission is using the best data to inform developing and implementing quality-based payment systems under Section 543A.0251, the commission shall evaluate the reliability, validity, and functionality of post-acute and long-term services

and supports data sets. The commission's evaluation should assess:

(1) to what degree data sets on which the commission relies meet a standard:

(A) for integrating care;

(B) for developing coordinated care plans; and

(C) that would allow for the meaningful development of risk adjustment techniques;

(2) whether the data sets will provide value for outcome or performance measures and cost containment; and

(3) how classification systems and data sets used for Medicaid long-term services and supports providers can be standardized and, where possible, simplified. (Gov. Code, Sec. 536.252.)

Source Law

> Sec. 536.252. EVALUATION OF DATA SETS. To ensure that the commission is using the best data to inform the development and implementation of quality-based payment systems under Section 536.251, the commission shall evaluate the reliability, validity, and functionality of post-acute and long-term services and supports data sets. The commission's evaluation under this section should assess:
>
> (1) to what degree data sets relied on by the commission meet a standard:
>
> (A) for integrating care;
>
> (B) for developing coordinated care plans; and
>
> (C) that would allow for the meaningful development of risk adjustment techniques;
>
> (2) whether the data sets will provide value for outcome or performance measures and cost containment; and
>
> (3) how classification systems and data sets used for Medicaid long-term services and supports providers can be standardized and, where possible, simplified.

Revised Law

Sec. 543A.0253. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN PROVIDERS. (a) The executive commissioner shall adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term services and supports recipients.

(b) The commission shall establish a program to provide to

each Medicaid long-term services and supports provider in this state a report regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits. To the extent possible, the report should include applicable potentially preventable events information across all Medicaid payment systems.

(c) Except as provided by Subsection (d), a report provided to a provider under Subsection (b) is confidential and not subject to Chapter 552.

(d) The commission may release information in a report described by Subsection (b):

(1) not earlier than one year after the date the report is provided to the provider; and

(2) only after deleting any data that relates to a provider's performance with respect to a particular resource utilization group or an individual recipient. (Gov. Code, Sec. 536.253.)

Source Law

Sec. 536.253. COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) The executive commissioner shall adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term services and supports recipients.

(b) The commission shall establish a program to provide a report to each Medicaid long-term services and supports provider in this state regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits. To the extent possible, a report provided under this section should include applicable potentially preventable events information across all Medicaid payment systems.

(c) Subject to Subsection (d), a report provided to a provider under this section is confidential and is not subject to Chapter 552.

(d) The commission may release the information in the report described by Subsection (b):

(1) not earlier than one year after the date the report is submitted to the provider; and

(2) only after deleting any data that relates to a provider's performance with respect to particular resource utilization groups or individual recipients.

CHAPTER 544. FRAUD, WASTE, ABUSE, AND OVERCHARGES RELATING TO HEALTH AND HUMAN SERVICES
SUBCHAPTER A. GENERAL PROVISIONS
Sec. 544.0001. DEFINITIONS . . . . . 676
Sec. 544.0002. REFERENCE TO OFFICE OF INVESTIGATIONS AND ENFORCEMENT . . . . . 681
Sec. 544.0003. AUTHORITY OF STATE AGENCY OR GOVERNMENTAL ENTITY NOT LIMITED . . . . . 681
SUBCHAPTER B. HEALTH AND HUMAN SERVICES COMMISSION: ADMINISTRATIVE PROVISIONS
Sec. 544.0051. COORDINATION WITH OFFICE OF ATTORNEY GENERAL; ANNUAL REPORT . . . . . 682
Sec. 544.0052. RULES REGARDING ENFORCEMENT AND PUNITIVE ACTIONS . . . . . 687
Sec. 544.0053. PROVISION OF INFORMATION TO PHARMACY SUBJECT TO AUDIT; INFORMAL HEARING ON AUDIT FINDINGS . . . . . 688
Sec. 544.0054. RECORDS OF ALLEGATIONS OF FRAUD OR ABUSE . . . . . 690
Sec. 544.0055. RECORD AND CONFIDENTIALITY OF INFORMAL RESOLUTION MEETINGS . . . . . 690
Sec. 544.0056. EXPUNCTION OF CHILD'S CHEMICAL DEPENDENCY DIAGNOSIS IN CERTAIN RECORDS . . . . . 691
SUBCHAPTER C. OFFICE OF INSPECTOR GENERAL: GENERAL PROVISIONS
Sec. 544.0101. APPOINTMENT OF INSPECTOR GENERAL; TERM . . . 692
Sec. 544.0102. COMMISSION POWERS AND DUTIES RELATED TO OFFICE OF INSPECTOR GENERAL . . . . . 693
Sec. 544.0103. OFFICE OF INSPECTOR GENERAL: GENERAL POWERS AND DUTIES . . . . . 697
Sec. 544.0104. EMPLOYMENT OF MEDICAL DIRECTOR . . . . . 701
Sec. 544.0105. EMPLOYMENT OF DENTAL DIRECTOR . . . . . 701
Sec. 544.0106. CONTRACT FOR REVIEW OF INVESTIGATIVE FINDINGS BY QUALIFIED EXPERT . . . . . 702

Sec. 544.0107. EMPLOYMENT OF PEACE OFFICERS . . . . . 703
Sec. 544.0108. INVESTIGATIVE PROCESS REVIEW . . . . . 704
Sec. 544.0109. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES . . . . . 704
Sec. 544.0110. REPORTS ON AUDITS, INSPECTIONS, AND INVESTIGATIONS . . . . . 707
Sec. 544.0111. COMPLIANCE WITH FEDERAL CODING GUIDELINES . . . . . 709
Sec. 544.0112. HOSPITAL UTILIZATION REVIEWS AND AUDITS: PROVIDER EDUCATION PROCESS . . . . 709
Sec. 544.0113. PROGRAM EXCLUSIONS . . . . . 710
Sec. 544.0114. REPORT . . . . . 710
SUBCHAPTER D. MEDICAID PROVIDER CRIMINAL HISTORY RECORD INFORMATION AND ELIGIBILITY
Sec. 544.0151. DEFINITIONS . . . . . 711
Sec. 544.0152. EXCHANGE OF CRIMINAL HISTORY RECORD INFORMATION BETWEEN PARTICIPATING AGENCIES . . . . . 713
Sec. 544.0153. PROVIDER ELIGIBILITY FOR MEDICAID PARTICIPATION: CRIMINAL HISTORY RECORD INFORMATION . . . . . 716
Sec. 544.0154. MONITORING OF CERTAIN FEDERAL DATABASES . . . 720
Sec. 544.0155. PERIOD FOR DETERMINING PROVIDER ELIGIBILITY FOR MEDICAID . . . . . 720
SUBCHAPTER E. PREVENTION AND DETECTION OF FRAUD, WASTE, AND ABUSE
Sec. 544.0201. SELECTION AND REVIEW OF MEDICAID CLAIMS TO DETERMINE RESOURCE ALLOCATION . . . . . 722
Sec. 544.0202. DUTIES RELATED TO FRAUD PREVENTION . . . . . 723
Sec. 544.0203. FRAUD, WASTE, AND ABUSE DETECTION TRAINING . . . . . 725
Sec. 544.0204. HEALTH AND HUMAN SERVICES AGENCY MEDICAID FRAUD, WASTE, AND ABUSE DETECTION GOAL . . . . . 725

Sec. 544.0205. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES . . . . . 726
SUBCHAPTER F. INVESTIGATION OF FRAUD, WASTE, ABUSE, AND OVERCHARGES
Sec. 544.0251. CLAIMS CRITERIA REQUIRING COMMENCEMENT OF INVESTIGATION . . . . . 727
Sec. 544.0252. CIRCUMSTANCES REQUIRING COMMENCEMENT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE . . . . . 727
Sec. 544.0253. CONDUCT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE . . . . . 728
Sec. 544.0254. FINDING OF CERTAIN MEDICAID FRAUD OR ABUSE FOLLOWING PRELIMINARY INVESTIGATION: CRIMINAL REFERRAL OR FULL INVESTIGATION . . . . . 729
Sec. 544.0255. IMMEDIATE CRIMINAL REFERRAL UNDER CERTAIN CIRCUMSTANCES . . . . . 730
Sec. 544.0256. CONTINUATION OF PAYMENT HOLD FOLLOWING REFERRAL TO LAW ENFORCEMENT AGENCY . . . . . 730
Sec. 544.0257. COMPLETION OF FULL INVESTIGATION OF ALLEGED MEDICAID FRAUD OR ABUSE . . . . . 732
Sec. 544.0258. MEMORANDUM OF UNDERSTANDING FOR ASSISTING ATTORNEY GENERAL INVESTIGATIONS RELATED TO MEDICAID . . . . 733
Sec. 544.0259. SUBPOENAS . . . . . 734
SUBCHAPTER G. PAYMENT HOLDS
Sec. 544.0301. IMPOSITION OF PAYMENT HOLD . . . . . 736
Sec. 544.0302. NOTICE . . . . . 738
Sec. 544.0303. EXPEDITED ADMINISTRATIVE HEARING . . . . . 740
Sec. 544.0304. INFORMAL RESOLUTION . . . . . 742
Sec. 544.0305. WEBSITE POSTING . . . . . 744
SUBCHAPTER H. MANAGED CARE ORGANIZATION PREVENTION AND INVESTIGATION OF FRAUD AND ABUSE
Sec. 544.0351. APPLICABILITY OF SUBCHAPTER . . . . . 745

Sec. 544.0352. SPECIAL INVESTIGATIVE UNIT OR CONTRACTED ENTITY TO INVESTIGATE FRAUD AND ABUSE . . . . . 746
Sec. 544.0353. FRAUD AND ABUSE PREVENTION PLAN . . . . . 747
Sec. 544.0354. ASSISTANCE AND OVERSIGHT BY OFFICE OF INSPECTOR GENERAL . . . . . 748
Sec. 544.0355. RULES . . . . . 750
SUBCHAPTER I. FINANCIAL ASSISTANCE FRAUD
Sec. 544.0401. DEFINITION . . . . . 751
Sec. 544.0402. FALSE OR MISLEADING INFORMATION RELATED TO FINANCIAL ASSISTANCE ELIGIBILITY . . . . 751
Sec. 544.0403. COMMISSION ACTION FOLLOWING DETERMINATION OF VIOLATION . . . . . 752
Sec. 544.0404. INELIGIBILITY FOR FINANCIAL ASSISTANCE FOLLOWING VIOLATION; RIGHT TO APPEAL . . . 752
Sec. 544.0405. HOUSEHOLD ELIGIBILITY FOR FINANCIAL ASSISTANCE NOT AFFECTED . . . . . 753
Sec. 544.0406. RULES . . . . . 754
SUBCHAPTER J. USE OF TECHNOLOGY TO DETECT, INVESTIGATE, AND PREVENT FRAUD, ABUSE, AND OVERCHARGES
Sec. 544.0451. LEARNING, NEURAL NETWORK, OR OTHER TECHNOLOGY RELATING TO MEDICAID . . . . . 754
Sec. 544.0452. MEDICAID FRAUD INVESTIGATION TRACKING SYSTEM . . . . . 755
Sec. 544.0453. MEDICAID FRAUD DETECTION TECHNOLOGY . . . . . 756
Sec. 544.0454. DATA MATCHING AGAINST FEDERAL FELON LIST . . . . . 757
Sec. 544.0455. ELECTRONIC DATA MATCHING . . . . . 758
Sec. 544.0456. METHODS TO REDUCE FRAUD, WASTE, AND ABUSE IN CERTAIN PUBLIC ASSISTANCE PROGRAMS . . . . . 760
SUBCHAPTER K. RECOVERY AND RECOUPMENT IN CASES OF FRAUD, ABUSE, AND OVERCHARGES
Sec. 544.0501. RECOVERY MONITORING SYSTEM . . . . . 763

Sec. 544.0502. PAYMENT RECOVERY EFFORTS BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS . . . . . 764
Sec. 544.0503. PROCESS FOR MANAGED CARE ORGANIZATIONS TO RECOUP OVERPAYMENTS RELATED TO ELECTRONIC VISIT VERIFICATION TRANSACTIONS . . . . . 768
Sec. 544.0504. RECOVERY AUDIT CONTRACTORS . . . . . 769
Sec. 544.0505. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES . . . . . 770
Sec. 544.0506. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT . . . . . 770
Sec. 544.0507. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT . . . . . 772

## CHAPTER 544. FRAUD, WASTE, ABUSE, AND OVERCHARGES RELATING TO HEALTH AND HUMAN SERVICES

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 544.0001. DEFINITIONS. In this chapter:

(1) "Abuse" means:

(A) a practice a provider engages in that is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) an unnecessary cost to Medicaid; or

(ii) reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; or

(B) a practice a recipient engages in that results in an unnecessary cost to Medicaid.

(2) "Allegation of fraud" means an allegation of Medicaid fraud the commission receives from any source that has not been verified by this state, including an allegation based on:

(A) a fraud hotline complaint;

(B) claims data mining;

(C) data analysis processes; or

(D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.

(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by this state. An allegation is considered credible when the commission has:

(A) verified that the allegation has indicia of reliability; and

(B) carefully reviewed all allegations, facts, and evidence and acts judiciously on a case-by-case basis.

(4) "Fraud" means an intentional deception or misrepresentation a person makes with the knowledge that the deception or misrepresentation could result in an unauthorized benefit to that person or another person. The term does not include unintentional technical, clerical, or administrative errors.

(5) "Furnished" refers to the provision of items or services directly by or under the direct supervision of, or the ordering of items or services by:

(A) a practitioner or other individual acting as an employee or in the individual's own capacity;

(B) a provider; or

(C) another supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

(6) "Inspector general" means the inspector general the governor appoints under Section 544.0101.

(7) "Office of inspector general" means the commission's office of inspector general.

(8) "Payment hold" means the temporary denial of Medicaid reimbursement for items or services a specified provider furnished.

(9) "Physician" includes:

(A) an individual licensed to practice medicine in this state;

(B) a professional association composed solely of physicians;

(C) a partnership composed solely of physicians;

(D) a single legal entity authorized to practice medicine that is owned by two or more physicians; and

(E) a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code.

(10) "Practitioner" means a physician or other individual licensed under state law to practice the individual's profession.

(11) "Program exclusion" means the suspension of a provider's authorization under Medicaid to request reimbursement for items or services the provider furnished.

(12) "Provider" means, except as otherwise provided by this chapter, a person that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission. (Gov. Code, Sec. 531.1011; New.)

Source Law

Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:

(1) "Abuse" means:

(A) a practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) an unnecessary cost to Medicaid; or

(ii) the reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care; or

(B) a practice by a recipient that results in an unnecessary cost to Medicaid.

(2) "Allegation of fraud" means an allegation of Medicaid fraud received by the commission from any source that has not been verified by the state, including an allegation based on:

(A) a fraud hotline complaint;

(B) claims data mining;

(C) data analysis processes; or

(D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.

(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by the state. An allegation is considered to be credible when the commission has:

(A) verified that the allegation has indicia of reliability; and

(B) reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(4) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. The term does not include unintentional technical, clerical, or administrative errors.

(5) "Furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual (either as an employee or in the individual's own capacity), a provider, or other supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

(6) "Payment hold" means the temporary denial of reimbursement under Medicaid for items or services furnished by a specified provider.

(7) "Physician" includes an individual licensed to practice medicine in this state, a professional association composed solely of physicians, a partnership composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, and a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code.

(8) "Practitioner" means a physician or other individual licensed under state law to practice the individual's profession.

(9) "Program exclusion" means the suspension of a provider from being authorized under Medicaid to request reimbursement of items or services furnished by that specific provider.

(10) "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission.

Revisor's Note

(1) Section 531.1011, Government Code, defines terms for purposes of "this subchapter," meaning Subchapter C, Chapter 531, Government Code. Subchapter C is substantially revised in this chapter. The revised law in this chapter also includes the revision of Section 531.0215, Government Code, which is not a

provision of Subchapter C, Chapter 531. The revised law substitutes "this chapter" for "this subchapter" and applies the definitions to the entire chapter, including the revised law derived from Section 531.0215, because that section does not use any of the defined terms.

(2) The definitions of "inspector general" and "office of inspector general" are added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

(3) Section 531.1011(10), Government Code, defines "provider" for purposes of Subchapter C, Chapter 531, Government Code, which is substantially revised in this chapter. Section 531.1031(a)(3), Government Code, which is revised in this chapter as Section 544.0151(5), defines "provider" in a different manner for purposes of Sections 531.1031, 531.1032, 531.1033, and 531.1034, Government Code, each of which is included in Subchapter C, Chapter 531, and revised in Subchapter D of this chapter. For clarity and the convenience of the reader, the revised law in this section defines "provider" for purposes of the chapter in the manner specified by Section 531.1011(10), "except as otherwise provided by this chapter," to reflect that a different definition of the term applies in Subchapter D of this chapter.

(4) Section 531.1011(10), Government Code, refers to a person, "firm, partnership, corporation, agency, association, institution, or other entity." The revised law omits the quoted language because Section 311.005(2), Government Code (Code Construction Act), defines "person" to include any legal entity.

Revised Law

Sec. 544.0002. REFERENCE TO OFFICE OF INVESTIGATIONS AND ENFORCEMENT. Notwithstanding any other law, a reference in law or rule to the commission's office of investigations and enforcement means the office of inspector general. (Gov. Code, Sec. 531.102(i).)

Source Law

> (i) Notwithstanding any other provision of law, a reference in law or rule to the commission's office of investigations and enforcement means the office of inspector general established under this section.

Revisor's Note

Section 531.102(i), Government Code, refers to the office of inspector general "established under this section." The revised law omits the quoted language as unnecessary because Section 544.0001(7) of this chapter defines "office of inspector general" to mean the Health and Human Services Commission's office of inspector general.

Revised Law

Sec. 544.0003. AUTHORITY OF STATE AGENCY OR GOVERNMENTAL ENTITY NOT LIMITED. Nothing in the following provisions limits the authority of any other state agency or governmental entity:

(1) Section 544.0052;

(2) Section 544.0101;

(3) Section 544.0102;

(4) Section 544.0103;

(5) Section 544.0104;

(6) Section 544.0105;

(7) Section 544.0106;

(8) Section 544.0108;

(9) Sections 544.0109(b) and (d);

(10) Section 544.0110;

(11) Section 544.0113;

(12) Section 544.0114;

(13) Section 544.0251;

(14) Section 544.0252(b);

(15) Section 544.0254;

(16) Section 544.0255;

(17) Section 544.0257;

(18) Section 544.0301;

(19) Section 544.0302;

(20) Section 544.0303; and

(21) Section 544.0304. (Gov. Code, Sec. 531.102(o).)

Source Law

(o) Nothing in this section limits the authority of any other state agency or governmental entity.

Revisor's Note

Section 531.102(o), Government Code, states that nothing in Section 531.102 limits the authority of any other state agency or governmental entity. The relevant provisions of Section 531.102 that could be interpreted as limiting the authority of another state agency or governmental entity are revised in various provisions throughout this chapter, and the revised law references those relevant provisions.

SUBCHAPTER B. HEALTH AND HUMAN SERVICES COMMISSION: ADMINISTRATIVE PROVISIONS

Revised Law

Sec. 544.0051. COORDINATION WITH OFFICE OF ATTORNEY GENERAL; ANNUAL REPORT. (a) The commission, acting through the office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing:

(1) cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law; or

(2) other violations of state or federal law under Medicaid or another program the commission or a health and human services agency administers, including:

(A) the financial assistance program under Chapter 31, Human Resources Code;

(B) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; and

(C) the child health plan program.

(b) The memorandum of understanding must:

(1) require the office of inspector general and the office of the attorney general to:

(A) set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to:

(i) enhance deterrence of fraud, waste, abuse, or other violations of state or federal law under the programs described by Subsection (a)(2), including a violation of Chapter 102, Occupations Code; and

(ii) maximize the imposition of penalties, the recovery of money, and the successful prosecution of cases; and

(B) submit information the comptroller requests about each resolved case for the comptroller's use in improving fraud detection;

(2) require the office of inspector general to:

(A) refer each case of suspected provider fraud, waste, or abuse to the office of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(B) keep detailed records for cases the office of inspector general or the office of the attorney general processes, including information on the total number of cases processed and, for each case:

(i) the agency and division to which the case is referred for investigation;

(ii) the date the case is referred; and

(iii) the nature of the suspected fraud,

waste, or abuse; and

(C) notify each appropriate division of the office of the attorney general of each case the office of inspector general refers;

(3) require the office of the attorney general to:

(A) take appropriate action in response to each case referred to the attorney general, which may include:

(i) directly initiating prosecution, with the appropriate local district or county attorney's consent;

(ii) directly initiating civil litigation;

(iii) referring the case to an appropriate United States attorney, a district attorney, or a county attorney; or

(iv) referring the case to a collections agency for initiation of civil litigation or other appropriate action;

(B) ensure that information relating to each case the office of the attorney general investigates is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse; and

(C) notify the office of inspector general of each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(4) require representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case;

(5) ensure that barriers to direct fraud referrals to the office of the attorney general's Medicaid fraud control unit or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are not imposed; and

(6) include procedures to facilitate the referral of cases directly to the office of the attorney general.

(c) An exchange of information under this section between

the office of the attorney general and the commission, the office of inspector general, or a health and human services agency does not affect whether the information is subject to disclosure under Chapter 552.

(d) The commission and the office of the attorney general may not assess or collect investigation and attorney's fees on any state agency's behalf unless the office of the attorney general or another state agency collects a penalty, restitution, or other reimbursement payment to this state.

(e) A district attorney, county attorney, city attorney, or private collection agency may collect and retain:

(1) costs associated with a case referred to the attorney or agency in accordance with procedures adopted under this section; and

(2) 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

(f) The commission and the office of the attorney general shall jointly prepare and submit to the governor, lieutenant governor, and speaker of the house of representatives an annual report concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under Medicaid or another program the commission or a health and human services agency administers. The commission and the office of the attorney general may consolidate the report with any other report relating to the same subject matter the commission or the office of the attorney general is required to submit under other law. (Gov. Code, Sec. 531.103.)

Source Law

Sec. 531.103. INTERAGENCY COORDINATION. (a) The commission, acting through the commission's office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law, or other violations of state or federal law under Medicaid or another program administered by the commission or a health and human services agency, including the financial assistance program under

Chapter 31, Human Resources Code, the supplemental nutrition assistance program under Chapter 33, Human Resources Code, and the child health plan program. The memorandum of understanding shall require:

(1) the office of inspector general and the office of the attorney general to set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to enhance deterrence of fraud, waste, abuse, or other violations of state or federal law, including a violation of Chapter 102, Occupations Code, in the programs and maximize the imposition of penalties, the recovery of money, and the successful prosecution of cases;

(1-a) the office of inspector general to refer each case of suspected provider fraud, waste, or abuse to the office of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(1-b) the office of the attorney general to take appropriate action in response to each case referred to the attorney general, which action may include direct initiation of prosecution, with the consent of the appropriate local district or county attorney, direct initiation of civil litigation, referral to an appropriate United States attorney, a district attorney, or a county attorney, or referral to a collections agency for initiation of civil litigation or other appropriate action;

(2) the office of inspector general to keep detailed records for cases processed by that office or the office of the attorney general, including information on the total number of cases processed and, for each case:

(A) the agency and division to which the case is referred for investigation;

(B) the date on which the case is referred; and

(C) the nature of the suspected fraud, waste, or abuse;

(3) the office of inspector general to notify each appropriate division of the office of the attorney general of each case referred by the office of inspector general;

(4) the office of the attorney general to ensure that information relating to each case investigated by that office is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse;

(5) the office of the attorney general to notify the office of inspector general of each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(6) representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case; and

(7) the office of inspector general and the office of the attorney general to submit information requested by the comptroller about each resolved case for the comptroller's use in improving fraud detection.

(b) An exchange of information under this section between the office of the attorney general and the commission, the office of inspector general, or a health and human services agency does not affect

whether the information is subject to disclosure under Chapter 552.

(c) The commission and the office of the attorney general shall jointly prepare and submit an annual report to the governor, lieutenant governor, and speaker of the house of representatives concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under Medicaid or another program administered by the commission or a health and human services agency. The report may be consolidated with any other report relating to the same subject matter the commission or office of the attorney general is required to submit under other law.

(d) The commission and the office of the attorney general may not assess or collect investigation and attorney's fees on behalf of any state agency unless the office of the attorney general or other state agency collects a penalty, restitution, or other reimbursement payment to the state.

(e) In addition to the provisions required by Subsection (a), the memorandum of understanding required by this section must also ensure that no barriers to direct fraud referrals to the office of the attorney general's Medicaid fraud control unit or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are imposed, and must include procedures to facilitate the referral of cases directly to the office of the attorney general.

(f) A district attorney, county attorney, city attorney, or private collection agency may collect and retain costs associated with a case referred to the attorney or agency in accordance with procedures adopted under this section and 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

Revisor's Note

Section 531.103(a), Government Code, directs the Health and Human Services Commission's office of inspector general and the office of the attorney general to enter into a memorandum of understanding that "shall" include certain requirements. The revised law substitutes "must" for "shall" because under Section 311.016, Government Code (Code Construction Act), applicable to this code, the term "shall" imposes a duty on an actor and the term "must" is more commonly used when no duty is imposed on an actor and the sentence's subject is an inanimate object.

Revised Law

Sec. 544.0052. RULES REGARDING ENFORCEMENT AND PUNITIVE

ACTIONS. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules establishing criteria for determining enforcement and punitive actions regarding a provider who violated state law, program rules, or the provider's Medicaid provider agreement.

(b) The rules must include:

(1) direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration:

(A) the seriousness of the violation;

(B) the prevalence of errors by the provider;

(C) the financial or other harm to this state or recipients resulting or potentially resulting from those errors; and

(D) mitigating factors the office of inspector general determines appropriate; and

(2) a specific list of potential penalties, including the amount of the penalties, for fraud and other Medicaid violations. (Gov. Code, Sec. 531.102(x).)

Source Law

(x) The executive commissioner, in consultation with the office, shall adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement that include:

(1) direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration:

(A) the seriousness of the violation;

(B) the prevalence of errors by the provider;

(C) the financial or other harm to the state or recipients resulting or potentially resulting from those errors; and

(D) mitigating factors the office determines appropriate; and

(2) a specific list of potential penalties, including the amount of the penalties, for fraud and other Medicaid violations.

Revised Law

Sec. 544.0053. PROVISION OF INFORMATION TO PHARMACY SUBJECT TO AUDIT; INFORMAL HEARING ON AUDIT FINDINGS. (a) To increase

transparency, the office of inspector general shall, if the office has access to the information, provide to pharmacies that are subject to audit by the office or by an entity that contracts with the federal government to audit Medicaid providers information relating to the extrapolation methodology used as part of the audit and the methods used to determine whether the pharmacy has been overpaid under Medicaid in sufficient detail so that the audit results may be demonstrated to be statistically valid and are fully reproducible.

(b) A pharmacy has a right to request an informal hearing before the commission's appeals division to contest the findings of an audit that the office of inspector general or an entity that contracts with the federal government to audit Medicaid providers conducted if the audit findings do not include findings that the pharmacy engaged in Medicaid fraud.

(c) In an informal hearing held under this section, the commission's appeals division staff, assisted by staff responsible for the commission's vendor drug program with expertise in the law governing pharmacies' participation in Medicaid, make the final decision on whether the audit findings are accurate. Office of inspector general staff may not serve on the panel that makes the decision on the accuracy of an audit. (Gov. Code, Sec. 531.1203.)

Source Law

> Sec. 531.1203. RIGHTS OF AND PROVISION OF INFORMATION TO PHARMACIES SUBJECT TO CERTAIN AUDITS. (a) A pharmacy has a right to request an informal hearing before the commission's appeals division to contest the findings of an audit conducted by the commission's office of inspector general or an entity that contracts with the federal government to audit Medicaid providers if the findings of the audit do not include findings that the pharmacy engaged in Medicaid fraud.
>
> (b) In an informal hearing held under this section, staff of the commission's appeals division, assisted by staff responsible for the commission's vendor drug program who have expertise in the law governing pharmacies' participation in Medicaid, make the final decision on whether the findings of an audit are accurate. Staff of the commission's office of inspector general may not serve on the panel that makes the decision on the accuracy of an audit.
>
> (c) In order to increase transparency, the commission's office of inspector general shall, if the

office has access to the information, provide to pharmacies that are subject to audit by the office, or by an entity that contracts with the federal government to audit Medicaid providers, information relating to the extrapolation methodology used as part of the audit and the methods used to determine whether the pharmacy has been overpaid under Medicaid in sufficient detail so that the audit results may be demonstrated to be statistically valid and are fully reproducible.

Revised Law

Sec. 544.0054. RECORDS OF ALLEGATIONS OF FRAUD OR ABUSE. The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 544.0259(e) and is subject to Section 544.0259(f). (Gov. Code, Sec. 531.118(a).)

Source Law

Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF FRAUD OR ABUSE AND FRAUD REFERRALS. (a) The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 531.1021(g) and is subject to Section 531.1021(h).

Revised Law

Sec. 544.0055. RECORD AND CONFIDENTIALITY OF INFORMAL RESOLUTION MEETINGS. (a) On the written request of a provider who requests an informal resolution meeting held under Section 544.0304 or 544.0506(b), the commission shall, at no expense to the provider, provide for the meeting to be recorded and for the recording to be made available to the provider. The commission may not record an informal resolution meeting unless the commission receives a written request from a provider.

(b) Notwithstanding Section 544.0259(e) and except as provided by this section:

(1) an informal resolution meeting held under Section 544.0304 or 544.0506(b) is confidential; and

(2) any information or materials the office of inspector general, including the office's employees or agents,

obtains during or in connection with an informal resolution meeting, including a recording made under Subsection (a), are privileged, confidential, and not subject to disclosure under Chapter 552 or any other means of legal compulsion for release, including disclosure, discovery, or subpoena. (Gov. Code, Sec. 531.1202.)

Source Law

> Sec. 531.1202. RECORD AND CONFIDENTIALITY OF INFORMAL RESOLUTION MEETINGS. (a) On the written request of the provider, the commission shall, at no expense to the provider who requested the meeting, provide for an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) to be recorded. The recording of an informal resolution meeting shall be made available to the provider who requested the meeting. The commission may not record an informal resolution meeting unless the commission receives a written request from a provider under this subsection.
>
> (b) Notwithstanding Section 531.1021(g) and except as provided by this section, an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) is confidential, and any information or materials obtained by the commission's office of inspector general, including the office's employees or the office's agents, during or in connection with an informal resolution meeting, including a recording made under Subsection (a), are privileged and confidential and not subject to disclosure under Chapter 552 or any other means of legal compulsion for release, including disclosure, discovery, or subpoena.

Revised Law

Sec. 544.0056. EXPUNCTION OF CHILD'S CHEMICAL DEPENDENCY DIAGNOSIS IN CERTAIN RECORDS. (a) In this section:

(1) "Chemical dependency" has the meaning assigned by Section 461A.002, Health and Safety Code.

(2) "Child" means an individual who is 13 years of age or younger.

(b) After a chemical dependency treatment provider is finally convicted of an offense in which an element of the offense involves submitting a fraudulent claim for reimbursement for services under Medicaid, the commission or other health and human services agency that operates a portion of Medicaid shall expunge or provide for the expunction of a child's diagnosis of chemical dependency that the provider made and that has been entered in any:

(1) appropriate official record of the commission or agency;

(2) applicable medical record that is in the commission's or agency's custody; and

(3) applicable record of a company with which the commission contracts for processing and paying Medicaid claims. (Gov. Code, Sec. 531.112.)

Source Law

Sec. 531.112. EXPUNCTION OF INFORMATION RELATED TO CERTAIN CHEMICAL DEPENDENCY DIAGNOSES IN CERTAIN RECORDS. (a) In this section:

(1) "Chemical dependency" has the meaning assigned by Section 461A.002, Health and Safety Code.

(2) "Child" means a person 13 years of age or younger.

(b) Following the final conviction of a chemical dependency treatment provider for an offense, an element of which involves submitting a fraudulent claim for reimbursement for services under Medicaid, the commission or other health and human services agency that operates a portion of Medicaid shall expunge or provide for the expunction of a diagnosis of chemical dependency in a child that has been made by the treatment provider and entered in any:

(1) appropriate official record of the commission or agency;

(2) applicable medical record that is in the commission's or agency's custody; and

(3) applicable record of a company that the commission contracts with for the processing and payment of claims under Medicaid.

Revisor's Note

Section 531.112(a)(2), Government Code, defines the term "child" to mean a "person" who is 13 years of age or younger. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), applicable to this code.

SUBCHAPTER C. OFFICE OF INSPECTOR GENERAL: GENERAL PROVISIONS

Revised Law

Sec. 544.0101. APPOINTMENT OF INSPECTOR GENERAL; TERM. (a) The governor shall appoint an inspector general to serve as

director of the office of inspector general.

(b) The inspector general serves a one-year term that expires February 1. (Gov. Code, Sec. 531.102(a-1).)

Source Law

> (a-1) The governor shall appoint an inspector general to serve as director of the office. The inspector general serves a one-year term that expires on February 1.

Revised Law

Sec. 544.0102. COMMISSION POWERS AND DUTIES RELATED TO OFFICE OF INSPECTOR GENERAL. (a) The executive commissioner shall work in consultation with the office of inspector general when the executive commissioner is required by law to adopt a rule or policy necessary to implement a power or duty of the office of inspector general, including a rule necessary to carry out a responsibility of the office of inspector general under Section 544.0103(a).

(b) The executive commissioner is responsible for performing all administrative support services functions necessary to operate the office of inspector general in the same manner that the executive commissioner is responsible for providing administrative support services functions for the health and human services system, including office functions related to:

(1) procurement processes;

(2) contracting policies;

(3) information technology services;

(4) legal services, but only those related to:

(A) open records;

(B) procurement;

(C) contracting;

(D) human resources;

(E) privacy;

(F) litigation support by the attorney general;

(G) bankruptcy; and

(H) other legal services as detailed in the memorandum of understanding or other written agreement required

under Subchapter E, Chapter 524;

(5) budgeting; and

(6) personnel and employment policies.

(c) The commission's internal audit division shall:

(1) regularly audit the office of inspector general as part of the commission's internal audit program; and

(2) include the office of inspector general in the commission's risk assessments.

(d) The commission's chief counsel is the final authority for all legal interpretations related to statutes, rules, and commission policies on programs the commission administers.

(e) The commission shall:

(1) in consultation with the inspector general, set clear objectives, priorities, and performance standards for the office of inspector general that emphasize:

(A) coordinating investigative efforts to aggressively recover money;

(B) allocating resources to cases that have the strongest supportive evidence and greatest potential to recover money; and

(C) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 544.0051; and

(2) train office of inspector general staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.

(f) The commission may require employees of health and human services agencies to provide assistance to the office of inspector general in connection with its duties relating to the investigation of fraud and abuse in the provision of health and human services. The office of inspector general is entitled to access to any information a health and human services agency maintains that is relevant to the office of inspector general's functions, including internal records.

(g) To the extent permitted by federal law, the executive commissioner, on the office of inspector general's behalf, shall adopt rules establishing:

(1) criteria for:

(A) initiating a full-scale fraud or abuse investigation;

(B) conducting the investigation;

(C) collecting evidence; and

(D) accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee; and

(2) minimum training requirements for Medicaid provider fraud or abuse investigators.

(h) The executive commissioner, in consultation with the office of inspector general, shall adopt rules establishing criteria:

(1) for opening a case;

(2) for prioritizing cases for the efficient management of the office of inspector general's workload, including rules that direct the office to prioritize:

(A) provider cases according to the highest potential for recovery or risk to this state as indicated through:

(i) the provider's volume of billings;

(ii) the provider's history of noncompliance with the law; and

(iii) identified fraud trends;

(B) recipient cases according to the highest potential for recovery and federal timeliness requirements; and

(C) internal affairs investigations according to the seriousness of the threat to recipient safety and the risk to program integrity in terms of the amount or scope of fraud, waste, and abuse the allegation that is the subject of the investigation poses; and

(3) to guide field investigators in closing a case

that is not worth pursuing through a full investigation. (Gov. Code, Secs. 531.102(a-2), (a-3), (a-4), (a-7), (a-8), (b), (c), (d), (n), (p).)

Source Law

(a-2) The executive commissioner shall work in consultation with the office whenever the executive commissioner is required by law to adopt a rule or policy necessary to implement a power or duty of the office, including a rule necessary to carry out a responsibility of the office under Subsection (a).

(a-3) The executive commissioner is responsible for performing all administrative support services functions necessary to operate the office in the same manner that the executive commissioner is responsible for providing administrative support services functions for the health and human services system, including functions of the office related to the following:

(1) procurement processes;

(2) contracting policies;

(3) information technology services;

(4) subject to Subsection (a-8), legal services;

(5) budgeting; and

(6) personnel and employment policies.

(a-4) The commission's internal audit division shall regularly audit the office as part of the commission's internal audit program and shall include the office in the commission's risk assessments.

(a-7) The chief counsel for the commission is the final authority for all legal interpretations related to statutes, rules, and commission policy on programs administered by the commission.

(a-8) For purposes of Subsection (a-3), "legal services" includes only legal services related to open records, procurement, contracting, human resources, privacy, litigation support by the attorney general, bankruptcy, and other legal services as detailed in the memorandum of understanding or other written agreement required under Section 531.00553, as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

(b) The commission, in consultation with the inspector general, shall set clear objectives, priorities, and performance standards for the office that emphasize:

(1) coordinating investigative efforts to aggressively recover money;

(2) allocating resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and

(3) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 531.103.

(c) The commission shall train office staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.

(d) The commission may require employees of health and human services agencies to provide assistance to the office in connection with the office's duties relating to the investigation of fraud

and abuse in the provision of health and human services. The office is entitled to access to any information maintained by a health and human services agency, including internal records, relevant to the functions of the office.

(n) To the extent permitted under federal law, the executive commissioner, on behalf of the office, shall adopt rules establishing the criteria for initiating a full-scale fraud or abuse investigation, conducting the investigation, collecting evidence, accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee, and establishing minimum training requirements for Medicaid provider fraud or abuse investigators.

(p) The executive commissioner, in consultation with the office, shall adopt rules establishing criteria:

(1) for opening a case;

(2) for prioritizing cases for the efficient management of the office's workload, including rules that direct the office to prioritize:

(A) provider cases according to the highest potential for recovery or risk to the state as indicated through the provider's volume of billings, the provider's history of noncompliance with the law, and identified fraud trends;

(B) recipient cases according to the highest potential for recovery and federal timeliness requirements; and

(C) internal affairs investigations according to the seriousness of the threat to recipient safety and the risk to program integrity in terms of the amount or scope of fraud, waste, and abuse posed by the allegation that is the subject of the investigation; and

(3) to guide field investigators in closing a case that is not worth pursuing through a full investigation.

Revisor's Note

Section 531.102(a-8), Government Code, refers to a memorandum of understanding or other written agreement required under Section 531.00553, Government Code. Section 531.00553 is revised in this subtitle as Subchapter E, Chapter 524, and the revised law is drafted accordingly.

Revised Law

Sec. 544.0103. OFFICE OF INSPECTOR GENERAL: GENERAL POWERS AND DUTIES. (a) The office of inspector general is responsible for:

(1) preventing, detecting, auditing, inspecting, reviewing, and investigating fraud, waste, and abuse in the

provision and delivery of all health and human services in this state, including services provided:

(A) through any state-administered health or human services program that is wholly or partly federally funded; or

(B) by the Department of Family and Protective Services; and

(2) enforcing state law relating to providing those services.

(b) The commission may obtain any information or technology necessary for the office of inspector general to meet its responsibilities under this chapter or other law.

(c) The office of inspector general shall closely coordinate with the executive commissioner and relevant staff of health and human services system programs the office of inspector general oversees in performing functions relating to preventing fraud, waste, and abuse in the delivery of health and human services and enforcing state law relating to the provision of those services, including audits, utilization reviews, provider education, and data analysis.

(d) The office of inspector general shall conduct audits, inspections, and investigations independent of the executive commissioner and the commission but shall rely on the coordination required by Subsection (c) to ensure that the office of inspector general has a thorough understanding of the health and human services system to knowledgeably and effectively perform its duties.

(e) The office of inspector general may:

(1) assess administrative penalties otherwise authorized by law on behalf of the commission or a health and human services agency;

(2) request that the attorney general obtain an injunction to prevent a person from disposing of an asset the office of inspector general identifies as potentially subject to recovery

by the office of inspector general due to the person's fraud or abuse;

(3) provide for coordination between the office of inspector general and special investigative units formed by managed care organizations under Subchapter H or entities with which managed care organizations contract under that subchapter;

(4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from a health and human services agency;

(5) conduct investigations relating to the funds described by Subdivision (4); and

(6) recommend policies to:

(A) promote the economical and efficient administration of the funds described by Subdivision (4); and

(B) prevent and detect fraud and abuse in the administration of those funds. (Gov. Code, Secs. 531.102(a), (a-5), (a-6), (h).)

Source Law

Sec. 531.102. OFFICE OF INSPECTOR GENERAL. (a) The commission's office of inspector general is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by the Department of Family and Protective Services, and the enforcement of state law relating to the provision of those services. The commission may obtain any information or technology necessary to enable the office to meet its responsibilities under this subchapter or other law.

(a-5) The office shall closely coordinate with the executive commissioner and the relevant staff of health and human services system programs that the office oversees in performing functions relating to the prevention of fraud, waste, and abuse in the delivery of health and human services and the enforcement of state law relating to the provision of those services, including audits, utilization reviews, provider education, and data analysis.

(a-6) The office shall conduct audits, inspections, and investigations independent of the executive commissioner and the commission but shall rely on the coordination required by Subsection (a-5) to ensure that the office has a thorough understanding

of the health and human services system for purposes of knowledgeably and effectively performing the office's duties under this section and any other law.

(h) In addition to performing functions and duties otherwise provided by law, the office may:

(1) assess administrative penalties otherwise authorized by law on behalf of the commission or a health and human services agency;

(2) request that the attorney general obtain an injunction to prevent a person from disposing of an asset identified by the office as potentially subject to recovery by the office due to the person's fraud or abuse;

(3) provide for coordination between the office and special investigative units formed by managed care organizations under Section 531.113 or entities with which managed care organizations contract under that section;

(4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from a health and human services agency;

(5) conduct investigations relating to the funds described by Subdivision (4); and

(6) recommend policies promoting economical and efficient administration of the funds described by Subdivision (4) and the prevention and detection of fraud and abuse in administration of those funds.

Revisor's Note

(1) Section 531.102(a), Government Code, refers to the responsibilities of the Health and Human Services Commission's office of inspector general under "this subchapter," meaning Subchapter C, Chapter 531, Government Code, "or other law," and Section 531.102(a-6), Government Code, refers to the office's duties under "this section," meaning Section 531.102, Government Code, "and any other law." The provisions of the referenced subchapter and section relating to the responsibilities and duties of the office are revised throughout this chapter. The revised law substitutes "this chapter" for the references to "this subchapter" and "this section" because each provision revised in this chapter that is not derived from the referenced source law is already included in the source law reference to "other law."

(2) Section 531.102(h), Government Code,

permits the Health and Human Services Commission's office of inspector general to engage in certain actions "[i]n addition to performing functions and duties otherwise provided by law." The revised law omits the quoted language as redundant because the authorizations provided by other law to perform those functions and duties apply by their own terms, and an additional statement to that effect is unnecessary.

Revised Law

Sec. 544.0104. EMPLOYMENT OF MEDICAL DIRECTOR. (a) The office of inspector general shall employ a medical director who:

(1) is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules the Texas Medical Board adopts under that subtitle; and

(2) preferably has significant knowledge of Medicaid.

(b) The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office of inspector general imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties. (Gov. Code, Sec. 531.102(l).)

Source Law

(l) The office shall employ a medical director who is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules adopted under that subtitle by the Texas Medical Board, and who preferably has significant knowledge of Medicaid. The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

Revised Law

Sec. 544.0105. EMPLOYMENT OF DENTAL DIRECTOR. (a) The office of inspector general shall employ a dental director who:

(1) is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules the State Board of Dental Examiners

adopts under that subtitle; and

(2) preferably has significant knowledge of Medicaid.

(b) The dental director shall ensure that any investigative findings based on the necessity of dental services or the quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office of inspector general imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties. (Gov. Code, Sec. 531.102(m).)

Source Law

> (m) The office shall employ a dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules adopted under that subtitle by the State Board of Dental Examiners, and who preferably has significant knowledge of Medicaid. The dental director shall ensure that any investigative findings based on the necessity of dental services or the quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

Revised Law

Sec. 544.0106. CONTRACT FOR REVIEW OF INVESTIGATIVE FINDINGS BY QUALIFIED EXPERT. (a) If the commission does not receive any responsive bids under Chapter 2155 on a competitive solicitation for the services of a qualified expert to review investigative findings under Section 544.0104 or 544.0105 and the number of contracts to be awarded under this subsection is not otherwise limited, the commission may negotiate with and award a contract for the services to a qualified expert on the basis of:

(1) the contractor's agreement to a set fee, either as a range or lump-sum amount; and

(2) the contractor's affirmation and the office of inspector general's verification that the contractor possesses the necessary occupational licenses and experience.

(b) Notwithstanding Sections 2155.083 and 2261.051, a contract awarded under Subsection (a) is not subject to competitive advertising and proposal evaluation requirements. (Gov. Code, Secs. 531.102(m-1), (m-2).)

Source Law

(m-1) If the commission does not receive any responsive bids under Chapter 2155 on a competitive solicitation for the services of a qualified expert to review investigative findings under Subsection (l) or (m) and the number of contracts to be awarded under this subsection is not otherwise limited, the commission may negotiate with and award a contract for the services to a qualified expert on the basis of:

(1) the contractor's agreement to a set fee, either as a range or lump-sum amount; and

(2) the contractor's affirmation and the office's verification that the contractor possesses the necessary occupational licenses and experience.

(m-2) Notwithstanding Sections 2155.083 and 2261.051, a contract awarded under Subsection (m-1) is not subject to competitive advertising and proposal evaluation requirements.

Revised Law

Sec. 544.0107. EMPLOYMENT OF PEACE OFFICERS. (a) The office of inspector general shall employ and commission not more than five peace officers at any given time to assist the office in carrying out the office's duties relating to the investigation of Medicaid fraud, waste, and abuse.

(b) A peace officer the office of inspector general employs and commissions is administratively attached to the Department of Public Safety. The commission shall provide administrative support to the department as necessary to support the assignment of the peace officers.

(c) A peace officer the office of inspector general employs and commissions:

(1) is a peace officer for purposes of Article 2.12, Code of Criminal Procedure; and

(2) shall obtain the office of the attorney general's prior approval before carrying out any duties requiring peace officer status. (Gov. Code, Sec. 531.1022.)

Source Law

Sec. 531.1022. PEACE OFFICERS. (a) The commission's office of inspector general shall employ and commission not more than five peace officers at any given time for the purpose of assisting the office in carrying out the duties of the office relating to the investigation of fraud, waste, and abuse in Medicaid.

(b) Peace officers employed under this section are administratively attached to the Department of Public Safety. The commission shall provide

administrative support to the department necessary to support the assignment of peace officers employed under this section.

(c) A peace officer employed and commissioned by the office under this section is a peace officer for purposes of Article 2.12, Code of Criminal Procedure.

(d) A peace officer employed and commissioned under this section shall obtain prior approval from the office of attorney general before carrying out any duties requiring peace officer status.

Revised Law

Sec. 544.0108. INVESTIGATIVE PROCESS REVIEW. (a) Office of inspector general staff who are not directly involved in investigations the office conducts shall review the office's investigative process, including the office's use of sampling and extrapolation to audit provider records.

(b) The office of inspector general shall 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 offices of inspectors general, the executive commissioner, in consultation with the office, shall by rule adopt sampling and extrapolation standards for the office's use in conducting audits. (Gov. Code, Secs. 531.102(r), (s).)

Source Law

(r) The office shall review the office's investigative process, including the office's use of sampling and extrapolation to audit provider records. The review shall be performed by staff who are not directly involved in investigations conducted by the office.

(s) The office shall 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 offices of inspectors general, the executive commissioner, in consultation with the office, shall by rule adopt sampling and extrapolation standards to be used by the office in conducting audits.

Revised Law

Sec. 544.0109. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Notwithstanding any other law, the office of inspector general may conduct a performance audit of any program or project administered or agreement entered into by the commission or a health and human services agency, including an audit related to:

(1) the commission's or a health and human services agency's contracting procedures; or

(2) the commission's or a health and human services agency's performance.

(b) The office of inspector general shall coordinate all audit and oversight activities, including those relating to providers and including developing audit plans, risk assessments, and findings, with the commission to minimize duplicative activities. In coordinating the activities, the office shall:

(1) to determine whether to audit a Medicaid managed care organization, annually seek the commission's input and consider previous audits and on-site visits the commission made to determine whether to audit a Medicaid managed care organization; and

(2) request the results of an informal audit or on-site visit the commission performed that could inform the office's risk assessment when determining whether to conduct or the scope of an audit of a Medicaid managed care organization.

(c) In addition to the coordination required by Subsection (b), the office of inspector general shall coordinate the office's other audit activities with those of the commission, including developing audit plans, performing risk assessments, and reporting findings, to minimize duplicative audit activities. In coordinating audit activities with the commission under this subsection, the office shall:

(1) to determine whether to conduct a performance audit, seek the commission's input and consider previous audits the commission conducted; and

(2) request the results of an audit the commission conducted if those results could inform the office's risk assessment when determining whether to conduct or the scope of a performance audit.

(d) In accordance with Section 540.0057(b), the office of inspector general shall consult with the executive commissioner

regarding the adoption of rules defining the office's role in and jurisdiction over, and the frequency of, audits of Medicaid managed care organizations that the office and commission conduct. (Gov. Code, Secs. 531.102(q), (v), (w), 531.1025.)

Source Law

[Sec. 531.102]

(q) The office shall coordinate all audit and oversight activities, including the development of audit plans, risk assessments, and findings, with the commission to minimize the duplication of activities. In coordinating activities under this subsection, the office shall:

(1) on an annual basis, seek input from the commission and consider previous audits and onsite visits made by the commission for purposes of determining whether to audit a managed care organization participating in Medicaid; and

(2) request the results of any informal audit or onsite visit performed by the commission that could inform the office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

(v) In accordance with Section 533.015(b), the office shall consult with the executive commissioner regarding the adoption of rules defining the office's role in and jurisdiction over, and the frequency of, audits of managed care organizations participating in Medicaid that are conducted by the office and the commission.

(w) The office shall coordinate all audit and oversight activities relating to providers, including the development of audit plans, risk assessments, and findings, with the commission to minimize the duplication of activities. In coordinating activities under this subsection, the office shall:

(1) on an annual basis, seek input from the commission and consider previous audits and on-site visits made by the commission for purposes of determining whether to audit a managed care organization participating in Medicaid; and

(2) request 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, or the scope of, an audit of a managed care organization participating in Medicaid.

Sec. 531.1025. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Notwithstanding any other law, the commission's office of inspector general may conduct a performance audit of any program or project administered or agreement entered into by the commission or a health and human services agency, including an audit related to:

(1) contracting procedures of the commission or a health and human services agency; or

(2) the performance of the commission or a health and human services agency.

(b) In addition to the coordination required by Section 531.102(w), the office shall coordinate the

office's other audit activities with those of the commission, including the development of audit plans, the performance of risk assessments, and the reporting of findings, to minimize the duplication of audit activities. In coordinating audit activities with the commission under this subsection, the office shall:

(1) seek input from the commission and consider previous audits conducted by the commission for purposes of determining whether to conduct a performance audit; and

(2) request the results of an audit conducted by the commission if those results could inform the office's risk assessment when determining whether to conduct, or the scope of, a performance audit.

Revisor's Note

Sections 531.102(q), (v), and (w), Government Code, refer to managed care organizations participating in Medicaid. A managed care organization that participates in Medicaid is a Medicaid managed care organization, which is defined by Section 521.0001 as a managed care organization that contracts with the Health and Human Services Commission under Chapter 533, Government Code, which is revised in this subtitle as Chapters 540 and 540A, to provide health care services to Medicaid recipients. That definition applies subtitle-wide, including to the law revised in this chapter. For consistency of terminology, the revised law substitutes references to a "Medicaid managed care organization" for references to a "managed care organization participating in Medicaid."

Revised Law

Sec. 544.0110. REPORTS ON AUDITS, INSPECTIONS, AND INVESTIGATIONS. (a) The office of inspector general shall prepare a final report on each audit, inspection, or investigation conducted under Section 544.0102, 544.0103, 544.0252(b), 544.0254, or 544.0257. The final report must include:

(1) a summary of the activities the office performed in conducting the audit, inspection, or investigation;

(2) a statement on whether the audit, inspection, or

investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(b) A final report on an audit, inspection, or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit, inspection, or investigation remain confidential and not subject to required disclosure in accordance with Section 544.0259(e).

(c) A confidential draft report on an audit, inspection, or investigation that concerns the death of a child may be shared with the Department of Family and Protective Services. A draft report that is shared with the Department of Family and Protective Services remains confidential and is not subject to disclosure under Chapter 552. (Gov. Code, Secs. 531.102(j), (k).)

Source Law

(j) The office shall prepare a final report on each audit, inspection, or investigation conducted under this section. The final report must include:

(1) a summary of the activities performed by the office in conducting the audit, inspection, or investigation;

(2) a statement regarding whether the audit, inspection, or investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(k) A final report on an audit, inspection, or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit, inspection, or investigation remain confidential and not subject to required disclosure in accordance with Section 531.1021(g). A confidential draft report on an audit, inspection, or investigation that concerns the death of a child may be shared with the Department of Family and Protective Services. A draft report that is shared with the Department of Family and Protective Services remains confidential and is not subject to disclosure under Chapter 552.

Revisor's Note

Section 531.102(j), Government Code, refers to a final report on each audit, inspection, or investigation conducted under "this section," meaning Section 531.102, Government Code. The provisions of Section 531.102 that relate to the conduct of an audit, inspection, or investigation are revised in various provisions throughout this chapter, and the revised

law references the relevant provisions.

Revised Law

Sec. 544.0111. COMPLIANCE WITH FEDERAL CODING GUIDELINES. (a) In this section, "federal coding guidelines" means the code sets and guidelines the United States Department of Health and Human Services adopts in accordance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

(b) The office of inspector general, including office staff and any third party with which the office contracts to perform coding services, and the commission's medical and utilization review appeals unit shall comply with federal coding guidelines, including guidelines for diagnosis-related group (DRG) validation and related audits. (Gov. Code, Sec. 531.1023.)

Source Law

> Sec. 531.1023. COMPLIANCE WITH FEDERAL CODING GUIDELINES. (a) The commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, and the commission's medical and utilization review appeals unit shall comply with federal coding guidelines, including guidelines for diagnosis-related group (DRG) validation and related audits.
>
> (b) In this section, "federal coding guidelines" means the code sets and guidelines adopted by the United States Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

Revised Law

Sec. 544.0112. HOSPITAL UTILIZATION REVIEWS AND AUDITS: PROVIDER EDUCATION PROCESS. The executive commissioner, in consultation with the office of inspector general, shall develop by rule a process for the office, including office staff and any third party with which the office contracts to perform coding services, to communicate with and educate providers about the diagnosis-related group (DRG) validation criteria that the office uses in conducting hospital utilization reviews and audits. (Gov. Code, Sec. 531.1024.)

Source Law

> Sec. 531.1024. HOSPITAL UTILIZATION REVIEWS AND AUDITS: PROVIDER EDUCATION PROCESS. The executive commissioner, in consultation with the office, shall by rule develop a process for the commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, to communicate with and educate providers about the diagnosis-related group (DRG) validation criteria that the office uses in conducting hospital utilization reviews and audits.

Revised Law

Sec. 544.0113. PROGRAM EXCLUSIONS. The office of inspector general, in consultation with this state's Medicaid fraud control unit, shall establish guidelines under which program exclusions:

(1) may permissively be imposed on a provider; or

(2) shall automatically be imposed on a provider.

(Gov. Code, Sec. 531.102(g)(7).)

Source Law

> (7) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which program exclusions:
>
> (A) may permissively be imposed on a provider; or
>
> (B) shall automatically be imposed on a provider.

Revised Law

Sec. 544.0114. REPORT. (a) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the commission's operation, the inspector general shall submit to the executive commissioner, the governor, and the legislature a report on:

(1) the office of inspector general's activities;

(2) the office's performance with respect to performance measures the executive commissioner establishes for the office;

(3) fraud trends the office has identified;

(4) any recommendations for policy changes to prevent or address fraud, waste, and abuse in the delivery of health and human services in this state; and

(5) the amount of money recovered during the preceding

quarter as a result of investigations involving peace officers employed and commissioned by the office for each program for which the office has investigative authority.

(b) The office of inspector general shall publish each report required under this section on the office's Internet website. (Gov. Code, Secs. 531.102(t), (u).)

Source Law

(t) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the operation of the commission, the inspector general shall submit a report to the executive commissioner, the governor, and the legislature on:

(1) the office's activities;

(2) the office's performance with respect to performance measures established by the executive commissioner for the office;

(3) fraud trends identified by the office;

(4) any recommendations for changes in policy to prevent or address fraud, waste, and abuse in the delivery of health and human services in this state; and

(5) the amount of money recovered during the preceding quarter as a result of investigations involving peace officers employed and commissioned by the office for each program for which the office has investigative authority.

(u) The office shall publish each report required under Subsection (t) on the office's Internet website.

SUBCHAPTER D. MEDICAID PROVIDER CRIMINAL HISTORY RECORD INFORMATION AND ELIGIBILITY

Revised Law

Sec. 544.0151. DEFINITIONS. In this subchapter:

(1) "Health care professional" means an individual issued a license to engage in a health care profession.

(2) "License" means a license, certificate, registration, permit, or other authorization that:

(A) a licensing authority issues; and

(B) must be obtained before a person may practice or engage in a particular business, occupation, or profession.

(3) "Licensing authority" means a department, commission, board, office, or other state agency that issues a license.

(4) "Participating agency" means:

(A) the Medicaid fraud enforcement divisions of the office of the attorney general;

(B) each licensing authority with authority to issue a license to a health care professional or managed care organization that may participate in Medicaid; and

(C) the office of inspector general.

(5) "Provider" means a person that was or is approved by the commission to provide Medicaid services under a contract or provider agreement with the commission. (Gov. Code, Secs. 531.1011(10) (part), 531.1031(a)(1), (1-a), (1-b), (2), (3).)

Source Law

[Sec. 531.1011.]

(10) "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

. . . .

Sec. 531.1031. DUTY TO EXCHANGE INFORMATION. (a) In this section and Sections 531.1032, 531.1033, and 531.1034:

(1) "Health care professional" means a person issued a license to engage in a health care profession.

(1-a) "License" means a license, certificate, registration, permit, or other authorization that:

(A) is issued by a licensing authority; and

(B) must be obtained before a person may practice or engage in a particular business, occupation, or profession.

(1-b) "Licensing authority" means a department, commission, board, office, or other agency of the state that issues a license.

(2) "Participating agency" means:

(A) the Medicaid fraud enforcement divisions of the office of the attorney general;

(B) each licensing authority with authority to issue a license to a health care professional or managed care organization that may participate in Medicaid; and

(C) the office.

(3) "Provider" has the meaning assigned by Section 531.1011(10)(A).

Revisor's Note

Section 531.1031(a)(1-c), Government Code, defines "office" for purposes of Sections 531.1031, 531.1032, 531.1033, and 531.1034, Government Code,

which are revised as this subchapter, as the Health and Human Services Commission's office of inspector general "unless a different meaning is plainly required by the context in which the term appears." Section 544.0001(7) of this chapter defines "office of inspector general" for purposes of this chapter to mean the commission's office of inspector general. The revised law omits the definition of "office" provided by Section 531.1031(a)(1-c) as unnecessary because of the chapter-wide definition provided by Section 544.0001(7), and to the extent a different meaning is required by the context, the revised law throughout this subchapter clarifies that different meaning. The omitted law reads:

> (1-c) "Office" means the commission's office of inspector general unless a different meaning is plainly required by the context in which the term appears.

Revised Law

Sec. 544.0152. EXCHANGE OF CRIMINAL HISTORY RECORD INFORMATION BETWEEN PARTICIPATING AGENCIES. (a) This section applies only to:

(1) criminal history record information a participating agency holds that relates to a health care professional; and

(2) information a participating agency holds that relates to a health care professional or managed care organization that is the subject of an investigation by a participating agency for alleged Medicaid fraud or abuse.

(b) A participating agency may submit to another participating agency a written request for information to which this section applies. The participating agency that receives the request shall provide the requesting agency with the requested information unless releasing the information:

(1) would jeopardize an ongoing investigation or

prosecution by the participating agency that possesses the information; or

(2) is prohibited by other law.

(c) Notwithstanding any other law, a participating agency may enter into a memorandum of understanding or agreement with another participating agency for exchanging criminal history record information relating to a health care professional that both participating agencies are authorized access to under Chapter 411. Confidential criminal history record information in a participating agency's possession that is provided to another participating agency remains confidential while in the possession of the participating agency that receives the information.

(d) A participating agency that discovers information that may indicate fraud or abuse by a health care professional or managed care organization may provide the information to any other participating agency unless the release of the information is prohibited by other law.

(e) If after receiving a request for information under Subsection (b) a participating agency determines that the agency is prohibited from releasing the information, the agency shall, not later than the 30th day after the date the agency received the request, inform the requesting agency of that determination in writing.

(f) Confidential information shared under this section is subject to the same confidentiality requirements and legal restrictions on access to the information that are imposed by law on the participating agency that originally obtained or collected the information. Sharing information under this section does not affect whether the information is subject to disclosure under Chapter 552.

(g) A participating agency that receives information from another participating agency under this section must obtain written permission from the agency that shared the information before using the information in a licensure or enforcement action.

(h) This section does not affect a participating agency's authority to exchange information under other law. (Gov. Code, Secs. 531.1031(b), (c), (c-1), (d), (e), (f), (g), (h).)

Source Law

(b) This section applies only to criminal history record information held by a participating agency that relates to a health care professional and information held by a participating agency that relates to a health care professional or managed care organization that is the subject of an investigation by a participating agency for alleged fraud or abuse under Medicaid.

(c) A participating agency may submit to another participating agency a written request for information described by Subsection (b) regarding a health care professional or managed care organization. The participating agency that receives the request shall provide the requesting agency with the information regarding the health care professional or managed care organization unless:

(1) the release of the information would jeopardize an ongoing investigation or prosecution by the participating agency with possession of the information; or

(2) the release of the information is prohibited by other law.

(c-1) Notwithstanding any other law, a participating agency may enter into a memorandum of understanding or agreement with another participating agency for the purpose of exchanging criminal history record information relating to a health care professional that both participating agencies are authorized to access under Chapter 411. Confidential criminal history record information in the possession of a participating agency that is provided to another participating agency in accordance with this subsection remains confidential while in the possession of the participating agency that receives the information.

(d) A participating agency that discovers information that may indicate fraud or abuse by a health care professional or managed care organization may provide that information to any other participating agency unless the release of the information is prohibited by other law.

(e) Not later than the 30th day after the date the agency receives a request for information under Subsection (c), a participating agency that determines the agency is prohibited from releasing the requested information shall inform the agency requesting the information of that determination in writing.

(f) Confidential information shared under this section remains subject to the same confidentiality requirements and legal restrictions on access to the information that are imposed by law on the participating agency that originally obtained or collected the information. The sharing of information under this section does not affect whether the information is subject to disclosure under Chapter 552.

(g) A participating agency that receives information from another participating agency under this section must obtain written permission from the

agency that shared the information before using the information in a licensure or enforcement action.

(h) This section does not affect the participating agencies' authority to exchange information under other law.

Revised Law

Sec. 544.0153. PROVIDER ELIGIBILITY FOR MEDICAID PARTICIPATION: CRIMINAL HISTORY RECORD INFORMATION. (a) The office of inspector general and each licensing authority that requires the submission of fingerprints to conduct a criminal history record information check of a health care professional shall enter into a memorandum of understanding to ensure that only individuals who are licensed and in good standing as health care professionals participate as Medicaid providers. The memorandum under this section may be combined with a memorandum authorized under Section 544.0152(c) and must include a process by which:

(1) to determine a health care professional's eligibility to participate in Medicaid, the office may confirm with a licensing authority that the professional is licensed and in good standing; and

(2) the licensing authority immediately notifies the office if:

(A) a provider's license has been revoked or suspended; or

(B) the licensing authority has taken disciplinary action against a provider.

(b) To determine a health care professional's eligibility to participate as a Medicaid provider, the office of inspector general may not conduct a criminal history record information check of a health care professional who the office has confirmed under Subsection (a) is licensed and in good standing. This subsection does not prohibit the office from conducting a criminal history record information check of a provider that is required or appropriate for other reasons, including for conducting an investigation of fraud, waste, or abuse.

(c) To determine a provider's eligibility to participate in

Medicaid and subject to Subsection (d), the office of inspector general, after seeking public input, shall establish and the executive commissioner by rule shall adopt guidelines for evaluating criminal history record information of providers and potential providers. The guidelines must outline conduct, by provider type, that may be contained in criminal history record information that will result in excluding a person as a Medicaid provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided through Medicaid;

(2) the degree to which the person would interact with Medicaid recipients as a provider; and

(3) any previous evidence that the person engaged in Medicaid fraud, waste, or abuse.

(d) The guidelines adopted under Subsection (c) may not impose stricter standards for an individual's eligibility to participate in Medicaid than a licensing authority described by Subsection (a) requires for the individual to engage in a health care profession without restriction in this state.

(e) The office of inspector general and the commission shall use the guidelines the executive commissioner adopts under Subsection (c) to determine whether a Medicaid provider continues to be eligible to participate as a Medicaid provider.

(f) The provider enrollment contractor, if applicable, and a Medicaid managed care organization shall defer to the office of inspector general on whether an individual's criminal history record information precludes the individual from participating as a Medicaid provider. (Gov. Code, Secs. 531.1032(a), (b), (c), as added Acts 84th Leg., R.S., Ch. 945, (d), (e), (f).)

Source Law

> Sec. 531.1032. OFFICE OF INSPECTOR GENERAL: CRIMINAL HISTORY RECORD INFORMATION CHECK. (a) The office and each licensing authority that requires the submission of fingerprints for the purpose of conducting a criminal history record information check of a health care professional shall enter into a memorandum of understanding to ensure that only

persons who are licensed and in good standing as health care professionals participate as providers in Medicaid. The memorandum under this section may be combined with a memorandum authorized under Section 531.1031(c-1) and must include a process by which:

(1) the office may confirm with a licensing authority that a health care professional is licensed and in good standing for purposes of determining eligibility to participate in Medicaid; and

(2) the licensing authority immediately notifies the office if:

(A) a provider's license has been revoked or suspended; or

(B) the licensing authority has taken disciplinary action against a provider.

(b) The office may not, for purposes of determining a health care professional's eligibility to participate in Medicaid as a provider, conduct a criminal history record information check of a health care professional who the office has confirmed under Subsection (a) is licensed and in good standing. This subsection does not prohibit the office from performing a criminal history record information check of a provider that is required or appropriate for other reasons, including for conducting an investigation of fraud, waste, or abuse.

(c) For purposes of determining eligibility to participate in Medicaid and subject to Subsection (d), the office, after seeking public input, shall establish and the executive commissioner by rule shall adopt guidelines for the evaluation of criminal history record information of providers and potential providers. The guidelines must outline conduct, by provider type, that may be contained in criminal history record information that will result in exclusion of a person from Medicaid as a provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided under Medicaid;

(2) the degree to which the person would interact with Medicaid recipients as a provider; and

(3) any previous evidence that the person engaged in fraud, waste, or abuse under Medicaid.

(d) The guidelines adopted under Subsection (c) may not impose stricter standards for the eligibility of a person to participate in Medicaid than a licensing authority described by Subsection (a) requires for the person to engage in a health care profession without restriction in this state.

(e) The office and the commission shall use the guidelines adopted under Subsection (c) to determine whether a provider participating in Medicaid continues to be eligible to participate in Medicaid as a provider.

(f) The provider enrollment contractor, if applicable, and a managed care organization participating in Medicaid shall defer to the office regarding whether a person's criminal history record information precludes the person from participating in Medicaid as a provider.

Revisor's Note

(1) Section 531.1032(c), Government Code, as added by Section 2.15(b), Chapter 837 (S.B. 200), Acts

of the 84th Legislature, Regular Session, 2015, requires the Health and Human Services Commission's office of inspector general, after seeking public input from various geographic areas across this state in person or through teleconferencing centers, to establish guidelines for evaluating certain criminal history record information. Section 531.1032(c), Government Code, as added by Section 5, Chapter 945 (S.B. 207), Acts of the 84th Legislature, Regular Session, 2015, imposes the same duties on the office, except that the office is not required to seek public input from various geographic areas across this state in person or through teleconferencing centers. Because Section 531.1032(c), as added by Chapter 837, is more specific in its requirements than Section 531.1032(c), as added by Chapter 945, the statutes are irreconcilable. Under Section 311.025(a), Government Code (Code Construction Act), if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails. Under Section 311.025(d), Government Code (Code Construction Act), the date of enactment is the date on which the last legislative vote is taken on the bill enacting the statute. The last legislative vote on Chapter 837 was taken May 28, 2015. The last legislative vote on Chapter 945 was taken May 30, 2015. Accordingly, the revised law omits Section 531.1032(c), as added by Chapter 837, as superseded by Section 531.1032(c), as added by Chapter 945. The omitted law reads:

> (c) For purposes of determining eligibility to participate in Medicaid and subject to Subsection (d), the office, after seeking public input from various geographic areas across this state, either in person or through teleconferencing centers, shall establish and the executive

commissioner by rule shall adopt guidelines for the evaluation of criminal history record information of providers and potential providers. The guidelines must outline conduct, by provider type, that may be contained in criminal history record information that will result in exclusion of a person from Medicaid as a provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided under Medicaid;

(2) the degree to which the person would interact with Medicaid recipients as a provider; and

(3) any previous evidence that the person engaged in fraud, waste, or abuse under Medicaid.

(2) Section 531.1032(f), Government Code, refers to a "managed care organization participating in Medicaid." The revised law substitutes "Medicaid managed care organization" for "managed care organization participating in Medicaid" for the reason stated in the revisor's note to Section 544.0109 of this chapter.

Revised Law

Sec. 544.0154. MONITORING OF CERTAIN FEDERAL DATABASES. The office of inspector general shall routinely check appropriate federal databases, including databases referenced in 42 C.F.R. Section 455.436, to ensure that a person excluded by the federal government from participating in Medicaid or Medicare is not participating as a Medicaid provider. (Gov. Code, Sec. 531.1033.)

Source Law

Sec. 531.1033. MONITORING OF CERTAIN FEDERAL DATABASES. The office shall routinely check appropriate federal databases, including databases referenced in 42 C.F.R. Section 455.436, to ensure that a person who is excluded from participating in Medicaid or in the Medicare program by the federal government is not participating as a provider in Medicaid.

Revised Law

Sec. 544.0155. PERIOD FOR DETERMINING PROVIDER ELIGIBILITY FOR MEDICAID. (a) Not later than the 10th day after the date the office of inspector general receives a health care professional's complete application seeking to participate in Medicaid, the office

shall inform the commission or the health care professional, as appropriate, of the office's determination of whether the health care professional should be denied participation in Medicaid based on:

(1) information concerning the health care professional's licensing status obtained as described by Section 544.0153(a);

(2) information contained in the criminal history record information check that is evaluated in accordance with guidelines the executive commissioner adopts under Section 544.0153(c);

(3) a review of federal databases under Section 544.0154;

(4) the pendency of an open investigation by the office; or

(5) any other reason the office determines appropriate.

(b) Completion of an on-site visit of a health care professional during the period prescribed by Subsection (a) is not required.

(c) The office of inspector general shall develop performance metrics to measure the length of time for conducting a determination described by Subsection (a) with respect to:

(1) applications that are complete when submitted; and

(2) all other applications. (Gov. Code, Sec. 531.1034.)

Source Law

Sec. 531.1034. TIME TO DETERMINE PROVIDER ELIGIBILITY; PERFORMANCE METRICS. (a) Not later than the 10th day after the date the office receives the complete application of a health care professional seeking to participate in Medicaid, the office shall inform the commission or the health care professional, as appropriate, of the office's determination regarding whether the health care professional should be denied participation in Medicaid based on:

(1) information concerning the licensing status of the health care professional obtained as described by Section 531.1032(a);

(2) information contained in the criminal

history record information check that is evaluated in accordance with guidelines adopted under Section 531.1032(c);

(3) a review of federal databases under Section 531.1033;

(4) the pendency of an open investigation by the office; or

(5) any other reason the office determines appropriate.

(b) Completion of an on-site visit of a health care professional during the period prescribed by Subsection (a) is not required.

(c) The office shall develop performance metrics to measure the length of time for conducting a determination described by Subsection (a) with respect to applications that are complete when submitted and all other applications.

SUBCHAPTER E. PREVENTION AND DETECTION OF FRAUD, WASTE, AND ABUSE

Revised Law

Sec. 544.0201. SELECTION AND REVIEW OF MEDICAID CLAIMS TO DETERMINE RESOURCE ALLOCATION. (a) The commission shall annually select and review a random, statistically valid sample of all claims for Medicaid reimbursement, including under the vendor drug program, for potential cases of fraud, waste, or abuse.

(b) In conducting the annual review of claims, the commission may directly contact a recipient by telephone, in person, or both to verify that the services for which a provider submitted a reimbursement claim were actually provided to the recipient.

(c) Based on the results of the annual review of claims, the commission shall determine the types of claims toward which commission resources for fraud and abuse detection should be primarily directed.

(d) Absent an allegation of fraud, waste, or abuse, the commission may conduct an annual review of claims only after the commission completes the prior year's annual review of claims. (Gov. Code, Sec. 531.109.)

Source Law

Sec. 531.109. SELECTION AND REVIEW OF CLAIMS. (a) The commission shall annually select and review a random, statistically valid sample of all claims for reimbursement under Medicaid, including under the vendor drug program, for potential cases of fraud, waste, or abuse.

(b) In conducting the annual review of claims under Subsection (a), the commission may directly

contact a recipient by telephone or in person, or both, to verify that the services for which a claim for reimbursement was submitted by a provider were actually provided to the recipient.

(c) Based on the results of the annual review of claims, the commission shall determine the types of claims at which commission resources for fraud and abuse detection should be primarily directed.

(d) Absent an allegation of fraud, waste, or abuse, the commission may conduct an annual review of claims under this section only after the commission has completed the prior year's annual review of claims.

Revised Law

Sec. 544.0202. DUTIES RELATED TO FRAUD PREVENTION. (a) The office of inspector general shall compile and disseminate accurate information and statistics relating to:

(1) fraud prevention; and

(2) post-fraud referrals received and accepted or rejected from the commission's or a health and human services agency's case management system.

(b) The commission shall:

(1) aggressively publicize successful fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases; and

(2) ensure that the commission or a health and human services agency maintains and promotes a toll-free telephone hotline for reporting suspected fraud in programs the commission or a health and human services agency administers.

(c) The commission shall develop a cost-effective method to identify applicants for public assistance in counties bordering other states and in metropolitan areas the commission selects who are already receiving benefits in other states. If economically feasible, the commission may develop a computerized matching system.

(d) The commission shall:

(1) verify automobile information that is used as eligibility criteria; and

(2) establish with the Texas Department of Criminal Justice a computerized matching system to prevent an incarcerated individual from illegally receiving public assistance benefits the

commission administers.

(e) Not later than October 1 of each year, the commission shall submit to the governor and Legislative Budget Board a report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas Department of Criminal Justice. The commission may consolidate the report with any other report relating to the same subject matter the commission is required to submit under other law.

(f) The commission and each health and human services agency that administers part of Medicaid shall maintain statistics on the number, type, and disposition of fraudulent benefits claims submitted under the part of the program the agency administers. (Gov. Code, Secs. 531.0215, 531.108.)

Source Law

Sec. 531.0215. COMPILATION OF STATISTICS RELATING TO FRAUD. The commission and each health and human services agency that administers a part of Medicaid shall maintain statistics on the number, type, and disposition of fraudulent claims for benefits submitted under the part of the program the agency administers.

Sec. 531.108. FRAUD PREVENTION. (a) The commission's office of inspector general shall compile and disseminate accurate information and statistics relating to:

(1) fraud prevention; and

(2) post-fraud referrals received and accepted or rejected from the commission's case management system or the case management system of a health and human services agency.

(b) The commission shall:

(1) aggressively publicize successful fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases; and

(2) ensure that a toll-free hotline for reporting suspected fraud in programs administered by the commission or a health and human services agency is maintained and promoted, either by the commission or by a health and human services agency.

(c) The commission shall develop a cost-effective method of identifying applicants for public assistance in counties bordering other states and in metropolitan areas selected by the commission who are already receiving benefits in other states. If economically feasible, the commission may develop a computerized matching system.

(d) The commission shall:

(1) verify automobile information that is used as criteria for eligibility; and

(2) establish a computerized matching system with the Texas Department of Criminal Justice to prevent an incarcerated individual from illegally receiving public assistance benefits administered by the commission.

(e) Not later than October 1 of each year, the commission shall submit to the governor and Legislative Budget Board an annual report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas Department of Criminal Justice. The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.

Revised Law

Sec. 544.0203. FRAUD, WASTE, AND ABUSE DETECTION TRAINING. (a) The commission shall develop and implement a program to provide annual training on identifying potential cases of Medicaid fraud, waste, or abuse to:

(1) contractors who process Medicaid claims; and

(2) appropriate health and human services agency staff.

(b) The training must include clear criteria that specify:

(1) the circumstances under which a person should refer a potential case to the commission; and

(2) the time by which a referral should be made. (Gov. Code, Sec. 531.105(a).)

Source Law

Sec. 531.105. FRAUD DETECTION TRAINING. (a) The commission shall develop and implement a program to provide annual training to contractors who process Medicaid claims and to appropriate staff of the health and human services agencies in identifying potential cases of fraud, waste, or abuse under Medicaid. The training provided to the contractors and staff must include clear criteria that specify:

(1) the circumstances under which a person should refer a potential case to the commission; and

(2) the time by which a referral should be made.

Revised Law

Sec. 544.0204. HEALTH AND HUMAN SERVICES AGENCY MEDICAID FRAUD, WASTE, AND ABUSE DETECTION GOAL. (a) The health and human services agencies, in cooperation with the commission, shall periodically set a goal for the number of potential cases of Medicaid fraud, waste, or abuse that each agency will attempt to

identify and refer to the commission.

(b) The commission shall include in the report required by Section 544.0051(f) information on the health and human services agencies' goals and the success of each agency in meeting the agency's goal. (Gov. Code, Sec. 531.105(b).)

Source Law

> (b) The health and human services agencies, in cooperation with the commission, shall periodically set a goal of the number of potential cases of fraud, waste, or abuse under Medicaid that each agency will attempt to identify and refer to the commission. The commission shall include information on the agencies' goals and the success of each agency in meeting the agency's goal in the report required by Section 531.103(c).

Revised Law

Sec. 544.0205. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may grant an award to an individual who reports activity that constitutes fraud or abuse of Medicaid funds or who reports Medicaid overcharges if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity the individual reported.

(b) The commission shall determine the amount of an award. The award may not exceed five percent of the amount of the administrative penalty imposed under Section 32.039, Human Resources Code, that resulted from the individual's disclosure. In determining the award amount, the commission:

(1) shall consider how important the disclosure is in ensuring the fiscal integrity of Medicaid; and

(2) may consider whether the individual participated in the fraud, abuse, or overcharge.

(c) A person who brings an action under Subchapter C, Chapter 36, Human Resources Code, is not eligible for an award under this section. (Gov. Code, Sec. 531.101.)

Source Law

Sec. 531.101. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may grant an award to an individual who reports activity that constitutes fraud or abuse of funds in Medicaid or reports overcharges in Medicaid if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity reported by the individual.

(b) The commission shall determine the amount of an award. The award may not exceed five percent of the amount of the administrative penalty imposed under Section 32.039, Human Resources Code, that resulted from the individual's disclosure. In determining the amount of the award, the commission shall consider how important the disclosure is in ensuring the fiscal integrity of Medicaid. The commission may also consider whether the individual participated in the fraud, abuse, or overcharge.

(c) A person who brings an action under Subchapter C, Chapter 36, Human Resources Code, is not eligible for an award under this section.

SUBCHAPTER F. INVESTIGATION OF FRAUD, WASTE, ABUSE, AND OVERCHARGES

Revised Law

Sec. 544.0251. CLAIMS CRITERIA REQUIRING COMMENCEMENT OF INVESTIGATION. The executive commissioner, in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office of inspector general to begin an investigation. (Gov. Code, Sec. 531.102(e).)

Source Law

(e) The executive commissioner, in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office to begin an investigation.

Revised Law

Sec. 544.0252. CIRCUMSTANCES REQUIRING COMMENCEMENT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE. (a) The office of inspector general shall conduct a preliminary investigation of an allegation of fraud or abuse against a provider that the commission receives from any source to determine whether there is a sufficient basis to warrant a full investigation. The office must begin a preliminary investigation not later than the

30th day and complete the preliminary investigation not later than the 45th day after the date the commission receives or identifies an allegation of fraud or abuse.

(b) The office of inspector general shall conduct a preliminary investigation as provided by Section 544.0253 of a complaint or allegation of Medicaid fraud or abuse that the commission receives from any source to determine whether there is a sufficient basis to warrant a full investigation. The office must begin a preliminary investigation not later than the 30th day and complete the preliminary investigation not later than the 45th day after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. (Gov. Code, Secs. 531.102(f)(1), 531.118(b).)

Source Law

[Sec. 531.102]

(f)(1) If the commission receives a complaint or allegation of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation as provided by Section 531.118(c) to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day, and be completed not later than the 45th day, after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred.

[Sec. 531.118]

(b) If the commission receives an allegation of fraud or abuse against a provider from any source, the commission's office of inspector general shall conduct a preliminary investigation of the allegation to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day, and be completed not later than the 45th day, after the date the commission receives or identifies an allegation of fraud or abuse.

Revised Law

Sec. 544.0253. CONDUCT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE. In conducting a preliminary investigation of an allegation of fraud or abuse and before the allegation may proceed to a full investigation, the office of inspector general must:

(1) review the allegation and all facts and evidence relating to the allegation; and

(2) prepare a preliminary investigation report that documents:

(A) the allegation;

(B) the evidence the office reviewed, if available;

(C) the procedures the office used to conduct the preliminary investigation;

(D) the preliminary investigation findings; and

(E) the office's determination of whether a full investigation is warranted. (Gov. Code, Sec. 531.118(c).)

Source Law

> (c) In conducting a preliminary investigation, the office must review the allegations of fraud or abuse and all facts and evidence relating to the allegation and must prepare a preliminary investigation report before the allegation of fraud or abuse may proceed to a full investigation. The preliminary investigation report must document the allegation, the evidence reviewed, if available, the procedures used to conduct the preliminary investigation, the findings of the preliminary investigation, and the office's determination of whether a full investigation is warranted.

Revised Law

Sec. 544.0254. FINDING OF CERTAIN MEDICAID FRAUD OR ABUSE FOLLOWING PRELIMINARY INVESTIGATION: CRIMINAL REFERRAL OR FULL INVESTIGATION. If the findings of a preliminary investigation give the office of inspector general reason to believe that an incident of Medicaid fraud or abuse involving possible criminal conduct has occurred, not later than the 30th day after completing the preliminary investigation, the office, as appropriate:

(1) must refer the case to this state's Medicaid fraud control unit if a provider is suspected of fraud or abuse involving criminal conduct, provided that the criminal referral does not preclude the office from continuing the office's investigation of the provider that may lead to the imposition of appropriate administrative or civil sanctions; or

(2) may conduct a full investigation, subject to Section 544.0253, if there is reason to believe that a recipient has

defrauded Medicaid. (Gov. Code, Sec. 531.102(f)(2).)

Source Law

> (2) If the findings of a preliminary investigation give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in Medicaid, the office must take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation:
>
> (A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions; or
>
> (B) if there is reason to believe that a recipient has defrauded Medicaid, the office may conduct a full investigation of the suspected fraud, subject to Section 531.118(c).

Revised Law

Sec. 544.0255. IMMEDIATE CRIMINAL REFERRAL UNDER CERTAIN CIRCUMSTANCES. If the office of inspector general learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to this state's Medicaid fraud control unit. The criminal referral does not preclude the office from continuing the office's investigation of the provider that may lead to the imposition of appropriate administrative or civil sanctions. (Gov. Code, Sec. 531.102(g)(1).)

Source Law

> (g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

Revised Law

Sec. 544.0256. CONTINUATION OF PAYMENT HOLD FOLLOWING REFERRAL TO LAW ENFORCEMENT AGENCY. (a) If this state's Medicaid fraud control unit or another law enforcement agency accepts a fraud referral from the office of inspector general for

investigation, a payment hold based on a credible allegation of fraud may be continued until:

(1) the investigation and any associated enforcement proceedings are complete; or

(2) the Medicaid fraud control unit, another law enforcement agency, or another prosecuting authority determines that there is insufficient evidence of fraud by the provider that is the subject of the investigation.

(b) If this state's Medicaid fraud control unit or another law enforcement agency declines to accept a fraud referral from the office of inspector general for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless:

(1) the commission has alternative federal or state authority under which the commission may impose a payment hold; or

(2) the office makes a fraud referral to another law enforcement agency.

(c) On a quarterly basis, the office of inspector general shall request a certification from this state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter the unit or agency accepted on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of a payment hold is warranted. (Gov. Code, Secs. 531.118(d), (e), (f).)

Source Law

> (d) If the state's Medicaid fraud control unit or any other law enforcement agency accepts a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud may be continued until:
>
> (1) that investigation and any associated enforcement proceedings are complete; or
>
> (2) the state's Medicaid fraud control unit, another law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
>
> (e) If the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless the commission has alternative federal or state authority under which it may impose a payment hold or the office makes a fraud referral to another law enforcement agency.

(f) On a quarterly basis, the office must request a certification from the state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter accepted by the unit or agency on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted.

Revisor's Note

Section 531.118(f), Government Code, provides that the Health and Human Services Commission's office of inspector general "must" request a certification of certain information. The revised law substitutes "shall" for "must" because under Section 311.016, Government Code (Code Construction Act), applicable to the revised law, the term "shall" imposes a duty on an actor, and it is clear that requesting the certification is a duty imposed on the office of inspector general.

Revised Law

Sec. 544.0257. COMPLETION OF FULL INVESTIGATION OF ALLEGED MEDICAID FRAUD OR ABUSE. (a) The office of inspector general shall complete a full investigation of a complaint or allegation of Medicaid fraud or abuse against a provider not later than the 180th day after the date the full investigation begins unless the office determines that more time is needed to complete the investigation.

(b) Except as otherwise provided by this subsection, if the office of inspector general determines that more time is needed to complete a full investigation, the office shall provide notice to the provider who is the subject of the investigation stating that the length of the investigation will exceed 180 days and specifying the reasons why the office was unable to complete the investigation within the 180-day period. The office is not required to provide notice to the provider under this subsection if the office determines that providing notice would jeopardize the investigation. (Gov. Code, Sec. 531.102(f-1).)

Source Law

(f-1) The office shall complete a full investigation of a complaint or allegation of Medicaid

fraud or abuse against a provider not later than the 180th day after the date the full investigation begins unless the office determines that more time is needed to complete the investigation. Except as otherwise provided by this subsection, if the office determines that more time is needed to complete the investigation, the office shall provide notice to the provider who is the subject of the investigation stating that the length of the investigation will exceed 180 days and specifying the reasons why the office was unable to complete the investigation within the 180-day period. The office is not required to provide notice to the provider under this subsection if the office determines that providing notice would jeopardize the investigation.

Revised Law

Sec. 544.0258. MEMORANDUM OF UNDERSTANDING FOR ASSISTING ATTORNEY GENERAL INVESTIGATIONS RELATED TO MEDICAID. (a) The commission and the attorney general shall enter into a memorandum of understanding under which the commission shall:

(1) provide investigative support to the attorney general as required in connection with cases under Subchapter B, Chapter 36, Human Resources Code; and

(2) assist in performing preliminary investigations and ongoing investigations for actions the attorney general prosecutes under Subchapter C, Chapter 36, Human Resources Code.

(b) The memorandum of understanding must specify the type, scope, and format of the investigative support the commission provides to the attorney general.

(c) The memorandum of understanding must ensure that barriers to direct fraud referrals to this state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are not imposed. (Gov. Code, Sec. 531.104.)

Source Law

Sec. 531.104. ASSISTING INVESTIGATIONS BY ATTORNEY GENERAL. (a) The commission and the attorney general shall execute a memorandum of understanding under which the commission shall provide investigative support as required to the attorney general in connection with cases under Subchapter B, Chapter 36, Human Resources Code. Under the memorandum of understanding, the commission shall assist in performing preliminary investigations and ongoing investigations for actions prosecuted by the attorney general under Subchapter C, Chapter 36, Human Resources Code.

(b) The memorandum of understanding must specify the type, scope, and format of the investigative support provided to the attorney general under this section.

(c) The memorandum of understanding must ensure that no barriers to direct fraud referrals to the state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the state's Medicaid fraud control unit will be imposed.

Revised Law

Sec. 544.0259. SUBPOENAS. (a) The office of inspector general may issue a subpoena in connection with an investigation the office conducts. The subpoena may be:

(1) issued to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence in this state; and

(2) served personally or by certified mail.

(b) The office of inspector general, acting through the attorney general, may file suit in a district court in this state to enforce a subpoena with which a person fails to comply. On finding that good cause exists for issuing the subpoena, the court shall order the person to comply with the subpoena. The court may punish a person who fails to obey the court order.

(c) Reimbursement of the expenses of a witness whose attendance is compelled under this section is governed by Section 2001.103.

(d) The office of inspector general shall pay a reasonable fee for subpoenaed photocopies. The fee may not exceed the amount the office of inspector general may charge for copies of its records.

(e) Except for the disclosure of information to the state auditor's office, law enforcement agencies, and other entities as permitted by other law, all information and materials subpoenaed or compiled by the office of inspector general in connection with an audit, inspection, or investigation or by the office of the attorney general in connection with a Medicaid fraud investigation are:

(1) confidential and not subject to disclosure under

Chapter 552; and

(2) not subject to disclosure, discovery, subpoena, or other means of legal compulsion for release to anyone other than the office of inspector general, the attorney general, or the office's or attorney general's employees or agents involved in the audit, inspection, or investigation.

(f) A person who receives information under Subsection (e) may disclose the information only in accordance with Subsection (e) and in a manner that is consistent with the authorized purpose for which the person first received the information. (Gov. Code, Sec. 531.1021.)

Source Law

Sec. 531.1021. SUBPOENAS. (a) The office of inspector general may issue a subpoena in connection with an investigation conducted by the office. A subpoena may be issued under this section to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence that is in this state.

(b) A subpoena may be served personally or by certified mail.

(c) If a person fails to comply with a subpoena, the office, acting through the attorney general, may file suit to enforce the subpoena in a district court in this state.

(d) On finding that good cause exists for issuing the subpoena, the court shall order the person to comply with the subpoena. The court may punish a person who fails to obey the court order.

(e) The office shall pay a reasonable fee for photocopies subpoenaed under this section in an amount not to exceed the amount the office may charge for copies of its records.

(f) The reimbursement of the expenses of a witness whose attendance is compelled under this section is governed by Section 2001.103.

(g) All information and materials subpoenaed or compiled by the office in connection with an audit, inspection, or investigation or by the office of the attorney general in connection with a Medicaid fraud investigation are confidential and not subject to disclosure under Chapter 552, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the office or the attorney general or their employees or agents involved in the audit, inspection, or investigation conducted by the office or the attorney general, except that this information may be disclosed to the state auditor's office, law enforcement agencies, and other entities as permitted by other law.

(h) A person who receives information under Subsection (g) may disclose the information only in accordance with Subsection (g) and in a manner that is consistent with the authorized purpose for which the

person first received the information.

SUBCHAPTER G. PAYMENT HOLDS

Revised Law

Sec. 544.0301. IMPOSITION OF PAYMENT HOLD. (a) As authorized by state and federal law and except as provided by Subsections (d) and (e), the office of inspector general shall impose, as a serious enforcement tool to mitigate ongoing financial risk to this state, a payment hold on claims for reimbursement submitted by a provider only:

(1) to compel production of records;

(2) when requested by this state's Medicaid fraud control unit; or

(3) on the determination that a credible allegation of fraud exists, subject to Sections 544.0104(b) and 544.0105(b), as applicable.

(b) The office of inspector general shall impose a payment hold under this section without prior notice, and the payment hold takes effect immediately.

(c) The office of inspector general shall, in consultation with this state's Medicaid fraud control unit, establish guidelines regarding the imposition of payment holds authorized under this section.

(d) On the determination that a credible allegation of fraud exists and in accordance with 42 C.F.R. Sections 455.23(e) and (f), the office of inspector general may find that good cause exists to not impose a payment hold, to not continue a payment hold, to impose a payment hold only in part, or to convert a payment hold imposed in whole to one imposed only in part if:

(1) law enforcement officials specifically requested that a payment hold not be imposed because a payment hold would compromise or jeopardize an investigation;

(2) available remedies implemented by this state other than a payment hold would more effectively or quickly protect Medicaid funds;

(3) the office of inspector general determines, based on the submission of written evidence by the provider who is the subject of the payment hold, that the payment hold should be removed;

(4) Medicaid recipients' access to items or services would be jeopardized by a full or partial payment hold because the provider who is the subject of the payment hold:

(A) is the sole community physician or the sole source of essential specialized services in a community; or

(B) serves a large number of Medicaid recipients within a designated medically underserved area;

(5) the attorney general declines to certify that a matter continues to be under investigation; or

(6) the office of inspector general determines that a full or partial payment hold is not in the best interests of Medicaid.

(e) Unless the office of inspector general has evidence that a provider materially misrepresented documentation relating to medically necessary services, the office of inspector general may not impose a payment hold on claims for reimbursement the provider submits for those services if the provider obtained prior authorization from the commission or a commission contractor. (Gov. Code, Secs. 531.102(g)(2) (part), (7-a), (8), (9).)

Source Law

> (2) As authorized under state and federal law, and except as provided by Subdivisions (8) and (9), the office shall impose without prior notice a payment hold on claims for reimbursement submitted by a provider only to compel production of records, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation of fraud exists, subject to Subsections (l) and (m), as applicable. The payment hold is a serious enforcement tool that the office imposes to mitigate ongoing financial risk to the state. A payment hold imposed under this subdivision takes effect immediately. . . .
>
> (7-a) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines regarding the imposition of payment holds authorized under Subdivision (2).
>
> (8) In accordance with 42 C.F.R. Sections 455.23(e) and (f), on the determination that a

credible allegation of fraud exists, the office may find that good cause exists to not impose a payment hold, to not continue a payment hold, to impose a payment hold only in part, or to convert a payment hold imposed in whole to one imposed only in part, if any of the following are applicable:

(A) law enforcement officials have specifically requested that a payment hold not be imposed because a payment hold would compromise or jeopardize an investigation;

(B) available remedies implemented by the state other than a payment hold would more effectively or quickly protect Medicaid funds;

(C) the office determines, based on the submission of written evidence by the provider who is the subject of the payment hold, that the payment hold should be removed;

(D) Medicaid recipients' access to items or services would be jeopardized by a full or partial payment hold because the provider who is the subject of the payment hold:

(i) is the sole community physician or the sole source of essential specialized services in a community; or

(ii) serves a large number of Medicaid recipients within a designated medically underserved area;

(E) the attorney general declines to certify that a matter continues to be under investigation; or

(F) the office determines that a full or partial payment hold is not in the best interests of Medicaid.

(9) The office may not impose a payment hold on claims for reimbursement submitted by a provider for medically necessary services for which the provider has obtained prior authorization from the commission or a contractor of the commission unless the office has evidence that the provider has materially misrepresented documentation relating to those services.

Revised Law

Sec. 544.0302. NOTICE. (a) The office of inspector general shall notify a provider of a payment hold imposed under Section 544.0301(a) in accordance with 42 C.F.R. Section 455.23(b) and, except as provided by that regulation, not later than the fifth day after the date the office imposes the payment hold.

(b) In addition to the requirements of 42 C.F.R. Section 455.23(b), the payment hold notice must also include:

(1) the specific basis for the hold, including:

(A) the claims supporting the allegation at that point in the investigation;

(B) a representative sample of any documents that form the basis for the hold; and

(C) a detailed summary of the office of inspector general's evidence relating to the allegation;

(2) a description of administrative and judicial due process rights and remedies, including:

(A) the provider's option to seek informal resolution;

(B) the provider's right to seek a formal administrative appeal hearing; or

(C) the provider's ability to seek both an informal resolution and a formal administrative appeal hearing; and

(3) a detailed timeline for the provider to pursue the rights and remedies described in Subdivision (2). (Gov. Code, Sec. 531.102(g)(2) (part).)

Source Law

> (2) . . . The office must notify the provider of the payment hold in accordance with 42 C.F.R. Section 455.23(b) and, except as provided by that regulation, not later than the fifth day after the date the office imposes the payment hold. In addition to the requirements of 42 C.F.R. Section 455.23(b), the notice of payment hold provided under this subdivision must also include:
>
> (A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation, a representative sample of any documents that form the basis for the hold, and a detailed summary of the office's evidence relating to the allegation;
>
> (B) a description of administrative and judicial due process rights and remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both; and
>
> (C) a detailed timeline for the provider to pursue the rights and remedies described in Paragraph (B).

Revisor's Note

Section 531.102(g)(2), Government Code, specifies that the Health and Human Services Commission's office of inspector general "must" notify a provider of a payment hold. The revised law substitutes "shall" for "must" for the reason stated in the revisor's note to Section 544.0256 of this chapter.

Revised Law

Sec. 544.0303. EXPEDITED ADMINISTRATIVE HEARING. (a) A provider subject to a payment hold imposed under Section 544.0301(a), other than a hold this state's Medicaid fraud control unit requested, must request an expedited administrative hearing not later than the 10th day after the date the provider receives notice of the hold from the office of inspector general under Section 544.0302.

(b) On a provider's timely written request, the office of inspector general shall, not later than the third day after the date the office of inspector general receives the request, file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the payment hold for which the provider submitted the request.

(c) Not later than the 45th day after the date the State Office of Administrative Hearings receives a request from the office of inspector general for an expedited administrative hearing, the State Office of Administrative Hearings shall hold the hearing.

(d) In an expedited administrative hearing held under this section:

(1) the provider and the office of inspector general are each limited to four hours of testimony, excluding time for responding to questions from the administrative law judge;

(2) the provider and the office of inspector general are each entitled to two continuances under reasonable circumstances; and

(3) the office of inspector general is required to show probable cause that:

(A) the credible allegation of fraud that is the basis of the imposed payment hold has an indicia of reliability; and

(B) continuing to pay the provider presents an ongoing significant financial risk to this state and a threat to the integrity of Medicaid.

(e) The office of inspector general is responsible for the costs of the expedited administrative hearing, but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(f) In the expedited administrative hearing, the administrative law judge shall decide whether the payment hold should continue but may not adjust the amount or percent of the payment hold.

(g) Notwithstanding any other law, including Section 2001.058(e), the administrative law judge's decision in the expedited administrative hearing is final and may not be appealed. (Gov. Code, Secs. 531.102(g)(3), (4), (5).)

Source Law

> (3) On timely written request by a provider subject to a payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold not later than the third day after the date the office receives the provider's request. The provider must request an expedited administrative hearing under this subdivision not later than the 10th day after the date the provider receives notice from the office under Subdivision (2). The State Office of Administrative Hearings shall hold the expedited administrative hearing not later than the 45th day after the date the State Office of Administrative Hearings receives the request for the hearing. In a hearing held under this subdivision:
>
> (A) the provider and the office are each limited to four hours of testimony, excluding time for responding to questions from the administrative law judge;
>
> (B) the provider and the office are each entitled to two continuances under reasonable circumstances; and
>
> (C) the office is required to show probable cause that the credible allegation of fraud that is the basis of the payment hold has an indicia of reliability and that continuing to pay the provider presents an ongoing significant financial risk to the state and a threat to the integrity of Medicaid.
>
> (4) The office is responsible for the costs of a hearing held under Subdivision (3), but a provider is responsible for the provider's own costs incurred in preparing for the hearing.
>
> (5) In a hearing held under Subdivision (3), the administrative law judge shall decide if the payment hold should continue but may not adjust the amount or percent of the payment hold. Notwithstanding any other law, including Section 2001.058(e), the decision of the administrative law judge is final and may not be appealed.

Revisor's Note

(1) Section 531.102(g)(3), Government Code, refers to the imposition of a payment hold under Subdivision (2), meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to imposing a payment hold is revised in this chapter as Section 544.0301(a), and the revised law is drafted accordingly.

(2) Section 531.102(g)(3), Government Code, refers to a provider's receipt of notice under Subdivision (2), meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to a provider's receipt of notice is revised in this chapter as Section 544.0302, and the revised law is drafted accordingly.

Revised Law

Sec. 544.0304. INFORMAL RESOLUTION. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules that allow a provider subject to a payment hold imposed under Section 544.0301(a), other than a hold this state's Medicaid fraud control unit requested, to seek an informal resolution of the issues the office identifies in the notice provided under Section 544.0302.

(b) A provider must request an initial informal resolution meeting under this section not later than the deadline prescribed by Section 544.0303(a) for requesting an expedited administrative hearing.

(c) On receipt of a timely request, the office of inspector general shall:

(1) decide whether to grant the provider's request for an initial informal resolution meeting; and

(2) if the office decides to grant the request, schedule the initial informal resolution meeting and give notice to the provider of the time and place of the meeting.

(d) A provider may request a second informal resolution meeting after the date of an initial informal resolution meeting. On receipt of a timely request, the office of inspector general shall:

(1) decide whether to grant the provider's request for a second informal resolution meeting; and

(2) if the office decides to grant the request, schedule the second informal resolution meeting and give notice to the provider of the time and place of the second meeting.

(e) Before a second informal resolution meeting is held, a provider must have an opportunity to provide additional information for the office of inspector general to consider.

(f) A provider's decision to seek an informal resolution under this section does not extend the time by which the provider must request an expedited administrative hearing under Section 544.0303(a). The informal resolution process shall run concurrently with the administrative hearing process, and the informal resolution process shall be discontinued when the State Office of Administrative Hearings issues a final determination on the payment hold. (Gov. Code, Sec. 531.102(g)(6).)

Source Law

> (6) The executive commissioner, in consultation with the office, shall adopt rules that allow a provider subject to a payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must request an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3) for requesting an expedited administrative hearing. On receipt of a timely request, the office shall decide whether to grant the provider's request for an initial informal resolution meeting, and if the office decides to grant the request, the office shall schedule the initial informal resolution meeting. The office shall give notice to the provider of the time and place of the initial informal resolution meeting. A provider may request a second informal resolution meeting after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall decide whether to grant the provider's request for a second informal resolution meeting, and if the office decides to grant the request, the office shall schedule the second informal resolution meeting. The office shall

give notice to the provider of the time and place of the second informal resolution meeting. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office. A provider's decision to seek an informal resolution under this subdivision does not extend the time by which the provider must request an expedited administrative hearing under Subdivision (3). The informal resolution process shall run concurrently with the administrative hearing process, and the informal resolution process shall be discontinued once the State Office of Administrative Hearings issues a final determination on the payment hold.

Revisor's Note

(1) Section 531.102(g)(6), Government Code, refers to the imposition of a payment hold under Subdivision (2), meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to imposing a payment hold is revised in this chapter as Section 544.0301(a), and the revised law is drafted accordingly.

(2) Section 531.102(g)(6), Government Code, refers to a payment hold notice provided under "that subdivision," meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to a payment hold notice is revised in this chapter as Section 544.0302, and the revised law is drafted accordingly.

(3) Section 531.102(g)(6), Government Code, refers to the deadline for requesting an expedited administrative hearing prescribed by Subdivision (3), meaning Section 531.102(g)(3), Government Code. The provision of Section 531.102(g)(3) prescribing the deadline for requesting an expedited administrative hearing is revised in this chapter as Section 544.0303(a), and the revised law is drafted accordingly.

Revised Law

Sec. 544.0305. WEBSITE POSTING. The office of inspector general shall post on the office's publicly available Internet

website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider under this subchapter. (Gov. Code, Sec. 531.119.)

Source Law

> Sec. 531.119. WEBSITE POSTING. The commission's office of inspector general shall post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider under this subchapter.

Revisor's Note

Section 531.119, Government Code, refers to the processes and procedures the Health and Human Services Commission's office of inspector general uses in determining whether to impose a payment hold on a provider under "this subchapter," meaning Subchapter C, Chapter 531, Government Code. The provisions of Subchapter C, Chapter 531, relating to imposing a payment hold are revised as this subchapter, and the revised law is drafted accordingly.

SUBCHAPTER H. MANAGED CARE ORGANIZATION PREVENTION AND INVESTIGATION OF FRAUD AND ABUSE

Revised Law

Sec. 544.0351. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program, including Medicaid and the child health plan program. (Gov. Code, Sec. 531.113(a) (part).)

Source Law

> Sec. 531.113. MANAGED CARE ORGANIZATIONS: SPECIAL INVESTIGATIVE UNITS OR CONTRACTS. (a) Each managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program, including Medicaid and the child health plan program, . . .

Revised Law

Sec. 544.0352. SPECIAL INVESTIGATIVE UNIT OR CONTRACTED ENTITY TO INVESTIGATE FRAUD AND ABUSE. (a) A managed care organization to which this subchapter applies shall:

(1) establish and maintain a special investigative unit within the organization to investigate fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers; or

(2) contract with another entity to investigate fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers.

(b) A managed care organization that contracts for the investigation of fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers under Subsection (a)(2) shall file with the office of inspector general:

(1) a copy of the written contract;

(2) the names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the organization contracts; and

(3) a description of the qualifications of the principals of the entity with which the organization contracts. (Gov. Code, Secs. 531.113(a) (part), (c).)

Source Law

(a) [Each managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program] . . . shall:

(1) establish and maintain a special investigative unit within the managed care organization to investigate fraudulent claims and other types of program abuse by recipients and service providers; or

(2) contract with another entity for the investigation of fraudulent claims and other types of program abuse by recipients and service providers.

(c) If a managed care organization contracts for the investigation of fraudulent claims and other types of program abuse by recipients and service providers under Subsection (a)(2), the managed care organization shall file with the commission's office of inspector general:

(1) a copy of the written contract;

(2) the names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the managed care organization has contracted; and

(3) a description of the qualifications of the principals of the entity with which the managed care organization has contracted.

Revisor's Note

Sections 531.113(a) and (c), Government Code, refer to "recipients" under government-funded health care programs, including Medicaid and the child health plan program. A person who receives benefits under Medicaid is generally referred to as a "recipient" and a person who receives benefits under the child health plan program is generally referred to as an "enrollee." The revised law substitutes a reference to "recipients or enrollees, as applicable" for "recipients" for accuracy and consistency throughout Subtitle I, Title 4, Government Code, which includes this chapter.

Revised Law

Sec. 544.0353. FRAUD AND ABUSE PREVENTION PLAN. (a) A managed care organization to which this subchapter applies shall:

(1) adopt a plan to prevent and reduce fraud and abuse; and

(2) annually file the plan with the office of inspector general for approval.

(b) The plan must include:

(1) a description of the organization's procedures for:

(A) detecting and investigating possible acts of fraud or abuse;

(B) mandatory reporting of possible acts of fraud or abuse to the office of inspector general; and

(C) educating and training personnel to prevent fraud and abuse;

(2) the name, address, telephone number, and fax

number of the individual responsible for carrying out the plan;

(3) a description or chart outlining the organizational arrangement of the organization's personnel responsible for investigating and reporting possible acts of fraud or abuse;

(4) a detailed description of the results of fraud and abuse investigations the organization's special investigative unit or the entity with which the organization contracts under Section 544.0352(a)(2) conducts; and

(5) provisions for maintaining the confidentiality of any patient information relevant to a fraud or abuse investigation. (Gov. Code, Sec. 531.113(b).)

Source Law

> (b) Each managed care organization subject to this section shall adopt a plan to prevent and reduce fraud and abuse and annually file that plan with the commission's office of inspector general for approval. The plan must include:
>
> (1) a description of the managed care organization's procedures for detecting and investigating possible acts of fraud or abuse;
>
> (2) a description of the managed care organization's procedures for the mandatory reporting of possible acts of fraud or abuse to the commission's office of inspector general;
>
> (3) a description of the managed care organization's procedures for educating and training personnel to prevent fraud and abuse;
>
> (4) the name, address, telephone number, and fax number of the individual responsible for carrying out the plan;
>
> (5) a description or chart outlining the organizational arrangement of the managed care organization's personnel responsible for investigating and reporting possible acts of fraud or abuse;
>
> (6) a detailed description of the results of investigations of fraud and abuse conducted by the managed care organization's special investigative unit or the entity with which the managed care organization contracts under Subsection (a)(2); and
>
> (7) provisions for maintaining the confidentiality of any patient information relevant to an investigation of fraud or abuse.

Revised Law

Sec. 544.0354. ASSISTANCE AND OVERSIGHT BY OFFICE OF INSPECTOR GENERAL. (a) The office of inspector general may review the records of a managed care organization to which this subchapter applies to determine compliance with this subchapter.

(b) The office of inspector general, in consultation with the commission, shall:

(1) investigate, including by means of regular audits, possible fraud, waste, and abuse by managed care organizations to which this subchapter applies;

(2) establish requirements for providing training to and regular oversight of special investigative units established by managed care organizations under Section 544.0352(a)(1) and entities with which managed care organizations contract under Section 544.0352(a)(2);

(3) establish requirements for approving plans to prevent and reduce fraud and abuse that managed care organizations adopt under Section 544.0353;

(4) evaluate statewide Medicaid fraud, waste, and abuse trends and communicate those trends to special investigative units and contracted entities to determine the prevalence of those trends;

(5) as needed, assist managed care organizations in discovering or investigating fraud, waste, and abuse; and

(6) provide ongoing, regular training to appropriate commission and office staff concerning fraud, waste, and abuse in a managed care setting, including training relating to fraud, waste, and abuse by service providers, recipients, and enrollees. (Gov. Code, Secs. 531.113(d), (d-1).)

Source Law

(d) The commission's office of inspector general may review the records of a managed care organization to determine compliance with this section.

(d-1) The commission's office of inspector general, in consultation with the commission, shall:

(1) investigate, including by means of regular audits, possible fraud, waste, and abuse by managed care organizations subject to this section;

(2) establish requirements for the provision of training to and regular oversight of special investigative units established by managed care organizations under Subsection (a)(1) and entities with which managed care organizations contract under Subsection (a)(2);

(3) establish requirements for approving plans to prevent and reduce fraud and abuse adopted by managed care organizations under Subsection (b);

(4) evaluate statewide fraud, waste, and abuse trends in Medicaid and communicate those trends to special investigative units and contracted entities to determine the prevalence of those trends;

(5) assist managed care organizations in discovering or investigating fraud, waste, and abuse, as needed; and

(6) provide ongoing, regular training to appropriate commission and office staff concerning fraud, waste, and abuse in a managed care setting, including training relating to fraud, waste, and abuse by service providers and recipients.

Revisor's Note

Section 531.113(d-1)(6), Government Code, refers to fraud, waste, and abuse in a "managed care setting," including fraud, waste, and abuse by "recipients." It is clear from Section 531.113(a), Government Code, which is revised in relevant part as Section 544.0351 of this chapter, that the "managed care setting" to which Section 531.113(d-1)(6) refers includes managed care provided under Medicaid and the child health plan program. The revised law refers to both "recipients" and "enrollees" for the reason stated in the revisor's note to Section 544.0352 of this chapter.

Revised Law

Sec. 544.0355. RULES. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules as necessary to accomplish the purposes of this subchapter, including rules defining the investigative role of the office with respect to the investigative role of special investigative units established by managed care organizations under Section 544.0352(a)(1) and entities with which managed care organizations contract under Section 544.0352(a)(2).

(b) The rules must specify the office of inspector general's role in:

(1) reviewing the findings of special investigative units and contracted entities;

(2) investigating cases in which the overpayment amount sought to be recovered exceeds $100,000; and

(3) investigating providers who are enrolled in more

than one managed care organization. (Gov. Code, Sec. 531.113(e).)

Source Law

(e) The executive commissioner, in consultation with the office, shall adopt rules as necessary to accomplish the purposes of this section, including rules defining the investigative role of the commission's office of inspector general with respect to the investigative role of special investigative units established by managed care organizations under Subsection (a)(1) and entities with which managed care organizations contract under Subsection (a)(2). The rules adopted under this section must specify the office's role in:

(1) reviewing the findings of special investigative units and contracted entities;

(2) investigating cases in which the overpayment amount sought to be recovered exceeds $100,000; and

(3) investigating providers who are enrolled in more than one managed care organization.

SUBCHAPTER I. FINANCIAL ASSISTANCE FRAUD

Revised Law

Sec. 544.0401. DEFINITION. In this subchapter, "financial assistance" means assistance provided under the financial assistance program under Chapter 31, Human Resources Code. (Gov. Code, Sec. 531.114(a) (part).)

Source Law

(a) . . . financial assistance under Chapter 31, Human Resources Code, or . . . .

Revised Law

Sec. 544.0402. FALSE OR MISLEADING INFORMATION RELATED TO FINANCIAL ASSISTANCE ELIGIBILITY. To establish or maintain the eligibility of an individual and the individual's family for financial assistance or to increase or prevent a reduction in the amount of that assistance, an individual may not intentionally:

(1) make a statement that the individual knows is false or misleading;

(2) misrepresent, conceal, or withhold a fact; or

(3) knowingly misrepresent a statement as being true. (Gov. Code, Sec. 531.114(a) (part).)

Source Law

Sec. 531.114. FINANCIAL ASSISTANCE FRAUD. (a) For purposes of establishing or maintaining the eligibility of a person and the person's family for

financial assistance . . . for purposes of increasing or preventing a reduction in the amount of that assistance, a person may not intentionally:

(1) make a statement that the person knows is false or misleading;

(2) misrepresent, conceal, or withhold a fact; or

(3) knowingly misrepresent a statement as being true.

Revised Law

Sec. 544.0403. COMMISSION ACTION FOLLOWING DETERMINATION OF VIOLATION. If after an investigation the commission determines that an individual violated Section 544.0402, the commission shall:

(1) notify the individual of the alleged violation not later than the 30th day after the date the commission completes the investigation and provide the individual with an opportunity for a hearing on the matter; or

(2) refer the matter to the appropriate prosecuting attorney for prosecution. (Gov. Code, Sec. 531.114(b).)

Source Law

(b) If after an investigation the commission determines that a person violated Subsection (a), the commission shall:

(1) notify the person of the alleged violation not later than the 30th day after the date the commission completes the investigation and provide the person with an opportunity for a hearing on the matter; or

(2) refer the matter to the appropriate prosecuting attorney for prosecution.

Revised Law

Sec. 544.0404. INELIGIBILITY FOR FINANCIAL ASSISTANCE FOLLOWING VIOLATION; RIGHT TO APPEAL. (a) An individual is not eligible to receive financial assistance as provided by Subsection (b) if the individual waives the right to a hearing or a hearing officer at an administrative hearing held under this subchapter determines that the individual violated Section 544.0402. An individual who a hearing officer determines violated Section 544.0402 may appeal that determination by filing a petition in the district court in the county in which the violation occurred not later than the 30th day after the date the hearing officer makes the determination.

(b) An individual determined under Subsection (a) to have

violated Section 544.0402 is not eligible for financial assistance:

(1) before the first anniversary of the date of that determination if the individual has no previous violations; and

(2) permanently if the individual was previously determined to have committed a violation.

(c) An individual who is convicted of a state or federal offense for conduct described by Section 544.0402 or who is granted deferred adjudication or placed on community supervision for that conduct is permanently disqualified from receiving financial assistance. (Gov. Code, Secs. 531.114(c), (d), (e).)

Source Law

> (c) If a person waives the right to a hearing or if a hearing officer at an administrative hearing held under this section determines that a person violated Subsection (a), the person is ineligible to receive financial assistance as provided by Subsection (d). A person who a hearing officer determines violated Subsection (a) may appeal that determination by filing a petition in the district court in the county in which the violation occurred not later than the 30th day after the date the hearing officer made the determination.
>
> (d) A person determined under Subsection (c) to have violated Subsection (a) is not eligible for financial assistance:
>
> (1) before the first anniversary of the date of that determination, if the person has no previous violations; and
>
> (2) permanently, if the person was previously determined to have committed a violation.
>
> (e) If a person is convicted of a state or federal offense for conduct described by Subsection (a), or if the person is granted deferred adjudication or placed on community supervision for that conduct, the person is permanently disqualified from receiving financial assistance.

Revised Law

Sec. 544.0405. HOUSEHOLD ELIGIBILITY FOR FINANCIAL ASSISTANCE NOT AFFECTED. This subchapter does not affect the eligibility for financial assistance of any other member of the household of an individual who is ineligible as a result of Section 544.0404(b) or (c). (Gov. Code, Sec. 531.114(f).)

Source Law

> (f) This section does not affect the eligibility for financial assistance of any other member of the household of a person ineligible as a result of Subsection (d) or (e).

Revised Law

Sec. 544.0406. RULES. The executive commissioner shall adopt rules as necessary to implement this subchapter. (Gov. Code, Sec. 531.114(g).)

Source Law

(g) The executive commissioner shall adopt rules as necessary to implement this section.

SUBCHAPTER J. USE OF TECHNOLOGY TO DETECT, INVESTIGATE, AND PREVENT FRAUD, ABUSE, AND OVERCHARGES

Revised Law

Sec. 544.0451. LEARNING, NEURAL NETWORK, OR OTHER TECHNOLOGY RELATING TO MEDICAID. (a) The commission shall:

(1) use learning, neural network, or other technology to identify and deter Medicaid fraud throughout this state; and

(2) require each health and human services agency that performs any part of Medicaid to participate in implementing and using the technology.

(b) The commission shall contract with a private or public entity to develop and implement the technology. The commission may require the contracted entity to install and operate the technology at locations the commission specifies, including commission offices.

(c) The commission shall maintain all information necessary to apply the technology to claims data covering a period of at least two years. The data used for data processing shall be maintained as an independent subset for security purposes.

(d) The commission shall refer cases the technology identifies to the office of inspector general or the office of the attorney general, as appropriate.

(e) Each month, the technology must match vital statistics unit death records with Medicaid claims filed by a provider. If the commission determines that a provider filed a claim for services provided to an individual after the individual's date of death, as determined by the vital statistics unit death records, the

commission shall refer the case to the office of inspector general for investigation. (Gov. Code, Sec. 531.106.)

Source Law

> Sec. 531.106. LEARNING, NEURAL NETWORK, OR OTHER TECHNOLOGY. (a) The commission shall use learning, neural network, or other technology to identify and deter fraud in Medicaid throughout this state.
>
> (b) The commission shall contract with a private or public entity to develop and implement the technology. The commission may require the entity it contracts with to install and operate the technology at locations specified by the commission, including commission offices.
>
> (c) The data used for data processing shall be maintained as an independent subset for security purposes.
>
> (d) The commission shall require each health and human services agency that performs any aspect of Medicaid to participate in the implementation and use of the technology.
>
> (e) The commission shall maintain all information necessary to apply the technology to claims data covering a period of at least two years.
>
> (f) The commission shall refer cases identified by the technology to the commission's office of inspector general or the office of the attorney general, as appropriate.
>
> (g) Each month, the technology implemented under this section must match vital statistics unit death records with Medicaid claims filed by a provider. If the commission determines that a provider has filed a claim for services provided to a person after the person's date of death, as determined by the vital statistics unit death records, the commission shall refer the case for investigation to the commission's office of inspector general.

Revised Law

Sec. 544.0452. MEDICAID FRAUD INVESTIGATION TRACKING SYSTEM. (a) The commission shall use an automated fraud investigation tracking system through the office of inspector general to monitor the progress of an investigation of suspected fraud, abuse, or insufficient quality of care in Medicaid.

(b) For each case of suspected fraud, abuse, or insufficient quality of care the technology required under Section 544.0451 identifies, the automated fraud investigation tracking system must:

(1) receive from the technology electronically transferred records relating to the case;

(2) record the details and monitor the status of an

investigation of the case, including maintaining a record of the beginning and completion dates for each phase of the case investigation;

(3) generate documents and reports related to the status of the case investigation; and

(4) generate standard letters to a provider regarding the status or outcome of an investigation.

(c) The commission shall require each health and human services agency that performs any part of Medicaid to participate in implementing and using the automated fraud investigation tracking system. (Gov. Code, Sec. 531.1061.)

Source Law

> Sec. 531.1061. FRAUD INVESTIGATION TRACKING SYSTEM. (a) The commission shall use an automated fraud investigation tracking system through the commission's office of inspector general to monitor the progress of an investigation of suspected fraud, abuse, or insufficient quality of care under Medicaid.
>
> (b) For each case of suspected fraud, abuse, or insufficient quality of care identified by the technology required under Section 531.106, the automated fraud investigation tracking system must:
>
> (1) receive electronically transferred records relating to the identified case from the technology;
>
> (2) record the details and monitor the status of an investigation of the identified case, including maintaining a record of the beginning and completion dates for each phase of the case investigation;
>
> (3) generate documents and reports related to the status of the case investigation; and
>
> (4) generate standard letters to a provider regarding the status or outcome of an investigation.
>
> (c) The commission shall require each health and human services agency that performs any aspect of Medicaid to participate in the implementation and use of the automated fraud investigation tracking system.

Revised Law

Sec. 544.0453. MEDICAID FRAUD DETECTION TECHNOLOGY. The commission may contract with a contractor who specializes in developing technology capable of identifying fraud patterns exhibited by Medicaid recipients to:

(1) develop and implement the fraud detection technology; and

(2) determine whether a fraud pattern by Medicaid

recipients is present in the recipients' eligibility files the commission maintains. (Gov. Code, Sec. 531.111.)

Source Law

> Sec. 531.111. FRAUD DETECTION TECHNOLOGY. The commission may contract with a contractor who specializes in developing technology capable of identifying patterns of fraud exhibited by Medicaid recipients to:
>
> (1) develop and implement the fraud detection technology; and
>
> (2) determine if a pattern of fraud by Medicaid recipients is present in the recipients' eligibility files maintained by the commission.

Revised Law

Sec. 544.0454. DATA MATCHING AGAINST FEDERAL FELON LIST. The commission shall develop and implement a system to cross-reference the list of fugitive felons the federal government maintains with data collected for the following programs:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) nutritional assistance programs under Chapter 33, Human Resources Code;

(5) long-term care services, as defined by Section 22.0011, Human Resources Code;

(6) community-based support services identified or provided in accordance with Subchapter D, Chapter 546; and

(7) other health and human services programs, as appropriate. (Gov. Code, Sec. 531.115.)

Source Law

> Sec. 531.115. FEDERAL FELONY MATCH. The commission shall develop and implement a system to cross-reference data collected for the programs listed under Section 531.008(c) with the list of fugitive felons maintained by the federal government.

Revisor's Note

Section 531.115, Government Code, refers to "the programs listed under Section 531.008(c)," Government Code. Before the enactment of Chapter 837 (S.B. 200),

Acts of the 84th Legislature, Regular Session, 2015, Section 531.008(c) required the establishment within the Health and Human Services Commission of a division to make eligibility determinations for listed health and human services programs. Section 1.09 of Chapter 837 amended Section 531.008(c) and repealed that list of programs. Because the remaining reference to "the programs listed under Section 531.008(c)" in Section 531.115 is an oversight, the revised law substitutes for the quoted language the health and human services programs that were listed in Section 531.008(c) before the subsection was amended. The revised law also substitutes "Subchapter D, Chapter 546" for the reference to Section 531.02481 for the reason stated in Revisor's Note (4) to Section 524.0001 of this subtitle.

Revised Law

Sec. 544.0455. ELECTRONIC DATA MATCHING. (a) In this section, "public assistance program" includes:

(1) Medicaid;

(2) the financial assistance program under Chapter 31, Human Resources Code; and

(3) a nutritional assistance program under Chapter 33, Human Resources Code, including the supplemental nutrition assistance program under that chapter.

(b) At least quarterly, the commission shall conduct electronic data matches for a recipient of public assistance program benefits to verify the identity, income, employment status, and other factors that affect the recipient's eligibility. To verify a recipient's eligibility, the electronic data matching must match information the recipient provided with information contained in databases appropriate federal and state agencies maintain.

(c) Health and human services agencies shall cooperate with

the commission by providing data or any other assistance necessary to conduct the electronic data matches required by this section.

(d) The commission shall enter into a memorandum of understanding with each state agency from which data is required to conduct electronic data matches under this section and Section 544.0456.

(e) The commission may contract with a public or private entity to conduct the electronic data matches required by this section.

(f) The executive commissioner shall establish procedures by which the commission or a health and human services agency the commission designates verifies the electronic data matches the commission conducts under this section. Not later than the 20th day after the date an electronic data match is verified, the commission shall remove from eligibility a recipient who is determined to be ineligible for a public assistance program. (Gov. Code, Sec. 531.110.)

Source Law

Sec. 531.110. ELECTRONIC DATA MATCHING PROGRAM. (a) In this section, "public assistance program" includes:

(1) Medicaid;

(2) the financial assistance program under Chapter 31, Human Resources Code; and

(3) a nutritional assistance program under Chapter 33, Human Resources Code, including the supplemental nutrition assistance program under that chapter.

(a-1) The commission shall conduct electronic data matches for a recipient of benefits under a public assistance program at least quarterly to verify the identity, income, employment status, and other factors that affect the eligibility of the recipient.

(b) To verify eligibility of a recipient of public assistance program benefits, the electronic data matching must match information provided by the recipient with information contained in databases maintained by appropriate federal and state agencies.

(c) The health and human services agencies shall cooperate with the commission by providing data or any other assistance necessary to conduct the electronic data matches required by this section.

(c-1) The commission shall enter into a memorandum of understanding with each state agency from which data is required to conduct electronic data matches under this section and Section 531.1081.

(d) The commission may contract with a public or private entity to conduct the electronic data matches required by this section.

(e) The executive commissioner shall establish procedures by which the commission, or a health and human services agency designated by the commission, verifies the electronic data matches conducted by the commission under this section. Not later than the 20th day after the date the electronic data match is verified, the commission shall remove from eligibility a recipient who is determined to be ineligible for a public assistance program.

Revised Law

Sec. 544.0456. METHODS TO REDUCE FRAUD, WASTE, AND ABUSE IN CERTAIN PUBLIC ASSISTANCE PROGRAMS. (a) In this section:

(1) "Financial assistance benefits" means monetary payments under:

(A) the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code; or

(B) this state's temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Supplemental nutrition assistance benefits" means monetary payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code.

(b) To the extent not otherwise provided by this subtitle or Title 2, Human Resources Code, and in accordance with this section, the commission shall develop and implement methods for reducing fraud, waste, and abuse in public assistance programs.

(c) On a monthly basis, the commission shall:

(1) conduct electronic data matches with the Texas Lottery Commission to determine whether a recipient of supplemental nutrition assistance benefits or a recipient's household member received reportable lottery winnings;

(2) use the database system developed under Section 532.0201 to:

(A) match vital statistics unit death records with a list of individuals eligible for financial assistance or supplemental nutrition assistance benefits; and

(B) ensure that any individual receiving

assistance under either program who is discovered to be deceased has the individual's eligibility for assistance promptly terminated; and

(3) review the out-of-state electronic benefit transfer card transactions a recipient of supplemental nutrition assistance benefits made to determine whether those transactions indicate a possible change in the recipient's residence.

(d) The commission shall immediately review a recipient's eligibility for public assistance benefits if the commission discovers information under this section that affects the recipient's eligibility.

(e) A recipient presumptively commits a program violation if the recipient fails to disclose lottery winnings that are required to be reported to the commission under a public assistance program.

(f) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 531.1081.)

Source Law

Sec. 531.1081. INTEGRITY OF CERTAIN PUBLIC ASSISTANCE PROGRAMS. (a) In this section:

(1) "Financial assistance benefits" means money payments under the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code, or under the state temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Supplemental nutrition assistance benefits" means money payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code.

(b) To the extent not otherwise provided by this subtitle or Title 2, Human Resources Code, the commission shall develop and implement, in accordance with this section, methods for reducing abuse, fraud, and waste in public assistance programs.

(c) On a monthly basis, the commission shall:

(1) conduct electronic data matches with the Texas Lottery Commission to determine if a recipient of supplemental nutrition assistance benefits or a recipient's household member received reportable lottery winnings;

(2) use the database system developed under Section 531.0214 to match vital statistics unit death records with a list of individuals eligible for financial assistance or supplemental nutrition assistance benefits, and ensure that any individual receiving assistance under either program who is discovered deceased has their eligibility for assistance promptly terminated; and

(3) review the out-of-state electronic benefit transfer card transactions made by a recipient of supplemental nutrition assistance benefits to determine whether those transactions indicate a possible change in the recipient's residence.

(d) The commission shall immediately review the eligibility of a recipient of public assistance benefits if the commission discovers information under this section that affects the recipient's eligibility.

(e) A recipient who fails to disclose lottery winnings that are required to be reported to the commission under a public assistance program presumptively commits a program violation.

(f) The executive commissioner shall adopt rules necessary to implement this section.

Revisor's Note
(End of Subchapter)

Section 531.1112, Government Code, requires the Health and Human Services Commission and the commission's office of inspector general to study the feasibility of increasing the use of technology to strengthen the detection and deterrence of Medicaid fraud and to implement any methods the commission and office determine are effective. Section 6(b), Chapter 268 (S.B. 10), Acts of the 80th Legislature, Regular Session, 2007, required the commission to submit to the legislature not later than December 1, 2008, a report detailing the findings of the study, including a description of any method described by Section 531.1112(b) that the commission has implemented or intends to implement. The commission conducted the study and, in December 2008, submitted the required report to the legislature. Therefore, the revised law omits the provision as executed. The omitted law reads:

> Sec. 531.1112. STUDY CONCERNING INCREASED USE OF TECHNOLOGY TO STRENGTHEN FRAUD DETECTION AND DETERRENCE; IMPLEMENTATION. (a) The commission and the commission's office of inspector general shall jointly study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in Medicaid. The study must include the determination of the feasibility of using technology to verify a person's citizenship and eligibility for coverage.
>
> (b) The commission shall implement

any methods the commission and the commission's office of inspector general determine are effective at strengthening fraud detection and deterrence.

SUBCHAPTER K. RECOVERY AND RECOUPMENT IN CASES OF FRAUD, ABUSE, AND OVERCHARGES

Revised Law

Sec. 544.0501. RECOVERY MONITORING SYSTEM. (a) The commission shall use an automated recovery monitoring system to monitor the collections process for a settled case of fraud, abuse, or insufficient quality of care in Medicaid.

(b) The recovery monitoring system must:

(1) monitor the collection of funds resulting from settled cases, including by recording:

(A) monetary payments received from a provider who agreed to a monetary payment plan; and

(B) deductions taken through the recoupment program from subsequent Medicaid claims the provider filed; and

(2) provide immediate notice of a provider who:

(A) agreed to a monetary payment plan or to deductions through the recoupment program from subsequent Medicaid claims; and

(B) fails to comply with the settlement agreement, including by providing notice of a provider who:

(i) does not make a scheduled payment; or

(ii) pays less than a scheduled amount. (Gov. Code, Sec. 531.1062.)

Source Law

Sec. 531.1062. RECOVERY MONITORING SYSTEM. (a) The commission shall use an automated recovery monitoring system to monitor the collections process for a settled case of fraud, abuse, or insufficient quality of care under Medicaid.

(b) The recovery monitoring system must:

(1) monitor the collection of funds resulting from settled cases, including:

(A) recording monetary payments received from a provider who has agreed to a monetary payment plan; and

(B) recording deductions taken through the recoupment program from subsequent Medicaid claims filed by the provider; and

(2) provide immediate notice of a provider

who has agreed to a monetary payment plan or to deductions through the recoupment program from subsequent Medicaid claims who fails to comply with the settlement agreement, including providing notice of a provider who does not make a scheduled payment or who pays less than the scheduled amount.

Revised Law

Sec. 544.0502. PAYMENT RECOVERY EFFORTS BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) In this section, "contracted entity" means an entity with which a managed care organization contracts under Section 544.0352(a)(2).

(b) A managed care organization or the organization's contracted entity that discovers Medicaid or child health plan program fraud or abuse shall:

(1) immediately submit written notice to the office of inspector general and the office of the attorney general that:

(A) is in the form and manner the office of inspector general prescribes; and

(B) contains a detailed description of:

(i) the fraud or abuse; and

(ii) each payment made to a provider as a result of the fraud or abuse;

(2) subject to Subsection (c), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with rules the executive commissioner adopts.

(c) A managed care organization or the organization's contracted entity may not engage in payment recovery efforts if:

(1) the amount sought to be recovered under Subsection (b)(2) exceeds $100,000; and

(2) not later than the 10th business day after the date the organization or entity notifies the office of inspector general and the office of the attorney general under Subsection (b)(1), the organization or entity receives a notice from either office indicating that the organization or entity is not authorized to proceed with recovery efforts.

(d) A managed care organization may retain one-half of any money the organization or the organization's contracted entity recovers under Subsection (b)(2). The organization shall remit the remaining amount of recovered money to the office of inspector general for deposit to the credit of the general revenue fund.

(e) If the office of inspector general notifies a managed care organization in accordance with Subsection (c), proceeds with recovery efforts, and recovers all or part of the payments the organization identified as required by Subsection (b)(1), the organization is entitled to one-half of the amount recovered for each payment the organization identified after any applicable federal share is deducted. The organization may not receive more than one-half of the total amount recovered after any applicable federal share is deducted.

(f) Notwithstanding this section, if the office of inspector general discovers Medicaid or child health plan program fraud, waste, or abuse in performing the office's duties, the office of inspector general may recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this chapter. All payments the office of inspector general recovers under this subsection shall be deposited to the credit of the general revenue fund.

(g) The office of inspector general shall coordinate with appropriate managed care organizations to ensure that the office of inspector general and an organization or an organization's contracted entity do not both begin payment recovery efforts under this section for the same case of fraud, waste, or abuse.

(h) A managed care organization shall submit a quarterly report to the office of inspector general detailing the amount of money the organization recovered under Subsection (b)(2).

(i) The executive commissioner shall adopt rules necessary to implement this section, including rules establishing due process procedures that a managed care organization must follow when engaging in payment recovery efforts as provided by this section.

In adopting the rules establishing due process procedures, the executive commissioner shall require that a managed care organization or an organization's contracted entity that engages in payment recovery efforts as provided by this section and Section 544.0503 provide to a provider required to use electronic visit verification:

(1) written notice of the organization's intent to recoup overpayments in accordance with Section 544.0503; and

(2) at least 60 days to cure any defect in a claim before the organization may begin efforts to collect overpayments. (Gov. Code, Sec. 531.1131.)

Source Law

Sec. 531.1131. FRAUD AND ABUSE RECOVERY BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) If a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) discovers fraud or abuse in Medicaid or the child health plan program, the organization or entity shall:

(1) immediately submit written notice to the commission's office of inspector general and the office of the attorney general in the form and manner prescribed by the office of inspector general and containing a detailed description of the fraud or abuse and each payment made to a provider as a result of the fraud or abuse;

(2) subject to Subsection (b), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with applicable rules adopted by the executive commissioner.

(b) If the amount sought to be recovered under Subsection (a)(2) exceeds $100,000, the managed care organization or the contracted entity described by Subsection (a) may not engage in payment recovery efforts if, not later than the 10th business day after the date the organization or entity notified the commission's office of inspector general and the office of the attorney general under Subsection (a)(1), the organization or entity receives a notice from either office indicating that the organization or entity is not authorized to proceed with recovery efforts.

(c) A managed care organization may retain one-half of any money recovered under Subsection (a)(2) by the organization or the contracted entity described by Subsection (a). The managed care organization shall remit the remaining amount of money recovered under Subsection (a)(2) to the commission's office of inspector general for deposit to the credit of the general revenue fund.

(c-1) If the commission's office of inspector general notifies a managed care organization under Subsection (b), proceeds with recovery efforts, and

recovers all or part of the payments the organization identified as required by Subsection (a)(1), the organization is entitled to one-half of the amount recovered for each payment the organization identified after any applicable federal share is deducted. The organization may not receive more than one-half of the total amount of money recovered after any applicable federal share is deducted.

(c-2) Notwithstanding any provision of this section, if the commission's office of inspector general discovers fraud, waste, or abuse in Medicaid or the child health plan program in the performance of its duties, the office may recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this subchapter. All payments recovered by the office under this subsection shall be deposited to the credit of the general revenue fund.

(c-3) The commission's office of inspector general shall coordinate with appropriate managed care organizations to ensure that the office and an organization or an entity with which an organization contracts under Section 531.113(a)(2) do not both begin payment recovery efforts under this section for the same case of fraud, waste, or abuse.

(d) A managed care organization shall submit a quarterly report to the commission's office of inspector general detailing the amount of money recovered under Subsection (a)(2).

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by this section.

(f) In adopting rules establishing due process procedures under Subsection (e), the executive commissioner shall require that a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) that engages in payment recovery efforts in accordance with this section and Section 531.1135 provide:

(1) written notice to a provider required to use electronic visit verification of the organization's intent to recoup overpayments in accordance with Section 531.1135; and

(2) a provider described by Subdivision (1) at least 60 days to cure any defect in a claim before the organization may begin any efforts to collect overpayments.

Revisor's Note

Section 531.1131(c-2), Government Code, authorizes the Health and Human Services Commission's office of inspector general to recover payments made to a provider as a result of fraud, waste, or abuse as otherwise provided by this "subchapter," meaning Subchapter C, Chapter 531, Government Code. Although the law revised in this chapter includes provisions not included in Subchapter C, Chapter 531, the revised

law substitutes "chapter" for "subchapter" because the law revised in this chapter is substantially derived from Subchapter C, Chapter 531, and the inclusion of provisions not derived from Subchapter C does not expand the scope of the office's authority to recover payments.

Revised Law

Sec. 544.0503. PROCESS FOR MANAGED CARE ORGANIZATIONS TO RECOUP OVERPAYMENTS RELATED TO ELECTRONIC VISIT VERIFICATION TRANSACTIONS. (a) The executive commissioner shall adopt rules that standardize the process by which a managed care organization collects alleged overpayments that are made to a health care provider and discovered through an audit or investigation the organization conducts secondary to missing electronic visit verification information. The rules must require that the organization:

(1) provide written notice to a provider:

(A) of the organization's intent to recoup overpayments not later than the 30th day after the date an audit is complete;

(B) of the specific claims and electronic visit verification transactions that are the basis of the overpayment;

(C) of the process the provider should use to communicate with the organization to provide information about the electronic visit verification transactions;

(D) of the provider's option to seek an informal resolution of the alleged overpayment;

(E) of the process to appeal the determination that an overpayment was made; and

(F) if the provider intends to respond to the notice, that the provider must respond not later than the 30th day after the date the provider receives the notice; and

(2) limit the duration of audits to 24 months.

(b) Notwithstanding any other law, a managed care

organization may not attempt to recover an overpayment described by Subsection (a) until the provider exhausts all rights to an appeal. (Gov. Code, Sec. 531.1135.)

Source Law

> Sec. 531.1135. MANAGED CARE ORGANIZATIONS: PROCESS TO RECOUP CERTAIN OVERPAYMENTS. (a) The executive commissioner shall adopt rules that standardize the process by which a managed care organization collects alleged overpayments that are made to a health care provider and discovered through an audit or investigation conducted by the organization secondary to missing electronic visit verification information. In adopting rules under this section, the executive commissioner shall require that the managed care organization:
>
> (1) provide written notice of the organization's intent to recoup overpayments not later than the 30th day after the date an audit is complete; and
>
> (2) limit the duration of audits to 24 months.
>
> (b) The executive commissioner shall require that the notice required under this section inform the provider:
>
> (1) of the specific claims and electronic visit verification transactions that are the basis of the overpayment;
>
> (2) of the process the provider should use to communicate with the managed care organization to provide information about the electronic visit verification transactions;
>
> (3) of the provider's option to seek an informal resolution of the alleged overpayment;
>
> (4) of the process to appeal the determination that an overpayment was made; and
>
> (5) if the provider intends to respond to the notice, that the provider must respond not later than the 30th day after the date the provider receives the notice.
>
> (c) Notwithstanding any other law, a managed care organization may not attempt to recover an overpayment described by Subsection (a) until the provider has exhausted all rights to an appeal.

Revised Law

Sec. 544.0504. RECOVERY AUDIT CONTRACTORS. To the extent required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), the commission shall establish a program under which the commission contracts with one or more recovery audit contractors to identify Medicaid underpayments and overpayments and recover the overpayments. (Gov. Code, Sec. 531.117.)

Source Law

> Sec. 531.117. RECOVERY AUDIT CONTRACTORS. To

the extent required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), the commission shall establish a program under which the commission contracts with one or more recovery audit contractors for purposes of identifying underpayments and overpayments under Medicaid and recovering the overpayments.

Revised Law

Sec. 544.0505. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Not later than December 1 of each year, the commission shall prepare and submit to the legislature a report on the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Subchapter H and Section 544.0502 by special investigative units or entities with which a managed care organization contracts under Section 544.0352(a)(2). The report must specify the amount of money each managed care organization retained under Section 544.0502(d). (Gov. Code, Sec. 531.1132.)

Source Law

Sec. 531.1132. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Not later than December 1 of each year, the commission shall prepare and submit a report to the legislature relating to the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Sections 531.113 and 531.1131 by special investigative units or entities with which a managed care organization contracts under Section 531.113(a)(2). The report must specify the amount of money retained by each managed care organization under Section 531.1131(c).

Revised Law

Sec. 544.0506. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the office of inspector general shall provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation. The notice must include:

(1) the specific basis for the overpayment or debt;

(2) a description of facts and supporting evidence;

(3) a representative sample of any documents that form the basis for the overpayment or debt;

(4) the extrapolation methodology;

(5) information relating to the extrapolation methodology used as part of the investigation and the methods used to determine the overpayment or debt in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and are fully reproducible;

(6) the calculation of the overpayment or debt amount;

(7) the amount of damages and penalties, if applicable; and

(8) a description of administrative and judicial due process remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both.

(b) A provider may request an informal resolution meeting. On receipt of the request, the office of inspector general shall schedule the meeting and give notice to the provider of the time and place of the meeting. The informal resolution process shall run concurrently with the administrative hearing process, and the administrative hearing process may not be delayed on account of the informal resolution process.

(c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid. (Gov. Code, Sec. 531.120.)

Source Law

> Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the commission's office of inspector general shall provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation. The notice must include:
>
> (1) the specific basis for the overpayment or debt;
>
> (2) a description of facts and supporting evidence;
>
> (3) a representative sample of any documents that form the basis for the overpayment or debt;
>
> (4) the extrapolation methodology;

(4-a) information relating to the extrapolation methodology used as part of the investigation and the methods used to determine the overpayment or debt in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and are fully reproducible;

(5) the calculation of the overpayment or debt amount;

(6) the amount of damages and penalties, if applicable; and

(7) a description of administrative and judicial due process remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both.

(b) A provider may request an informal resolution meeting under this section, and on receipt of the request, the office shall schedule the informal resolution meeting. The office shall give notice to the provider of the time and place of the informal resolution meeting. The informal resolution process shall run concurrently with the administrative hearing process, and the administrative hearing process may not be delayed on account of the informal resolution process.

(c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid.

Revised Law

Sec. 544.0507. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) A provider must request an appeal under this section not later than the 30th day after the date the provider is notified that the commission or the office of inspector general will seek to recover an overpayment or debt from the provider.

(b) On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the commission's appeals division, as the provider requests, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office of inspector general shall file the docketing request not later than the 60th day after the date of the provider's request or not later than the 60th day after completing the informal resolution process, if applicable.

(c) The office of inspector general is responsible for the costs of an administrative hearing, but a provider is responsible

for the provider's own costs incurred in preparing for the hearing.

(d) A provider who is the subject of a recoupment of overpayment or debt arising out of a fraud or abuse investigation may appeal a final administrative order issued after an administrative hearing by filing a petition for judicial review in a district court in Travis County. (Gov. Code, Sec. 531.1201.)

Source Law

> Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) A provider must request an appeal under this section not later than the 30th day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider. On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall file the docketing request under this section not later than the 60th day after the date of the provider's request for an administrative hearing or not later than the 60th day after the completion of the informal resolution process, if applicable.
>
> (b) The commission's office of inspector general is responsible for the costs of an administrative hearing held under Subsection (a), but a provider is responsible for the provider's own costs incurred in preparing for the hearing.
>
> (d) Following an administrative hearing under Subsection (a), a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

CHAPTER 545. CERTAIN PUBLIC ASSISTANCE BENEFITS

SUBCHAPTER A. PUBLIC ASSISTANCE BENEFITS PROGRAM ELIGIBILITY DETERMINATION AND SERVICE DELIVERY INTEGRATION


Sec. 545.0001. DEFINITIONS . . . . . 775

Sec. 545.0002. DEVELOPMENT AND IMPLEMENTATION OF INTEGRATION PLAN . . . . . 776

Sec. 545.0003. METHODS TO ADDRESS FRAUD AND ELIGIBILITY ERROR RATE . . . . . 777

Sec. 545.0004. CONTRACT FOR INTEGRATION PLAN IMPLEMENTATION . . . . . 778
Sec. 545.0005. USE OF OTHER AGENCIES' STAFF AND RESOURCES . . . . . 779
Sec. 545.0006. FUNDING . . . . . 779
SUBCHAPTER B. ADMINISTRATION OF CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAMS
Sec. 545.0051. CONSOLIDATED RECIPIENT IDENTIFICATION AND BENEFITS ISSUANCE METHOD . . . . . 780
Sec. 545.0052. EXPANSION OF BILLING COORDINATION AND INFORMATION COLLECTION ACTIVITIES . . . . . 782
Sec. 545.0053. SERVICE DELIVERY AREA ALIGNMENT . . . . . 783
Sec. 545.0054. PROGRAM TO IMPROVE AND MONITOR CERTAIN OUTCOMES OF MEDICAID RECIPIENTS AND CHILD HEALTH PLAN PROGRAM ENROLLEES . . . . 784
Sec. 545.0055. MINIMUM COLLECTION GOAL FOR RECOVERY OF CERTAIN BENEFITS . . . . . 784
Sec. 545.0056. DISTRIBUTION OF EARNED INCOME TAX CREDIT INFORMATION . . . . . 786
Sec. 545.0057. APPLICATION ASSISTANCE FOR FINANCIAL ASSISTANCE RECIPIENTS ELIGIBLE FOR FEDERAL PROGRAMS . . . . . 787
SUBCHAPTER C. CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAM ELIGIBILITY
Sec. 545.0101. MEMORANDUM OF UNDERSTANDING REGARDING MEDICAID AND CHILD HEALTH PLAN PROGRAM ELIGIBILITY DETERMINATIONS FOR CERTAIN CHILDREN . . . . . 788
Sec. 545.0102. VERIFICATION OF IMMIGRATION STATUS OF CERTAIN APPLICANTS FOR PUBLIC ASSISTANCE BENEFITS . . . . . 789
Sec. 545.0103. VERIFICATION OF SPONSORSHIP INFORMATION FOR CERTAIN BENEFITS RECIPIENTS OR ENROLLEES; REIMBURSEMENT . . . . . 791

Sec. 545.0104. CALL CENTERS . . . . . 793
SUBCHAPTER D. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN PUBLIC ASSISTANCE BENEFITS DECISIONS
Sec. 545.0151. DEFINITION . . . . . 799
Sec. 545.0152. ELECTRONIC RECORDING OF HEARING . . . . . 799
Sec. 545.0153. ADMINISTRATIVE REVIEW . . . . . 799
Sec. 545.0154. JUDICIAL REVIEW . . . . . 800
SUBCHAPTER E. CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAM PROVIDERS
Sec. 545.0201. COMPLIANCE WITH SOLICITATION PROHIBITIONS . . . . . 802
Sec. 545.0202. MARKETING ACTIVITIES BY MEDICAID OR CHILD HEALTH PLAN PROGRAM PROVIDERS . . . . 803
Sec. 545.0203. REIMBURSEMENT CLAIMS FOR CERTAIN MEDICAID OR CHILD HEALTH PLAN SERVICES INVOLVING SUPERVISED PROVIDERS . . . . . 807
Sec. 545.0204. PARTICIPATION OF DIAGNOSTIC LABORATORY SERVICE PROVIDERS IN CERTAIN PROGRAMS . . . 808

CHAPTER 545. CERTAIN PUBLIC ASSISTANCE BENEFITS

SUBCHAPTER A. PUBLIC ASSISTANCE BENEFITS PROGRAM ELIGIBILITY DETERMINATION AND SERVICE DELIVERY INTEGRATION

Revised Law

Sec. 545.0001. DEFINITIONS. In this subchapter:

(1) "Integrated system" means the integrated eligibility determination and service delivery system that is implemented under the integration plan.

(2) "Integration plan" means the plan to integrate services and functions relating to eligibility determination and service delivery required by Section 545.0002. (New.)

Revisor's Note

The definitions of "integrated system" and "integration plan" are added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the

definitions.

Revised Law

Sec. 545.0002. DEVELOPMENT AND IMPLEMENTATION OF INTEGRATION PLAN. (a) The commission, subject to the approval of the governor and the Legislative Budget Board, shall develop and implement a plan to integrate services and functions relating to eligibility determination and service delivery by health and human services agencies, the Texas Workforce Commission, and other agencies. The integration plan must include:

(1) a reengineering of eligibility determination business processes;

(2) streamlined service delivery;

(3) a unified and integrated process for the transition from welfare to work; and

(4) improved access to benefits and services for clients.

(b) In developing and implementing the integration plan, the commission:

(1) shall give priority to the design and development of computer hardware and software for and provide technical support relating to the integrated eligibility determination system;

(2) shall consult with agencies whose programs are included in the plan, including the Department of State Health Services and the Texas Workforce Commission; and

(3) may contract for appropriate professional and technical assistance.

(c) The commission shall develop and implement the integrated system to achieve:

(1) increased quality of and client access to services; and

(2) savings in the cost of providing administrative and other services and staff as a result of streamlining and eliminating duplication of services. (Gov. Code, Secs. 531.191(a) (part), (b) (part).)

Source Law

Sec. 531.191. INTEGRATED ELIGIBILITY DETERMINATION. (a) The commission, subject to the approval of the governor and the Legislative Budget Board, shall develop and implement a plan for the integration of services and functions relating to eligibility determination and service delivery by health and human services agencies, the Texas Workforce Commission, and other agencies. The plan must include a reengineering of eligibility determination business processes, streamlined service delivery, a unified and integrated process for the transition from welfare to work, and improved access to benefits and services for clients. In developing and implementing the plan, the commission:

(1) shall give priority to the design and development of computer hardware and software for and provide technical support relating to the integrated eligibility determination system;

(2) shall consult with agencies whose programs are included in the plan, including the Department of Aging and Disability Services, the Department of State Health Services, and the Texas Workforce Commission;

(3) may contract for appropriate professional and technical assistance; and

. . .

(b) The integrated eligibility determination and service delivery system shall be developed and implemented to achieve increased quality of and client access to services and savings in the cost of providing administrative and other services and staff resulting from streamlining and eliminating duplication of services. . . .

Revisor's Note

Section 531.191(a)(2), Government Code, lists the agencies the Health and Human Services Commission shall consult with, which includes the Department of Aging and Disability Services. The Department of Aging and Disability Services was abolished September 1, 2017, in accordance with Section 531.0202(b), Government Code, which is executed law that expired September 1, 2023. Because that agency has been abolished, the revised law omits the reference to the department as obsolete.

Revised Law

Sec. 545.0003. METHODS TO ADDRESS FRAUD AND ELIGIBILITY ERROR RATE. The commission shall examine cost-effective methods to address:

(1) fraud in assistance programs; and

(2) the error rate in eligibility determination. (Gov. Code, Sec. 531.191(c).)

Source Law

(c) The commission shall examine cost-effective methods to address:

(1) fraud in the assistance programs; and

(2) the error rate in eligibility determination.

Revised Law

Sec. 545.0004. CONTRACT FOR INTEGRATION PLAN IMPLEMENTATION. (a) On receipt by this state of any necessary federal approval and subject to the approval of the governor and the Legislative Budget Board, the commission may contract to implement all or part of the integration plan if the commission determines that contracting:

(1) may advance the objectives of Sections 545.0002 and 545.0006(b); and

(2) meets the criteria set out in the cost-benefit analysis described by this section.

(b) Before awarding a contract, the commission shall provide to the governor and the Legislative Budget Board a detailed cost-benefit analysis that demonstrates:

(1) the integration plan's cost-effectiveness;

(2) mechanisms for monitoring performance under the plan; and

(3) specific improvements the plan makes to the service delivery system and client access.

(c) The commission shall make the cost-benefit analysis described by Subsection (b) available to the public.

(d) On or before the 10th day after releasing a request for bids, proposals, offers, or other applicable expressions of interest relating to developing or implementing the integration plan, the commission shall hold a public hearing and receive public comment on the request. (Gov. Code, Sec. 531.191(d).)

Source Law

(d) On receipt by the state of any necessary

federal approval and subject to the approval of the governor and the Legislative Budget Board, the commission may contract for implementation of all or part of the plan required by Subsection (a) if the commission determines that contracting may advance the objectives of Subsections (a) and (b) and meets the criteria set out in the cost-benefit analysis described in this subsection. Before the awarding of a contract, the commission shall provide a detailed cost-benefit analysis to the governor and the Legislative Budget Board. The analysis must demonstrate the cost-effectiveness of the plan, mechanisms for monitoring performance under the plan, and specific improvements to the service delivery system and client access made by the plan. The commission shall make the analysis available to the public. Within 10 days after the release of a request for bids, proposals, offers, or other applicable expressions of interest relating to the development or implementation of the plan required by Subsection (a), the commission shall hold a public hearing and receive public comment on the request.

Revised Law

Sec. 545.0005. USE OF OTHER AGENCIES' STAFF AND RESOURCES. (a) The commission, in developing and implementing the integration plan, may use the staff and resources of agencies whose programs are included in the plan.

(b) The agencies whose programs are included in the integration plan shall cooperate with a commission request to provide available staff and resources that will be subject to the commission's direction. (Gov. Code, Secs. 531.191(a) (part), (e).)

Source Law

(a) . . . In developing and implementing the plan, the commission:

. . .

(4) may use the staff and resources of agencies whose programs are included in the plan.

(e) If requested by the commission, the agencies whose programs are included in the plan required by Subsection (a) shall cooperate with the commission to provide available staff and resources that will be subject to the direction of the commission.

Revised Law

Sec. 545.0006. FUNDING. (a) The design, development, and operation of an automated data processing system to support the integration plan may be financed through the issuance of bonds or other obligations under Chapter 1232.

(b) The commission, subject to any spending limitation prescribed in the General Appropriations Act, may use savings

described by Section 545.0002(c)(2) to further develop the integrated system and provide other health and human services. (Gov. Code, Secs. 531.191(b) (part), (f).)

Source Law

> (b) . . . The commission, subject to any spending limitation prescribed in the General Appropriations Act, may use the resulting savings to further develop the integrated system and to provide other health and human services.
>
> (f) The design, development, and operation of an automated data processing system to support the plan required by Subsection (a) may be financed through the issuance of bonds or other obligations under Chapter 1232.

SUBCHAPTER B. ADMINISTRATION OF CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAMS

Revised Law

Sec. 545.0051. CONSOLIDATED RECIPIENT IDENTIFICATION AND BENEFITS ISSUANCE METHOD. (a) If the commission determines that the implementation would be feasible and cost-effective, the commission may develop and implement a method to consolidate, to the extent possible, recipient identification and benefits issuance for the commission and health and human services agencies.

(b) The method may:

(1) provide for the use of a single integrated benefits issuance card or multiple cards capable of integrating benefits issuance or other program functions;

(2) incorporate a fingerprint image identifier to enable personal identity verification at a point of service and reduce fraud;

(3) enable immediate electronic verification of recipient eligibility; and

(4) replace multiple forms, cards, or other methods used for fraud reduction or provision of health and human services benefits, including:

(A) electronic benefits transfer cards; and

(B) smart cards used in Medicaid.

(c) In developing and implementing the method, the

commission shall:

(1) to the extent possible, use industry-standard communication, messaging, and electronic benefits transfer protocols;

(2) ensure that all identifying and descriptive information of recipients of each health and human services program included in the method can be accessed only by a provider or other entity participating in the particular program;

(3) ensure that a provider or other entity participating in a health and human services program included in the method cannot identify whether a program recipient is receiving benefits under another program included in the method; and

(4) ensure that the storage and communication of all identifying and descriptive information included in the method comply with existing federal and state privacy laws governing individually identifiable information for recipients of public benefits programs. (Gov. Code, Sec. 531.091.)

Source Law

Sec. 531.091. INTEGRATED BENEFITS ISSUANCE. (a) The commission may develop and implement a method to consolidate, to the extent possible, recipient identification and benefits issuance for the commission and health and human services agencies if the commission determines that the implementation would be feasible and cost-effective.

(b) The method may:

(1) provide for the use of a single integrated benefits issuance card or multiple cards capable of integrating benefits issuance or other program functions;

(2) incorporate a fingerprint image identifier to enable personal identity verification at a point of service and reduce fraud;

(3) enable immediate electronic verification of recipient eligibility; and

(4) replace multiple forms, cards, or other methods used for fraud reduction or provision of health and human services benefits, including:

(A) electronic benefits transfer cards; and

(B) smart cards used in Medicaid.

(c) In developing and implementing the method, the commission shall:

(1) to the extent possible, use industry-standard communication, messaging, and electronic benefits transfer protocols;

(2) ensure that all identifying and descriptive information of recipients of each health and human services program included in the method can

only be accessed by providers or other entities participating in the particular program;

(3) ensure that a provider or other entity participating in a health and human services program included in the method cannot identify whether a recipient of the program is receiving benefits under another program included in the method; and

(4) ensure that the storage and communication of all identifying and descriptive information included in the method complies with existing federal and state privacy laws governing individually identifiable information for recipients of public benefits programs.

Revised Law

Sec. 545.0052. EXPANSION OF BILLING COORDINATION AND INFORMATION COLLECTION ACTIVITIES. (a) If cost-effective, the commission may:

(1) contract to expand all or part of the billing coordination system established under Section 532.0058 to process claims for services provided through other benefits programs the commission or a health and human services agency administers;

(2) expand any other billing coordination tools and resources used to process claims for health care services provided through Medicaid to process claims for services provided through other benefits programs the commission or a health and human services agency administers; and

(3) expand the scope of individuals about whom information is collected under Section 32.042, Human Resources Code, to include recipients of services provided through other benefits programs the commission or a health and human services agency administers.

(b) Notwithstanding any other state law, each health and human services agency shall provide the commission with information necessary to allow the commission or the commission's designee to perform the billing coordination and information collection activities authorized by this section. (Gov. Code, Sec. 531.024131.)

Source Law

Sec. 531.024131. EXPANSION OF BILLING COORDINATION AND INFORMATION COLLECTION ACTIVITIES. (a) If cost-effective, the commission may:

(1) contract to expand all or part of the

billing coordination system established under Section 531.02413 to process claims for services provided through other benefits programs administered by the commission or a health and human services agency;

(2) expand any other billing coordination tools and resources used to process claims for health care services provided through Medicaid to process claims for services provided through other benefits programs administered by the commission or a health and human services agency; and

(3) expand the scope of persons about whom information is collected under Section 32.042, Human Resources Code, to include recipients of services provided through other benefits programs administered by the commission or a health and human services agency.

(b) Notwithstanding any other state law, each health and human services agency shall provide the commission with any information necessary to allow the commission or the commission's designee to perform the billing coordination and information collection activities authorized by this section.

Revisor's Note

Section 531.024131(a)(3), Government Code, refers to "persons about whom information is collected" under Section 32.042, Human Resources Code. Section 32.042 requires health insurers to maintain and provide certain information about individuals. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), which applies to this code.

Revised Law

Sec. 545.0053. SERVICE DELIVERY AREA ALIGNMENT. Notwithstanding Section 540.0701(d) or any other law and to the extent possible, the commission shall align Medicaid and the child health plan program service delivery areas. (Gov. Code, Sec. 531.024115.)

Source Law

Sec. 531.024115. SERVICE DELIVERY AREA ALIGNMENT. Notwithstanding Section 533.0025(e) or any other law, to the extent possible, the commission shall align service delivery areas under Medicaid and the child health plan program.

Revised Law

Sec. 545.0054. PROGRAM TO IMPROVE AND MONITOR CERTAIN OUTCOMES OF MEDICAID RECIPIENTS AND CHILD HEALTH PLAN PROGRAM ENROLLEES. The commission may design and implement a program to improve and monitor clinical and functional outcomes of a Medicaid recipient or child health plan program enrollee. The program may use financial, clinical, and other criteria based on pharmacy, medical services, and other claims data related to Medicaid or the child health plan program. (Gov. Code, Sec. 531.067.)

Source Law

> Sec. 531.067. PROGRAM TO IMPROVE AND MONITOR CERTAIN OUTCOMES OF RECIPIENTS UNDER CHILD HEALTH PLAN PROGRAM AND MEDICAID. The commission may design and implement a program to improve and monitor clinical and functional outcomes of a recipient of services under Medicaid or the state child health plan program. The program may use financial, clinical, and other criteria based on pharmacy, medical services, and other claims data related to Medicaid or the child health plan program.

Revisor's Note

Section 531.067, Government Code, refers to the "state child health plan program." The revised law substitutes "child health plan program" for "state child health plan program" for clarity and consistency in the terminology used in this chapter and because "child health plan program" is the defined term under Section 531.001, Government Code, which is revised in this subtitle as Section 521.0001 and applies to the revised law in this chapter.

Revised Law

Sec. 545.0055. MINIMUM COLLECTION GOAL FOR RECOVERY OF CERTAIN BENEFITS. (a) Not later than August 30 of each year, the executive commissioner by rule shall set a minimum goal for the commission specifying the percentage of the amount of benefits the commission granted in error under the supplemental nutrition assistance program under Chapter 33, Human Resources Code, or the financial assistance program under Chapter 31, Human Resources

Code, that the commission should recover. The executive commissioner shall set the percentage based on:

(1) comparable recovery rates other states reported; or

(2) other appropriate factors the executive commissioner identifies.

(b) If the commission fails to meet the goal set under Subsection (a) for the fiscal year, the executive commissioner shall notify the comptroller, and the comptroller shall reduce the commission's general revenue appropriation by an amount equal to the difference between the amount of state funds the commission would have collected had the commission met the goal and the amount of state funds the commission actually collected.

(c) The executive commissioner, the governor, and the Legislative Budget Board shall monitor the commission's performance in meeting the goal set under Subsection (a). The commission shall cooperate by providing to the governor and the Legislative Budget Board, on request, information concerning the commission's collection efforts. (Gov. Code, Sec. 531.050.)

Source Law

Sec. 531.050. MINIMUM COLLECTION GOAL. (a) Before August 31 of each year, the executive commissioner by rule shall set a minimum goal for the commission that specifies the percentage of the amount of benefits granted by the commission in error under the supplemental nutrition assistance program or the program of financial assistance under Chapter 31, Human Resources Code, that the commission should recover. The executive commissioner shall set the percentage based on comparable recovery rates reported by other states or other appropriate factors identified by the executive commissioner.

(b) If the commission fails to meet the goal set under Subsection (a) for the fiscal year, the executive commissioner shall notify the comptroller, and the comptroller shall reduce the commission's general revenue appropriation by an amount equal to the difference between the amount of state funds the commission would have collected had the commission met the goal and the amount of state funds the commission actually collected.

(c) The executive commissioner, the governor, and the Legislative Budget Board shall monitor the commission's performance in meeting the goal set under this section. The commission shall cooperate by providing to the governor and the Legislative Budget Board, on request, information concerning the

commission's collection efforts.

Revised Law

Sec. 545.0056. DISTRIBUTION OF EARNED INCOME TAX CREDIT INFORMATION. (a) The commission shall ensure that educational materials relating to the federal earned income tax credit are provided in accordance with this section to each individual receiving assistance or benefits under:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; or

(5) another appropriate health and human services program.

(b) In accordance with Section 526.0002, the commission shall, by mail or through the Internet, provide an individual described by Subsection (a) with access to:

(1) Internal Revenue Service publications relating to the federal earned income tax credit or information the comptroller prepares under Section 403.025 relating to that credit;

(2) federal income tax forms necessary to claim the federal earned income tax credit; and

(3) where feasible, the location of at least one program that:

(A) is in close geographic proximity to the individual; and

(B) provides free federal income tax preparation services to low-income and other eligible persons.

(c) In January of each year, the commission or a commission representative shall mail to each individual described by Subsection (a) information about the federal earned income tax credit that provides the individual with referrals to the resources described by Subsection (b). (Gov. Code, Sec. 531.087.)

Source Law

Sec. 531.087. DISTRIBUTION OF EARNED INCOME TAX CREDIT INFORMATION. (a) The commission shall ensure that educational materials relating to the federal earned income tax credit are provided in accordance with this section to each person receiving assistance or benefits under:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; or

(5) another appropriate health and human services program.

(b) In accordance with Section 531.0317, the commission shall, by mail or through the Internet, provide a person described by Subsection (a) with access to:

(1) Internal Revenue Service publications relating to the federal earned income tax credit or information prepared by the comptroller under Section 403.025 relating to that credit;

(2) federal income tax forms necessary to claim the federal earned income tax credit; and

(3) where feasible, the location of at least one program in close geographic proximity to the person that provides free federal income tax preparation services to low-income and other eligible persons.

(c) In January of each year, the commission or a representative of the commission shall mail to each person described by Subsection (a) information about the federal earned income tax credit that provides the person with referrals to the resources described by Subsection (b).

Revised Law

Sec. 545.0057. APPLICATION ASSISTANCE FOR FINANCIAL ASSISTANCE RECIPIENTS ELIGIBLE FOR FEDERAL PROGRAMS. The commission shall assist recipients of financial assistance under Chapter 31, Human Resources Code, who are eligible for assistance under federal programs to apply for benefits under those federal programs. The commission may delegate this responsibility to a health and human services agency, contract with a unit of local government, or use any other cost-effective method to assist financial assistance recipients who are eligible for federal programs. (Gov. Code, Sec. 531.044.)

Source Law

Sec. 531.044. FINANCIAL ASSISTANCE RECIPIENTS ELIGIBLE FOR FEDERAL PROGRAMS. The commission shall assist recipients of financial assistance under Chapter 31, Human Resources Code, who are eligible for assistance under federal programs to apply for

benefits under those federal programs. The commission may delegate this responsibility to a health and human services agency, contract with a unit of local government, or use any other cost-effective method to assist financial assistance recipients who are eligible for federal programs.

SUBCHAPTER C. CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAM ELIGIBILITY

Revised Law

Sec. 545.0101. MEMORANDUM OF UNDERSTANDING REGARDING MEDICAID AND CHILD HEALTH PLAN PROGRAM ELIGIBILITY DETERMINATIONS FOR CERTAIN CHILDREN. (a) The commission shall enter into a memorandum of understanding with the Texas Juvenile Justice Department to ensure that the commission assesses each individual who is committed, placed, or detained under Title 3, Family Code, for Medicaid and child health plan program eligibility before that individual's release from commitment, placement, or detention. A local juvenile probation department is subject to the requirements of the memorandum.

(b) The memorandum of understanding must specify:

(1) the information that must be provided to the commission;

(2) the process by which and time frame within which the information must be provided; and

(3) the roles and responsibilities of all parties to the memorandum, including a requirement that the commission pursue the actions necessary to complete eligibility applications.

(c) The memorandum of understanding must be tailored to:

(1) achieve the goal of ensuring that an individual described by Subsection (a) who the commission determines is eligible for Medicaid or the child health plan program:

(A) is enrolled in the program for which the individual is eligible; and

(B) may begin receiving services through the program as soon as possible after the eligibility determination is made; and

(2) if possible, achieve the goal of ensuring that the

individual may begin receiving services through the program on the date of the individual's release from commitment, placement, or detention.

(d) The executive commissioner may adopt rules as necessary to implement this section. (Gov. Code, Sec. 531.02418.)

Source Law

> Sec. 531.02418. MEDICAID AND CHILD HEALTH PLAN PROGRAM ELIGIBILITY DETERMINATIONS FOR CERTAIN INDIVIDUALS. (a) The commission shall enter into a memorandum of understanding with the Texas Juvenile Justice Department to ensure that each individual who is committed, placed, or detained under Title 3, Family Code, is assessed by the commission for eligibility for Medicaid and the child health plan program before that individual's release from commitment, placement, or detention. Local juvenile probation departments are subject to the requirements of the memorandum.
>
> (c) The memorandum of understanding entered into as required by this section must specify:
>
> (1) the information that must be provided to the commission;
>
> (2) the process by which and time frame within which the information must be provided; and
>
> (3) the roles and responsibilities of all parties to the memorandum, which must include a requirement that the commission pursue the actions needed to complete eligibility applications as necessary.
>
> (d) The memorandum of understanding required by Subsection (a) must be tailored to achieve the goal of ensuring that an individual described by Subsection (a) who is determined eligible by the commission for coverage under Medicaid or the child health plan program is enrolled in the program for which the individual is eligible and may begin receiving services through the program as soon as possible after the eligibility determination is made and, if possible, to achieve the goal of ensuring that the individual may begin receiving those services on the date of the individual's release from placement, detention, or commitment.
>
> (e) The executive commissioner may adopt rules as necessary to implement this section.

Revised Law

Sec. 545.0102. VERIFICATION OF IMMIGRATION STATUS OF CERTAIN APPLICANTS FOR PUBLIC ASSISTANCE BENEFITS. (a) This section applies only with respect to the following benefits programs:

(1) the child health plan program under Chapter 62, Health and Safety Code;

(2) the financial assistance program under Chapter 31,

Human Resources Code;

(3) Medicaid; and

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.

(b) If an individual states at the time of application for benefits under a program to which this section applies that the individual is a qualified alien, as that term is defined by 8 U.S.C. Section 1641(b), the commission shall, to the extent allowed by federal law, verify information regarding the individual's immigration status using an automated system where available.

(c) The executive commissioner shall adopt rules necessary to implement this section.

(d) Nothing in this section adds to or changes the eligibility requirements for a benefits program to which this section applies. (Gov. Code, Sec. 531.024181.)

Source Law

> Sec. 531.024181. VERIFICATION OF IMMIGRATION STATUS OF APPLICANTS FOR CERTAIN BENEFITS WHO ARE QUALIFIED ALIENS. (a) This section applies only with respect to the following benefits programs:
>
> (1) the child health plan program under Chapter 62, Health and Safety Code;
>
> (2) the financial assistance program under Chapter 31, Human Resources Code;
>
> (3) Medicaid; and
>
> (4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.
>
> (b) If, at the time of application for benefits under a program to which this section applies, a person states that the person is a qualified alien, as that term is defined by 8 U.S.C. Section 1641(b), the commission shall, to the extent allowed by federal law, verify information regarding the immigration status of the person using an automated system or systems where available.
>
> (c) The executive commissioner shall adopt rules necessary to implement this section.
>
> (d) Nothing in this section adds to or changes the eligibility requirements for any of the benefits programs to which this section applies.

Revisor's Note

Section 531.024181(b), Government Code, refers to using an "automated system or systems." The revised law omits "or systems" because Section 311.012(b), Government Code (Code Construction Act), which applies

to this code, provides that a reference to the singular includes the plural and vice versa.

Revised Law

Sec. 545.0103. VERIFICATION OF SPONSORSHIP INFORMATION FOR CERTAIN BENEFITS RECIPIENTS OR ENROLLEES; REIMBURSEMENT. (a) In this section, "sponsored alien" means an individual who:

(1) has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.); and

(2) as a condition of that admission, was sponsored by another individual who executed an affidavit of support on the lawfully admitted individual's behalf.

(b) This section applies only with respect to the following benefits programs:

(1) the child health plan program under Chapter 62, Health and Safety Code;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid; and

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.

(c) If an individual states at the time of application for benefits under a program to which this section applies that the individual is a sponsored alien, the commission:

(1) shall make a reasonable effort to notify the individual that the commission may seek reimbursement from the individual's sponsor for any program benefits the individual receives; and

(2) may, to the extent allowed by federal law and using an automated system where available, verify information relating to the sponsorship after the individual is determined eligible for and begins receiving program benefits.

(d) If the commission verifies that an individual who receives benefits under a program to which this section applies is a

sponsored alien and determines that seeking reimbursement is cost-effective, the commission may seek reimbursement from the individual's sponsor for the program benefits provided to the individual to the extent allowed by federal law.

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules that specify the most cost-effective procedures by which the commission may seek reimbursement under Subsection (d).

(f) Nothing in this section adds to or changes the eligibility requirements for a benefits program to which this section applies. (Gov. Code, Sec. 531.024182.)

Source Law

Sec. 531.024182. VERIFICATION OF SPONSORSHIP INFORMATION FOR CERTAIN BENEFITS RECIPIENTS; REIMBURSEMENT. (a) In this section, "sponsored alien" means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

(b) If, at the time of application for benefits, a person stated that the person is a sponsored alien, the commission may, to the extent allowed by federal law, verify information relating to the sponsorship, using an automated system or systems where available, after the person is determined eligible for and begins receiving benefits under any of the following benefits programs:

(1) the child health plan program under Chapter 62, Health and Safety Code;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid; or

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.

(c) If the commission verifies that a person who receives benefits under a program listed in Subsection (b) is a sponsored alien, the commission may seek reimbursement from the person's sponsor for benefits provided to the person under those programs to the extent allowed by federal law, provided the commission determines that seeking reimbursement is cost-effective.

(d) If, at the time a person applies for benefits under a program listed in Subsection (b), the person states that the person is a sponsored alien, the commission shall make a reasonable effort to notify the person that the commission may seek reimbursement from the person's sponsor for any benefits the person receives under those programs.

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules that specify the most cost-effective procedures by which the commission may seek reimbursement under

Subsection (c).

(f) Nothing in this section adds to or changes the eligibility requirements for any of the benefits programs listed in Subsection (b).

Revisor's Note

Section 531.024182(b), Government Code, refers to using an "automated system or systems." The revised law omits "or systems" for the reason stated in the revisor's note to Section 545.0102 of this chapter.

Revised Law

Sec. 545.0104. CALL CENTERS. (a) If cost-effective, the executive commissioner by rule shall establish at least one but not more than four call centers to determine and certify or recertify an individual's eligibility and need for services related to the following programs:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) nutritional assistance programs under Chapter 33, Human Resources Code;

(5) long-term care services, as defined by Section 22.0011, Human Resources Code;

(6) community-based support services identified or provided in accordance with Subchapter D, Chapter 546; and

(7) other health and human services programs, as appropriate.

(b) The commission shall contract with at least one but not more than four private entities to operate the call centers unless the commission determines that contracting would not be cost-effective.

(c) Each call center:

(1) must be located in this state, except that this subdivision does not prohibit a call center located in this state from processing overflow calls through a center located in another state; and

(2) shall provide translation services as required by federal law for consumers who are unable to speak, hear, or comprehend the English language.

(d) The commission shall develop consumer service and performance standards for the operation of each call center and make those standards available to the public. The standards must address a call center's:

(1) ability to serve consumers in a timely manner, including consideration of:

(A) consumers' ability to access the call center;

(B) whether the call center has toll-free telephone access;

(C) the average amount of time a consumer spends on hold;

(D) the frequency of call transfers;

(E) whether a consumer is able to communicate with a live individual at the call center; and

(F) whether the call center makes mail correspondence available;

(2) staff, including employee courtesy, friendliness, training, and knowledge about the programs listed under Subsection (a); and

(3) complaint handling procedures, including:

(A) the level of difficulty involved in filing a complaint; and

(B) whether the call center's complaint responses are timely.

(e) The commission shall develop:

(1) mechanisms for measuring consumer service satisfaction; and

(2) performance measures to evaluate whether each call center meets the standards the commission develops under Subsection (d).

(f) The commission may inspect a call center and analyze the

call center's consumer service performance through a consumer service evaluator posing as a consumer.

(g) Notwithstanding Subsection (a), the executive commissioner shall develop and implement policies that provide an applicant for services related to a program listed under Subsection (a) with an opportunity to appear in person to establish initial eligibility or comply with periodic eligibility recertification requirements if the applicant requests a personal interview. In implementing the policies, the commission shall maintain offices to serve applicants who request a personal interview. This subsection does not affect a law or rule that requires an applicant to appear in person to establish initial eligibility or comply with periodic eligibility recertification requirements. (Gov. Code, Sec. 531.063.)

Source Law

Sec. 531.063. CALL CENTERS. (a) The executive commissioner by rule shall establish at least one but not more than four call centers for purposes of determining and certifying or recertifying a person's eligibility and need for services related to the programs listed under Section 531.008(c), if cost-effective.

(b) The commission shall contract with at least one but not more than four private entities for the operation of call centers required by this section unless the commission determines that contracting would not be cost-effective.

(c) Each call center required by this section must be located in this state. This subsection does not prohibit a call center located in this state from processing overflow calls through a center located in another state.

(d) Each call center required by this section shall provide translation services as required by federal law for clients unable to speak, hear, or comprehend the English language.

(e) The commission shall develop consumer service and performance standards for the operation of each call center required by this section. The standards shall address a call center's:

(1) ability to serve its consumers in a timely manner, including consideration of the consumers' ability to access the call center, whether the call center has toll-free telephone access, the average amount of time a consumer spends on hold, the frequency of call transfers, whether a consumer is able to communicate with a live person at the call center, and whether the call center makes mail correspondence available;

(2) staff, including employee courtesy, friendliness, training, and knowledge about the programs listed under Section 531.008(c); and

(3) complaint handling procedures, including the level of difficulty involved in filing a complaint and whether the call center's complaint responses are timely.

(f) The commission shall make available to the public the standards developed under Subsection (e).

(g) The commission shall develop:

(1) mechanisms for measuring consumer service satisfaction; and

(2) performance measures to evaluate whether each call center meets the standards developed under Subsection (e).

(h) The commission may inspect each call center and analyze its consumer service performance through use of a consumer service evaluator who poses as a consumer of the call center.

(i) Notwithstanding Subsection (a), the executive commissioner shall develop and implement policies that provide an applicant for services related to the programs listed under Section 531.008(c) with an opportunity to appear in person to establish initial eligibility or to comply with periodic eligibility recertification requirements if the applicant requests a personal interview. In implementing the policies, the commission shall maintain offices to serve applicants who request a personal interview. This subsection does not affect a law or rule that requires an applicant to appear in person to establish initial eligibility or to comply with periodic eligibility recertification requirements.

Revisor's Note

(1) Section 531.063(a), Government Code, refers to "the programs listed under Section 531.008(c)," Government Code. Before the enactment of Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015, Section 531.008(c) required the establishment within the Health and Human Services Commission of a division to make eligibility determinations for listed health and human services programs. Section 1.09 of Chapter 837 amended Section 531.008(c) and repealed that list of programs. Because the remaining reference to "the programs listed under Section 531.008(c)" in Section 531.063(a) is an oversight, the revised law substitutes for the quoted language the health and human services programs that were listed in Section 531.008(c) before the subsection was amended. The revised law also substitutes "Subchapter D, Chapter 546" for the

reference to Section 531.02481 for the reason stated in Revisor's Note (4) to Section 524.0001 of this subtitle.

(2) Section 531.063(d), Government Code, requires that each call center required by Section 531.063, Government Code, provide certain translation services for "clients." Sections 531.063(e), (g), and (h), Government Code, refer to an individual a call center serves as a "consumer." For consistency of terminology throughout this section, the revised law substitutes "consumers" for "clients."

Revisor's Note
(End of Subchapter)

Section 531.02415, Government Code, requires the Health and Human Services Commission to establish a pilot project to determine the feasibility, costs, and benefits of accepting, for the purpose of establishing eligibility for benefits under state and federal health and human services programs the commission administers, the direct importation of electronic eligibility information from an electronic system operated by a regional safety net provider collaborative organization and to expand that system not later than September 1, 2010. According to the commission, the commission established the pilot program in accordance with Section 531.02415 and subsequently discontinued operation of the program. Accordingly, the revised law omits the provision as executed. The omitted law reads:

> Sec. 531.02415. ELECTRONIC ELIGIBILITY INFORMATION PILOT PROJECT. (a) The commission shall establish a pilot project in at least one urban area of this state to determine the feasibility, costs, and benefits of accepting, for the purpose of establishing eligibility for benefits under state and federal health and human services programs administered by the commission, the direct importation of

electronic eligibility information from an electronic system operated by a regional safety net provider collaborative organization.

(a-1) Not later than September 1, 2010, the commission shall expand the pilot project to at least one additional urban area of this state if the commission has implemented the Texas Integrated Eligibility Redesign System (TIERS) in the area selected for the expansion.

(b) An area selected for the pilot project under this section must possess a functioning safety net provider collaborative organization that includes a network of providers and assesses eligibility for health and human services programs using electronic systems. The electronic systems used by the collaborative organization must be able to interface with electronic systems managed by the commission to enable the commission to import application and eligibility information regarding applicants for health and human services programs.

(c) In establishing a pilot project under this section, the commission shall:

(1) create a project in which regional indigent care networks interface with the commission through the Texas Integrated Eligibility Redesign System (TIERS) or another state electronic eligibility system, as appropriate, to share electronic applications for indigent care created by the care network with the commission to facilitate enrollment in health and human services programs administered by the commission;

(2) automatically import the application information submitted under Subdivision (1) with minimal human intervention to eliminate double data entry and data entry errors and to ensure most appropriate use of commission resources while maintaining program integrity;

(3) solicit and obtain support for the project from local officials and indigent care providers;

(4) ensure that all identifying and descriptive information of recipients in each health and human services program included in the project can only be accessed by providers or other entities participating in the project; and

(5) ensure that the storage and communication of all identifying and descriptive information included in the project complies with existing federal and state privacy laws governing individually identifiable information for recipients of public benefits programs.

(d) In implementing the project under Subsection (c), the commission shall review and process applications in a timely manner and, to the extent allowed by federal law and regulations, work directly with each organization to obtain missing documents and resolve issues that impede enrollment.

Each organization must be authorized by the applicant to receive information concerning the applicant directly from the commission.

SUBCHAPTER D. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN PUBLIC ASSISTANCE BENEFITS DECISIONS

Revised Law

Sec. 545.0151. DEFINITION. In this subchapter, "public assistance benefits" means benefits provided under a public assistance program under Chapter 31, 32, or 33, Human Resources Code. (Gov. Code, Sec. 531.019(a).)

Source Law

Sec. 531.019. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN DECISIONS. (a) In this section, "public assistance benefits" means benefits provided under a public assistance program under Chapter 31, 32, or 33, Human Resources Code.

Revised Law

Sec. 545.0152. ELECTRONIC RECORDING OF HEARING. A hearing conducted by the commission, or by a health and human services agency to which the commission delegates a function related to public assistance benefits, that relates to a decision regarding public assistance benefits that is contested by an applicant for or recipient of the benefits must be recorded electronically. (Gov. Code, Sec. 531.019(b) (part).)

Source Law

(b) The proceedings of a hearing related to a decision regarding public assistance benefits contested by an applicant for or recipient of the benefits that is conducted by the commission or a health and human services agency to which the commission delegates a function related to the benefits must be recorded electronically. . . .

Revised Law

Sec. 545.0153. ADMINISTRATIVE REVIEW. (a) Before an applicant for or recipient of public assistance benefits may appeal a decision of a hearing officer for the commission or a health and human services agency related to those benefits and in accordance with rules of the executive commissioner, the applicant or recipient must request an administrative review by an appropriate attorney of the commission or a health and human services agency, as

applicable.

(b) Not later than the 15th business day after the date the appropriate attorney described by Subsection (a) receives the request for administrative review, the attorney shall:

(1) complete an administrative review of the decision; and

(2) notify the applicant or recipient in writing of the results of that review. (Gov. Code, Sec. 531.019(c).)

Source Law

> (c) Before an applicant for or recipient of public assistance benefits may appeal a decision of a hearing officer for the commission or a health and human services agency related to those benefits, the applicant or recipient must request an administrative review by an appropriate attorney of the commission or a health and human services agency, as applicable, in accordance with rules of the executive commissioner. Not later than the 15th business day after the date the attorney receives the request for administrative review, the attorney shall complete an administrative review of the decision and notify the applicant or recipient in writing of the results of that review.

Revised Law

Sec. 545.0154. JUDICIAL REVIEW. (a) An appeal of a decision made by a hearing officer for the commission or a health and human services agency related to public assistance benefits brought by an applicant for or recipient of the benefits:

(1) is governed by Subchapters G and H, Chapter 2001, except as provided by this subchapter; and

(2) takes precedence over all civil cases except workers' compensation and unemployment compensation cases.

(b) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits has exhausted all available administrative remedies and a decision, including a decision under Section 31.034 or 32.035, Human Resources Code, is final and appealable on the date that, after a hearing:

(1) the hearing officer for the commission or a health and human services agency reaches a final decision related to the benefits; and

(2) the appropriate attorney completes an

administrative review of the decision and notifies the applicant or recipient in writing of the results of that review.

(c) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits is not required to file a motion for rehearing with the commission or a health and human services agency, as applicable.

(d) Notwithstanding Section 2001.177, the cost of preparing the record and transcript of a hearing described by Section 545.0152 that is required to be sent to a reviewing court may not be charged to the applicant for or recipient of the public assistance benefits.

(e) Judicial review of a decision described by Subsection (a) is:

(1) instituted by filing a petition with a district court in Travis County, as provided by Subchapter G, Chapter 2001; and

(2) under the substantial evidence rule.

(f) The appellee is the commission. (Gov. Code, Secs. 531.019(b) (part), (d), (e), (f), (g), (h), (i).)

Source Law

> (b) . . . Notwithstanding Section 2001.177, the cost of preparing the record and transcript required to be sent to a reviewing court may not be charged to the applicant for or recipient of the benefits.
>
> (d) Except as provided by this section, Subchapters G and H, Chapter 2001, govern an appeal of a decision made by a hearing officer for the commission or a health and human services agency related to public assistance benefits brought by an applicant for or recipient of the benefits.
>
> (e) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits has exhausted all available administrative remedies and a decision, including a decision under Section 31.034 or 32.035, Human Resources Code, is final and appealable on the date that, after a hearing:
>
> (1) the hearing officer for the commission or a health and human services agency reaches a final decision related to the benefits; and
>
> (2) the appropriate attorney completes an administrative review of the decision and notifies the applicant or recipient in writing of the results of that review.
>
> (f) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits is not required to file a motion for rehearing

with the commission or a health and human services agency, as applicable.

(g) Judicial review of a decision made by a hearing officer for the commission or a health and human services agency related to public assistance benefits is under the substantial evidence rule and is instituted by filing a petition with a district court in Travis County, as provided by Subchapter G, Chapter 2001.

(h) An appeal described by Subsection (d) takes precedence over all civil cases except workers' compensation and unemployment compensation cases.

(i) The appellee is the commission.

SUBCHAPTER E. CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAM PROVIDERS

Revised Law

Sec. 545.0201. COMPLIANCE WITH SOLICITATION PROHIBITIONS. (a) In this section, "furnish" and "provider" have the meanings assigned by Section 544.0001.

(b) A provider who furnishes Medicaid or child health plan program services is subject to Chapter 102, Occupations Code. The provider's compliance with that chapter is a condition of the provider's eligibility to participate as a provider under those programs. (Gov. Code, Sec. 531.116; New.)

Source Law

Sec. 531.116. COMPLIANCE WITH LAW PROHIBITING SOLICITATION. A provider who furnishes services under Medicaid or the child health plan program is subject to Chapter 102, Occupations Code, and the provider's compliance with that chapter is a condition of the provider's eligibility to participate as a provider under those programs.

Revisor's Note

Section 531.116, Government Code, refers to a "provider" who "furnishes" certain services. Sections 531.1011(5) and (10), Government Code, define "furnished" and "provider," respectively, for purposes of "this subchapter," meaning Subchapter C, Chapter 531, Government Code. The majority of that subchapter is revised in this title as Chapter 544, and the definitions applicable to Subchapter C, Chapter 531, are revised as Section 544.0001 of Subchapter A, Chapter 544. Section 531.116 is also a provision of Subchapter C, Chapter 531. The revised law adds a

cross-reference to the definitions of "furnish" and "provider" that are derived from Sections 531.1011(5) and (10) to preserve their applicability to the law revised in this section.

Revised Law

Sec. 545.0202. MARKETING ACTIVITIES BY MEDICAID OR CHILD HEALTH PLAN PROGRAM PROVIDERS. (a) A Medicaid or child health plan program provider, including a provider participating in the network of a managed care organization that contracts with the commission to provide services under Medicaid or the child health plan program, may not engage in any marketing activity, including engaging in the dissemination of material or another attempt to communicate, that:

(1) involves unsolicited personal contact with a Medicaid recipient or a parent whose child is a Medicaid recipient or child health plan program enrollee, including by:

(A) door-to-door solicitation;

(B) solicitation at a child-care facility or other type of facility;

(C) direct mail; or

(D) telephone;

(2) is directed at an individual solely because the individual is a Medicaid recipient or is a parent of a child who is a Medicaid recipient or child health plan program enrollee; and

(3) is intended to influence the Medicaid recipient's or parent's choice of provider.

(b) A provider participating in the network of a managed care organization that contracts with the commission to provide services under Medicaid or the child health plan program must comply with the marketing guidelines the commission establishes under Section 540.0055.

(c) Nothing in this section prohibits:

(1) a Medicaid or child health plan program provider from:

(A) engaging in a marketing activity, including engaging in the dissemination of material or another attempt to communicate, that is intended to influence the choice of provider by a Medicaid recipient or a parent whose child is a Medicaid recipient or child health plan program enrollee, if the marketing activity:

(i) is conducted at a community-sponsored educational event, health fair, outreach activity, or other similar community or nonprofit event in which the provider participates and does not involve unsolicited personal contact or promotion of the provider's practice; or

(ii) involves only the general dissemination of information, including by television, radio, newspaper, or billboard advertisement, and does not involve unsolicited personal contact;

(B) as permitted under the provider's contract, engaging in the dissemination of material or another attempt to communicate with a Medicaid recipient or a parent whose child is a Medicaid recipient or child health plan program enrollee, including communication in person or by direct mail or telephone, to:

(i) provide an appointment reminder;

(ii) distribute promotional health materials;

(iii) provide information about the types of services the provider offers; or

(iv) coordinate patient care; or

(C) engaging in a marketing activity that the provider has submitted for review and for which the provider has received a notice of prior authorization under Subsection (d); or

(2) a STAR+PLUS Medicaid managed care program provider from, as permitted under the provider's contract, engaging in a marketing activity, including engaging in the dissemination of material or another attempt to communicate, that is intended to educate a Medicaid recipient about available long-term services and

supports.

(d) The commission shall establish a process by which a provider may submit a proposed marketing activity for review and prior authorization to ensure that the provider is in compliance with the requirements of this section and, if applicable, Section 540.0055, or to determine whether the provider is exempt from a requirement of this section and, if applicable, Section 540.0055. The commission may grant or deny a provider's request for authorization to engage in a proposed marketing activity.

(e) The executive commissioner shall adopt rules as necessary to implement this section, including rules relating to provider marketing activities that are exempt from the requirements of this section and, if applicable, Section 540.0055. (Gov. Code, Sec. 531.02115.)

Source Law

Sec. 531.02115. MARKETING ACTIVITIES BY PROVIDERS PARTICIPATING IN MEDICAID OR CHILD HEALTH PLAN PROGRAM. (a) A provider participating in Medicaid or the child health plan program, including a provider participating in the network of a managed care organization that contracts with the commission to provide services under Medicaid or the child health plan program, may not engage in any marketing activity, including any dissemination of material or other attempt to communicate, that:

(1) involves unsolicited personal contact, including by door-to-door solicitation, solicitation at a child-care facility or other type of facility, direct mail, or telephone, with a Medicaid client or a parent whose child is enrolled in Medicaid or the child health plan program;

(2) is directed at the client or parent solely because the client or the parent's child is receiving benefits under Medicaid or the child health plan program; and

(3) is intended to influence the client's or parent's choice of provider.

(b) In addition to the requirements of Subsection (a), a provider participating in the network of a managed care organization described by that subsection must comply with the marketing guidelines established by the commission under Section 533.008.

(c) Nothing in this section prohibits:

(1) a provider participating in Medicaid or the child health plan program from:

(A) engaging in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to influence the choice of provider by a Medicaid client or a parent whose child is enrolled in Medicaid or the child health plan program, if the marketing activity:

(i) is conducted at a community-sponsored educational event, health fair, outreach activity, or other similar community or nonprofit event in which the provider participates and does not involve unsolicited personal contact or promotion of the provider's practice; or

(ii) involves only the general dissemination of information, including by television, radio, newspaper, or billboard advertisement, and does not involve unsolicited personal contact;

(B) as permitted under the provider's contract, engaging in the dissemination of material or another attempt to communicate with a Medicaid client or a parent whose child is enrolled in Medicaid or the child health plan program, including communication in person or by direct mail or telephone, for the purpose of:

(i) providing an appointment reminder;

(ii) distributing promotional health materials;

(iii) providing information about the types of services offered by the provider; or

(iv) coordinating patient care; or

(C) engaging in a marketing activity that has been submitted for review and obtained a notice of prior authorization from the commission under Subsection (d); or

(2) a provider participating in the STAR + PLUS Medicaid managed care program from, as permitted under the provider's contract, engaging in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to educate a Medicaid client about available long-term care services and supports.

(d) The commission shall establish a process by which providers may submit proposed marketing activities for review and prior authorization to ensure that providers are in compliance with the requirements of this section and, if applicable, Section 533.008, or to determine whether the providers are exempt from a requirement of this section and, if applicable, Section 533.008. The commission may grant or deny a provider's request for authorization to engage in a proposed marketing activity.

(e) The executive commissioner shall adopt rules as necessary to implement this section, including rules relating to provider marketing activities that are exempt from the requirements of this section and, if applicable, Section 533.008.

Revisor's Note

(1) Sections 531.02115(a) and (c), Government Code, refer to a Medicaid "client." An individual who receives benefits under Medicaid is generally referred to as a "recipient." The revised law substitutes "recipient" for "client" for accuracy and consistency throughout Subtitle I, Title 4, Government Code, which includes this chapter.

(2) Section 531.02115(b), Government Code, provides that "[i]n addition to the requirements of Subsection (a)" of Section 531.02115, certain health care providers must comply with certain guidelines. The revised law omits the quoted language as unnecessary because the provisions of Section 531.02115(a), which is revised as Subsection (a) of this section, apply to a provider by their own terms.

(3) Sections 531.02115(c) and (d), Government Code, refer to marketing guidelines the Health and Human Services Commission establishes under Section 533.008, Government Code. The relevant portion of Section 533.008 requiring the commission to establish those guidelines is revised in this subtitle as Section 540.0055, and the revised law is drafted accordingly.

Revised Law

Sec. 545.0203. REIMBURSEMENT CLAIMS FOR CERTAIN MEDICAID OR CHILD HEALTH PLAN SERVICES INVOLVING SUPERVISED PROVIDERS. (a) In this section, "national provider identifier" means the national provider identifier required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) If a Medicaid or child health plan program provider, including a nurse practitioner or physician assistant, provides a referral or orders health care services for a Medicaid recipient or child health plan program enrollee at the direction or under the supervision of another provider and the referral or order is based on the supervised provider's evaluation of the recipient or enrollee, the names and associated national provider identifier numbers of the supervised provider and the supervising provider must be included on any claim for reimbursement a provider submits based on the referral or order.

(c) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 531.024161.)

Source Law

Sec. 531.024161. REIMBURSEMENT CLAIMS FOR CERTAIN MEDICAID OR CHILD HEALTH PLAN SERVICES INVOLVING SUPERVISED PROVIDERS. (a) If a provider, including a nurse practitioner or physician assistant, under Medicaid or the child health plan program provides a referral for or orders health care services for a recipient or enrollee, as applicable, at the direction or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the recipient or enrollee, the names and associated national provider identifier numbers of the supervised provider and the supervising provider must be included on any claim for reimbursement submitted by a provider based on the referral or order. For purposes of this section, "national provider identifier" means the national provider identifier required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The executive commissioner shall adopt rules necessary to implement this section.

Revised Law

Sec. 545.0204. PARTICIPATION OF DIAGNOSTIC LABORATORY SERVICE PROVIDERS IN CERTAIN PROGRAMS. Notwithstanding any other law, a diagnostic laboratory may participate as an in-state provider under any program a health and human services agency or the commission administers that involves diagnostic laboratory services, regardless of the location where any specific service is performed or where the laboratory's facilities are located, if:

(1) the laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains diagnostic laboratory operations in this state;

(2) the laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory collectively employ at least 1,000 individuals at places of employment located in this state;

(3) the laboratory is otherwise qualified to provide the services under the program; and

(4) the laboratory is not prohibited from participating as a provider under any benefits program a health and human services agency or the commission administers based on conduct that constitutes fraud, waste, or abuse. (Gov. Code, Sec. 531.066.)

Source Law

Sec. 531.066. PARTICIPATION OF DIAGNOSTIC LABORATORY SERVICE PROVIDERS IN CERTAIN PROGRAMS. Notwithstanding any other law, a diagnostic laboratory may participate as an in-state provider under any program administered by a health and human services agency or the commission that involves diagnostic laboratory services, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:

(1) the laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains diagnostic laboratory operations in this state;

(2) the laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and

(3) the laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefits programs administered by a health and human services agency or the commission based on conduct that constitutes fraud, waste, or abuse.

CHAPTER 546. LONG-TERM CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES AND ELDERLY INDIVIDUALS

SUBCHAPTER A. GENERAL PROVISIONS


Sec. 546.0001. DEFINITIONS . . . . . 815

Sec. 546.0002. LONG-TERM CARE PLAN; COORDINATION OF SERVICES . . . . . 816

Sec. 546.0003. EMPLOYMENT-FIRST POLICY . . . . . 818

Sec. 546.0004. LONG-TERM CARE INSURANCE AWARENESS AND EDUCATION CAMPAIGN . . . . . 820


SUBCHAPTER B. CARE SETTINGS AND SERVICE AND SUPPORT OPTIONS


Sec. 546.0051. DEFINITIONS . . . . . 822

Sec. 546.0052. COMPREHENSIVE PLAN FOR ENSURING APPROPRIATE CARE SETTING FOR INDIVIDUALS WITH DISABILITIES; BIENNIAL REPORT . . . . . 822

Sec. 546.0053. INFORMATION AND ASSISTANCE REGARDING CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES . . . . . 826

Sec. 546.0054. COMMUNITY LIVING OPTIONS INFORMATION PROCESS FOR CERTAIN INDIVIDUALS WITH INTELLECTUAL DISABILITY . . . . . 829
Sec. 546.0055. IMPLEMENTATION OF COMMUNITY LIVING OPTIONS INFORMATION PROCESS AT STATE INSTITUTIONS FOR CERTAIN ADULT RESIDENTS . . . . . 832
Sec. 546.0056. VOUCHER PROGRAM FOR TRANSITIONAL LIVING ASSISTANCE FOR INDIVIDUALS WITH DISABILITIES . . . . . 836
Sec. 546.0057. TRANSITION SERVICES FOR YOUTH WITH DISABILITIES . . . . . 839
Sec. 546.0058. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES . . . . . 840
SUBCHAPTER C. CONSUMER DIRECTION MODELS
Sec. 546.0101. DEFINITIONS . . . . . 841
Sec. 546.0102. IMPLEMENTATION OF CONSUMER DIRECTION MODELS . . . . . 844
Sec. 546.0103. RULES . . . . . 845
Sec. 546.0104. APPLICABILITY OF CERTAIN NURSING LICENSURE REQUIREMENTS . . . . . 846
Sec. 546.0105. LEGALLY AUTHORIZED REPRESENTATIVE SERVICE OVERSIGHT REQUIRED . . . . . 848
Sec. 546.0106. PROCEDURE TO PROVIDE NOTICE TO MEDICAID RECIPIENTS . . . . . 848
SUBCHAPTER D. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEM INITIATIVES AND GRANT PROGRAM
Sec. 546.0151. DEFINITION . . . . . 849
Sec. 546.0152. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEMS FOR LONG-TERM CARE SERVICES . . . . . 849
Sec. 546.0153. AREA AGENCIES ON AGING: MINIMUM NUMBER . . . . 851
Sec. 546.0154. PROPOSALS . . . . . 852
Sec. 546.0155. PROPOSAL REVIEW AND APPROVAL . . . . . 852

Sec. 546.0156. STANDARD AND PRIORITY OF REVIEW . . . . . 852
Sec. 546.0157. COMMUNITY-BASED ORGANIZATION MATCHING CONTRIBUTION REQUIRED . . . . . 853
Sec. 546.0158. PROPOSALS INVOLVING MULTIPLE COMMUNITY-BASED ORGANIZATIONS . . . . . 853
Sec. 546.0159. GUIDELINES . . . . . 854
Sec. 546.0160. CERTAIN AGENCIES' DUTY TO PROVIDE RESOURCES AND ASSISTANCE . . . . . 854
SUBCHAPTER E. PERMANENCY PLANNING
Sec. 546.0201. DEFINITIONS . . . . . 854
Sec. 546.0202. POLICY STATEMENT . . . . . 857
Sec. 546.0203. DEVELOPMENT OF PERMANENCY PLAN PROCEDURES . . . . . 857
Sec. 546.0204. PERMANENCY PLANNING FOR CERTAIN CHILDREN . . . . . 861
Sec. 546.0205. INSTITUTION TO ASSIST WITH PERMANENCY PLANNING EFFORTS . . . . . 862
Sec. 546.0206. IMPLEMENTATION SYSTEM: LOCAL PERMANENCY PLANNING SITES . . . . . 863
Sec. 546.0207. DESIGNATION OF VOLUNTEER ADVOCATE . . . . . 865
Sec. 546.0208. PREADMISSION NOTICE AND INFORMATION . . . . . 866
Sec. 546.0209. REQUIREMENTS OF PARENT OR GUARDIAN ON CHILD'S ADMISSION TO CERTAIN INSTITUTIONS . . . . . 869
Sec. 546.0210. DUTIES OF CERTAIN INSTITUTIONS: NOTIFICATION REQUIREMENTS AND PARENT OR GUARDIAN ACCOMMODATIONS . . . . . 870
Sec. 546.0211. NOTIFICATION OF PLACEMENT REQUIRED . . . . . 874
Sec. 546.0212. NOTICE TO PARENT OR GUARDIAN REGARDING PLACEMENT OPTIONS AND SERVICES . . . . . 875
Sec. 546.0213. PLACEMENT ON WAIVER PROGRAM WAITING LIST . . . . . 875
Sec. 546.0214. INTERFERENCE WITH PERMANENCY PLANNING EFFORTS . . . . . 876

Sec. 546.0215. INITIAL PLACEMENT OF CHILD IN INSTITUTION AND PLACEMENT EXTENSIONS . . . 876
Sec. 546.0216. REVIEW OF CERTAIN PLACEMENT DATA . . . . . 878
Sec. 546.0217. PROCEDURES FOR PLACEMENT REVIEWS . . . . . 879
Sec. 546.0218. ANNUAL REAUTHORIZATION OF PLANS OF CARE FOR CERTAIN CHILDREN . . . . . 879
Sec. 546.0219. TRANSFER OF CHILD BETWEEN INSTITUTIONS . . . 880
Sec. 546.0220. COMPLIANCE WITH PERMANENCY PLAN REQUIREMENTS AS PART OF INSPECTION, SURVEY, OR INVESTIGATION . . . . . 880
Sec. 546.0221. SEARCH FOR CHILD'S PARENT OR GUARDIAN . . . . 881
Sec. 546.0222. DOCUMENTATION OF ONGOING PERMANENCY PLANNING EFFORTS . . . . . 882
Sec. 546.0223. ACCESS TO RECORDS . . . . . 883
Sec. 546.0224. COLLECTION OF INFORMATION REGARDING INVOLVEMENT OF CERTAIN PARENTS AND GUARDIANS . . . . . 883
Sec. 546.0225. REPORTING SYSTEMS: SEMIANNUAL REPORTING . . . 884
Sec. 546.0226. EFFECT ON OTHER LAW . . . . . 886
SUBCHAPTER F. FAMILY-BASED ALTERNATIVES FOR CHILDREN
Sec. 546.0251. DEFINITIONS . . . . . 887
Sec. 546.0252. FAMILY-BASED ALTERNATIVES SYSTEM: PURPOSE, IMPLEMENTATION, AND ADMINISTRATION . . . . . 889
Sec. 546.0253. FAMILY-BASED ALTERNATIVES SYSTEM DESIGN REQUIREMENTS . . . . . 890
Sec. 546.0254. MEDICAID WAIVER PROGRAM ALIGNMENT . . . . . 891
Sec. 546.0255. COMMUNITY ORGANIZATION ELIGIBILITY; CONTRACT AND REQUIREMENTS . . . . . 892
Sec. 546.0256. PLACEMENT OPTIONS . . . . . 894
Sec. 546.0257. AGENCY COOPERATION . . . . . 894
Sec. 546.0258. DISPUTE RESOLUTION . . . . . 895
Sec. 546.0259. GIFTS, GRANTS, AND DONATIONS . . . . . 895
Sec. 546.0260. ANNUAL REPORT . . . . . 895

SUBCHAPTER G. LONG-TERM CARE INSTITUTIONS AND FACILITIES
Sec. 546.0301. PROCEDURES TO REVIEW CONDUCT RELATED TO CERTAIN INSTITUTIONS AND FACILITIES . . . . 896
Sec. 546.0302. ISSUANCE OF MATERIALS TO CERTAIN LONG-TERM CARE FACILITIES . . . . . 897
SUBCHAPTER H. INCENTIVE PAYMENT PROGRAM FOR CERTAIN NURSING FACILITIES
Sec. 546.0351. DEFINITIONS . . . . . 898
Sec. 546.0352. INCENTIVE PAYMENT PROGRAM . . . . . 899
Sec. 546.0353. COMMON PERFORMANCE MEASURES . . . . . 900
Sec. 546.0354. SUBJECT TO APPROPRIATIONS . . . . . 902
SUBCHAPTER I. MEDICAID GENERALLY
Sec. 546.0401. MEDICAID LONG-TERM CARE SYSTEM . . . . . 902
Sec. 546.0402. ADMINISTRATION AND DELIVERY OF CERTAIN WAIVER PROGRAMS; PUBLIC INPUT . . . . . 903
Sec. 546.0403. RECOVERY OF CERTAIN ASSISTANCE; MEDICAID ACCOUNT . . . . . 904
SUBCHAPTER J. MEDICAID WAIVER PROGRAMS
Sec. 546.0451. COMPETITIVE AND INTEGRATED EMPLOYMENT INITIATIVE FOR CERTAIN RECIPIENTS; BIENNIAL REPORT . . . . . 905
Sec. 546.0452. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER PROGRAMS . . . . . 908
Sec. 546.0453. PROTOCOL FOR MAINTAINING CONTACT INFORMATION OF INDIVIDUALS INTERESTED IN MEDICAID WAIVER PROGRAMS . . . . . 909
Sec. 546.0454. INTEREST LIST MANAGEMENT FOR CERTAIN MEDICAID WAIVER PROGRAMS . . . . . 910
Sec. 546.0455. INTEREST LIST MANAGEMENT FOR CERTAIN CHILDREN ENROLLED IN MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM . . . . . 913

Sec. 546.0456. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM; INTEREST LIST PLACEMENT . . . . . 916
SUBCHAPTER K. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM
Sec. 546.0501. LIMITATION ON NURSING FACILITY LEVEL OF CARE REQUIREMENT . . . . . 917
Sec. 546.0502. CONSUMER DIRECTION OF SERVICES . . . . . 917
Sec. 546.0503. ASSESSMENTS AND REASSESSMENTS . . . . . 918
Sec. 546.0504. QUALITY MONITORING BY EXTERNAL QUALITY REVIEW ORGANIZATION . . . . . 919
Sec. 546.0505. QUARTERLY REPORT . . . . . 921
SUBCHAPTER L. QUALITY ASSURANCE FEE PROGRAM
Sec. 546.0551. QUALITY ASSURANCE FEE FOR CERTAIN MEDICAID WAIVER PROGRAM SERVICES . . . . . 922
Sec. 546.0552. WAIVER PROGRAM QUALITY ASSURANCE FEE ACCOUNT . . . . . 923
Sec. 546.0553. REIMBURSEMENT UNDER CERTAIN MEDICAID WAIVER PROGRAMS . . . . . 924
Sec. 546.0554. INVALIDITY; FEDERAL MONEY . . . . . 925
Sec. 546.0555. EXPIRATION OF QUALITY ASSURANCE FEE PROGRAM . . . . . 926
SUBCHAPTER M. VOLUNTEER ADVOCATE PROGRAM FOR CERTAIN ELDERLY INDIVIDUALS
Sec. 546.0601. DEFINITIONS . . . . . 926
Sec. 546.0602. PROGRAM PRINCIPLES . . . . . 927
Sec. 546.0603. AGREEMENTS WITH NONPROFIT ORGANIZATIONS; ORGANIZATION ELIGIBILITY . . . . . 929
Sec. 546.0604. FUNDING . . . . . 929
Sec. 546.0605. RULES . . . . . 930
SUBCHAPTER N. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT PROGRAM
Sec. 546.0651. DEFINITION . . . . . 931

Sec. 546.0652. PILOT PROGRAM . . . . . 931
Sec. 546.0653. FEDERAL GUIDANCE AND FUNDING . . . . . 931
Sec. 546.0654. REPORT . . . . . 932
Sec. 546.0655. EXPIRATION . . . . . 932
SUBCHAPTER O. MORTALITY REVIEW FOR CERTAIN INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITY
Sec. 546.0701. DEFINITION . . . . . 933
Sec. 546.0702. MORTALITY REVIEW SYSTEM . . . . . 933
Sec. 546.0703. ACCESS TO INFORMATION AND RECORDS . . . . . 935
Sec. 546.0704. MORTALITY REVIEW REPORTS . . . . . 936
Sec. 546.0705. USE AND PUBLICATION RESTRICTIONS; CONFIDENTIALITY . . . . . 938
Sec. 546.0706. LIMITATION ON LIABILITY . . . . . 940

## CHAPTER 546. LONG-TERM CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES AND ELDERLY INDIVIDUALS

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 546.0001. DEFINITIONS. In this chapter:

(1) "ICF-IID" and "local intellectual and developmental disability authority" have the meanings assigned by Section 531.002, Health and Safety Code.

(2) "Recipient" means a Medicaid recipient. (New.)

Revisor's Note

The definitions of "ICF-IID," "local intellectual and developmental disability authority," and "recipient" are added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions. Although the added definitions are mostly defined in the same manner throughout the law revised in this chapter, in some instances the law revised in this chapter does not define the terms. However, because it is clear from the context that the added definitions have the same meaning in those

instances, applying the defined terms to the revision of that law does not result in a substantive change.

Revised Law

Sec. 546.0002. LONG-TERM CARE PLAN; COORDINATION OF SERVICES. (a) In this section, "long-term care" means the provision of health care, personal care, and assistance related to health and social services over a sustained period to individuals of all ages and their families, regardless of the setting in which the care is provided.

(b) In conjunction with appropriate state agencies, the executive commissioner shall develop a plan for access to individualized long-term care services for individuals with functional limitations or medical needs and their families that assists those individuals in achieving and maintaining the greatest possible independence, autonomy, and quality of life.

(c) The guiding principles and goals of the plan that focus on the individual and the individual's family must:

(1) recognize that it is the policy of this state that:

(A) children should grow up in families; and

(B) individuals with disabilities and elderly individuals should reside in the setting of their choice; and

(2) ensure that an individual needing assistance and the individual's family will have:

(A) the maximum possible control over their services;

(B) a choice of a broad, comprehensive array of services designed to meet individual needs; and

(C) the easiest possible access to appropriate care and support, regardless of the area of this state in which they reside.

(d) The guiding principles and goals of the plan that focus on services and delivery of those services by the state must:

(1) emphasize the development of home-based and community-based services and housing alternatives to complement

the long-term care services already in existence;

(2) ensure that the services will be of the highest possible quality, with a minimum amount of regulation, structure, and complexity at the service level;

(3) recognize that maximum independence and autonomy represent major goals, and with those comes a certain degree of risk;

(4) maximize resources to the greatest extent possible, with the consumer receiving only the services that the consumer prefers and that are indicated by a functional needs assessment; and

(5) structure the service delivery system to support these goals, ensuring that any necessary system complexity is at the administrative level rather than at the client level.

(e) The commission shall coordinate state services to ensure that:

(1) the roles and responsibilities of agencies providing long-term care are clarified; and

(2) duplication of services and resources is minimized. (Gov. Code, Sec. 531.043.)

Source Law

Sec. 531.043. LONG-TERM CARE VISION. (a) In conjunction with the appropriate state agencies, the executive commissioner shall develop a plan for access to individualized long-term care services for persons with functional limitations or medical needs and their families that assists those persons in achieving and maintaining the greatest possible independence, autonomy, and quality of life.

(b) The guiding principles and goals of the plan focusing on the individual and the individual's family must:

(1) recognize that it is the policy of this state that children should grow up in families and that persons with disabilities and elderly persons should live in the setting of their choice; and

(2) ensure that persons needing assistance and their families will have:

(A) the maximum possible control over their services;

(B) a choice of a broad, comprehensive array of services designed to meet individual needs; and

(C) the easiest possible access to appropriate care and support, regardless of the area of the state in which they live.

(c) The guiding principles and goals of the long-term care plan focusing on services and delivery of those services by the state must:

(1) emphasize the development of home-based and community-based services and housing alternatives to complement the long-term care services already in existence;

(2) ensure that services will be of the highest possible quality, with a minimum amount of regulation, structure, and complexity at the service level;

(3) recognize that maximum independence and autonomy represent major goals, and with those comes a certain degree of risk;

(4) maximize resources to the greatest extent possible, with the consumer receiving only the services that the consumer prefers and that are indicated by a functional assessment of need; and

(5) structure the service delivery system to support these goals, ensuring that any necessary complexity of the system is at the administrative level rather than at the client level.

(d) The commission shall coordinate state services to ensure that:

(1) the roles and responsibilities of the agencies providing long-term care are clarified; and

(2) duplication of services and resources is minimized.

(e) In this section, "long-term care" means the provision of health care, personal care, and assistance related to health and social services over a sustained period to people of all ages and their families, regardless of the setting in which the care is given.

Revisor's Note

Section 531.043(a), Government Code, refers to individualized long-term care services for "persons" with functional limitations or medical needs. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), applicable to this code.

Revised Law

Sec. 546.0003. EMPLOYMENT-FIRST POLICY. (a) It is the policy of this state that earning a living wage through competitive employment in the general workforce is the priority and preferred outcome for working-age individuals with disabilities who receive public benefits.

(b) The commission, the Texas Education Agency, and the Texas Workforce Commission shall jointly adopt and implement an employment-first policy in accordance with the state's policy under Subsection (a). The policy must:

(1) affirm that an individual with a disability is able to meet the same employment standards as an individual who does not have a disability;

(2) ensure that all working-age individuals with disabilities, including young adults, are offered factual information regarding employment as an individual with a disability, including the relationship between an individual's earned income and the individual's public benefits;

(3) ensure that individuals with disabilities are given the opportunity to understand and explore options for education or training, including postsecondary, graduate, and postgraduate education, vocational or technical training, or other training, as pathways to employment;

(4) promote the availability and accessibility of individualized training designed to prepare an individual with a disability for the individual's preferred employment;

(5) promote partnerships with employers to overcome barriers in meeting workforce needs with the creative use of technology and innovation;

(6) ensure that staff of public schools, vocational service programs, and community providers are supported and trained to assist in achieving the goal of competitive employment for all individuals with disabilities; and

(7) ensure that competitive employment, while being the priority and preferred outcome, is not required of an individual with a disability to secure or maintain public benefits for which the individual is otherwise eligible. (Gov. Code, Sec. 531.02447.)

Source Law

Sec. 531.02447. EMPLOYMENT-FIRST POLICY. (a)

It is the policy of the state that earning a living wage through competitive employment in the general workforce is the priority and preferred outcome for working-age individuals with disabilities who receive public benefits.

(b) The commission, the Texas Education Agency, and the Texas Workforce Commission shall jointly adopt and implement an employment-first policy in accordance with the state's policy under Subsection (a). The policy must:

(1) affirm that an individual with a disability is able to meet the same employment standards as an individual who does not have a disability;

(2) ensure that all working-age individuals with disabilities, including young adults, are offered factual information regarding employment as an individual with a disability, including the relationship between an individual's earned income and the individual's public benefits;

(3) ensure that individuals with disabilities are given the opportunity to understand and explore options for education or training, including postsecondary, graduate, and postgraduate education, vocational or technical training, or other training, as pathways to employment;

(4) promote the availability and accessibility of individualized training designed to prepare an individual with a disability for the individual's preferred employment;

(5) promote partnerships with employers to overcome barriers to meeting workforce needs with the creative use of technology and innovation;

(6) ensure that the staff of public schools, vocational service programs, and community providers are trained and supported to assist in achieving the goal of competitive employment for all individuals with disabilities; and

(7) ensure that competitive employment, while being the priority and preferred outcome, is not required of an individual with a disability to secure or maintain public benefits for which the individual is otherwise eligible.

Revised Law

Sec. 546.0004. LONG-TERM CARE INSURANCE AWARENESS AND EDUCATION CAMPAIGN. (a) The commission, in consultation with the Texas Department of Insurance, shall develop and implement a public awareness and education campaign designed to:

(1) educate the public on:

(A) the cost of long-term care, including the limits of Medicaid eligibility and the limits of Medicare benefits; and

(B) the value and availability of long-term care insurance; and

(2) encourage individuals to obtain long-term care

insurance.

(b) The Texas Department of Insurance shall cooperate with and assist the commission in implementing the campaign.

(c) The commission may coordinate the implementation of the campaign with any other state outreach campaign or activity relating to long-term care issues. (Gov. Code, Sec. 531.0841.)

Source Law

> Sec. 531.0841. LONG-TERM CARE INSURANCE AWARENESS AND EDUCATION CAMPAIGN. (a) The commission, in consultation with the Department of Aging and Disability Services and the Texas Department of Insurance, shall develop and implement a public awareness and education campaign designed to:
>
> (1) educate the public on the cost of long-term care, including the limits of Medicaid eligibility and the limits of Medicare benefits;
>
> (2) educate the public on the value and availability of long-term care insurance; and
>
> (3) encourage individuals to obtain long-term care insurance.
>
> (b) The Department of Aging and Disability Services and the Texas Department of Insurance shall cooperate with and assist the commission in implementing the campaign under this section.
>
> (c) The commission may coordinate the implementation of the campaign under this section with any other state outreach campaign or activity relating to long-term care issues.

Revisor's Note

Sections 531.0841(a) and (b), Government Code, require the Health and Human Services Commission, in consultation with the "Department of Aging and Disability Services," to develop and implement a public awareness and education campaign. The Department of Aging and Disability Services was abolished effective September 1, 2017, in accordance with Section 531.0202(b), Government Code, which is executed law that expired September 1, 2023, and the powers and duties of that department were transferred to the commission. Section 531.0011, Government Code, which is revised in this subtitle as Section 521.0002, provides that a reference to the department means the commission or the appropriate division of the commission. Because the department no longer exists

and the commission has assumed the powers and duties of the department, throughout this chapter, the revised law omits references to the Department of Aging and Disability Services.

SUBCHAPTER B. CARE SETTINGS AND SERVICE AND SUPPORT OPTIONS

Revised Law

Sec. 546.0051. DEFINITIONS. In this subchapter:

(1) "General residential operation" has the meaning assigned by Section 42.002, Human Resources Code.

(2) "Legally authorized representative" has the meaning assigned by Section 241.151, Health and Safety Code. (New.)

Revisor's Note

The revised law adds subchapter-wide definitions of "general residential operation" and "legally authorized representative" for drafting convenience and to avoid frequent, unnecessary repetition of the substance of the definitions.

Revised Law

Sec. 546.0052. COMPREHENSIVE PLAN FOR ENSURING APPROPRIATE CARE SETTING FOR INDIVIDUALS WITH DISABILITIES; BIENNIAL REPORT. (a) The commission and appropriate health and human services agencies shall implement a comprehensive, effectively working plan that provides a system of services and support to foster independence and productivity and provide meaningful opportunities for an individual with a disability to reside in the most appropriate care setting, considering:

(1) the individual's physical, medical, and behavioral needs;

(2) the least restrictive care setting in which the individual can reside;

(3) the individual's choice of care settings in which to reside;

(4) the availability of state resources; and

(5) the availability of state programs for which the

individual qualifies that can assist the individual.

(b) The plan must require appropriate health and human services agencies to:

(1) provide to an individual with a disability residing in an institution or another individual as required by Sections 546.0053 and 546.0054 information regarding care and support options available to the individual with a disability, including community-based services appropriate to that individual's needs;

(2) recognize that certain individuals with disabilities are represented by a legally authorized representative, whom the agencies must include in any decision-making facilitated by the plan's implementation;

(3) facilitate a timely and appropriate transfer of an individual with a disability from an institution to an appropriate community setting if:

(A) the individual chooses to reside in the community;

(B) the individual's treating professionals determine the transfer is appropriate; and

(C) the transfer can be reasonably accommodated, considering this state's available resources and the needs of other individuals with disabilities; and

(4) develop strategies to prevent the unnecessary placement in an institution of an individual with a disability who is:

(A) residing in the community; and

(B) in imminent risk of requiring placement in an institution because of a lack of community services.

(c) In implementing the plan, a health and human services agency may not deny an eligible individual with a disability access to an institution or remove an eligible individual with a disability from an institution if the individual prefers the type and degree of care provided in the institution and that care is

appropriate for the individual. A health and human services agency may deny the individual with a disability access to an institution or remove the individual from an institution to protect the individual's health or safety.

(d) Subject to the availability of funds, each appropriate health and human services agency shall implement the strategies and recommendations under the plan.

(e) To determine the appropriateness of transfers under Subsection (b)(3) and develop the strategies described by Subsection (b)(4), a health and human services agency shall presume that a child residing in a general residential operation is eligible for transfer to an appropriate community-based setting.

(f) To develop the strategies described by Subsection (b)(4), an individual with a mental illness who is admitted to a commission facility for inpatient mental health services three or more times during a 180-day period is presumed to be in imminent risk of requiring placement in an institution. The strategies must be developed in a manner that presumes the individual's eligibility for and the appropriateness of intensive community-based services and support.

(g) Not later than December 1 of each even-numbered year, the executive commissioner shall submit to the governor and the legislature a report on the status of the implementation of the plan. The report must include recommendations on any statutory or other action necessary to implement the plan.

(h) This section does not create a cause of action. (Gov. Code, Sec. 531.0244.)

Source Law

> Sec. 531.0244. ENSURING APPROPRIATE CARE SETTING FOR PERSONS WITH DISABILITIES. (a) The commission and appropriate health and human services agencies shall implement a comprehensive, effectively working plan that provides a system of services and support that fosters independence and productivity and provides meaningful opportunities for a person with a disability to live in the most appropriate care setting, considering:
>
> (1) the person's physical, medical, and behavioral needs;

(2) the least restrictive care setting in which the person can reside;

(3) the person's choice of care settings in which to reside;

(4) the availability of state resources; and

(5) the availability of state programs for which the person qualifies that can assist the person.

(b) The comprehensive, effectively working plan required by Subsection (a) must require appropriate health and human services agencies to:

(1) provide to a person with a disability living in an institution and to any other person as required by Sections 531.042 and 531.02442 information regarding care and support options available to the person with a disability, including community-based services appropriate to the needs of that person;

(2) recognize that certain persons with disabilities are represented by legally authorized representatives as defined by Section 241.151, Health and Safety Code, whom the agencies must include in any decision-making process facilitated by the plan's implementation;

(3) facilitate a timely and appropriate transfer of a person with a disability from an institution to an appropriate setting in the community if:

(A) the person chooses to live in the community;

(B) the person's treating professionals determine the transfer is appropriate; and

(C) the transfer can be reasonably accommodated, considering the state's available resources and the needs of other persons with disabilities; and

(4) develop strategies to prevent the unnecessary placement in an institution of a person with a disability who is living in the community but is in imminent risk of requiring placement in an institution because of a lack of community services.

(c) For purposes of developing the strategies required by Subsection (b)(4), a person with a mental illness who is admitted to a facility of the Department of State Health Services for inpatient mental health services three or more times during a 180-day period is presumed to be in imminent risk of requiring placement in an institution. The strategies must be developed in a manner that presumes the person's eligibility for and the appropriateness of intensive community-based services and support.

(c-1) For purposes of determining the appropriateness of transfers under Subsection (b)(3) and developing the strategies required by Subsection (b)(4), a health and human services agency shall presume the eligibility of a child residing in a general residential operation, as defined by Section 42.002, Human Resources Code, for transfer to an appropriate community-based setting.

(d) In implementing the plan required by Subsection (a), a health and human services agency may not deny an eligible person with a disability access to an institution or remove an eligible person with a disability from an institution if the person prefers the type and degree of care provided in the institution and that care is appropriate for the person. A health and human services agency may deny the person access to an institution or remove the person from an

institution to protect the person's health or safety.

(e) Each appropriate health and human services agency shall implement the strategies and recommendations under the plan required by Subsection (a) subject to the availability of funds.

(f) This section does not create a cause of action.

(g) Not later than December 1 of each even-numbered year, the executive commissioner shall submit to the governor and the legislature a report on the status of the implementation of the plan required by Subsection (a). The report must include recommendations on any statutory or other action necessary to implement the plan.

Revisor's Note

(1) Sections 531.0244(b)(2) and (c-1), Government Code, reference definitions for a "legally authorized representative" and a "general residential operation." Throughout this subchapter, the revised law omits references to the definitions of those terms because the references duplicate the subchapter-wide definitions for the terms added to this subchapter in Section 546.0051, which is applicable to the revised law.

(2) Section 531.0244(c), Government Code, refers to an individual with a mental illness who is admitted to a facility of the "Department of State Health Services." The powers and duties of that department regarding state-operated institutions were transferred to the Health and Human Services Commission in accordance with Section 531.02011(2), Government Code, which is executed law that expired September 1, 2023. Therefore, throughout this chapter, in instances relating to state-operated institutions, the revised law substitutes the commission for the Department of State Health Services.

Revised Law

Sec. 546.0053. INFORMATION AND ASSISTANCE REGARDING CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES. (a) The executive commissioner by rule shall require each health and human services agency to provide to each patient or client of the agency

and to at least one family member of the patient or client, if possible, information regarding all care and support options available to the patient or client, including community-based services appropriate to the patient's or client's needs, before the agency allows the patient or client to be placed in a care setting, including a nursing facility, an intermediate care facility for individuals with an intellectual disability, or a general residential operation for children with an intellectual disability that is licensed by the commission, to receive care or services provided by the agency or by a person under an agreement with the agency.

(b) The rules must require each health and human services agency to provide information about all long-term care and long-term support options available to the patient or client, including community-based options and options available through another agency or a private provider. The information must be provided in a manner designed to maximize the patient's or client's understanding of all available options. If the patient or client has a legally authorized representative, the information must also be provided to that representative. If the patient or client is in the conservatorship of a health and human services agency or the Department of Family and Protective Services, the information must be provided to the patient's or client's agency caseworker and foster parents, if applicable.

(c) A health and human services agency that provides a patient, client, or other individual with information regarding care and support options available to the patient or client shall assist the patient, client, or other individual in taking advantage of an option selected by the patient, client, or other individual, subject to the availability of funds. If the selected option is not immediately available for any reason, the agency shall provide assistance in placing the patient or client on a waiting list for that option. (Gov. Code, Sec. 531.042.)

Source Law

Sec. 531.042. INFORMATION AND ASSISTANCE REGARDING CARE AND SUPPORT OPTIONS. (a) The executive commissioner by rule shall require each health and human services agency to provide to each patient or client of the agency and to at least one family member of the patient or client, if possible, information regarding all care and support options available to the patient or client, including community-based services appropriate to the needs of the patient or client, before the agency allows the patient or client to be placed in a care setting, including a nursing facility, intermediate care facility for individuals with an intellectual disability, or general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services, to receive care or services provided by the agency or by a person under an agreement with the agency.

(b) The rules must require each health and human services agency to provide information about all long-term care options and long-term support options available to the patient or client, including community-based options and options available through another agency or a private provider. The information must be provided in a manner designed to maximize the patient's or client's understanding of all available options. If the patient or client has a legally authorized representative, as defined by Section 241.151, Health and Safety Code, the information must also be provided to that representative. If the patient or client is in the conservatorship of a health and human services agency, the information must be provided to the patient's or client's agency caseworker and foster parents, if applicable.

(c) A health and human services agency that provides a patient, client, or other person as required by this section with information regarding care and support options available to the patient or client shall assist the patient, client, or other person in taking advantage of an option selected by the patient, client, or other person, subject to the availability of funds. If the selected option is not immediately available for any reason, the agency shall provide assistance in placing the patient or client on a waiting list for that option.

Revisor's Note

(1) Section 531.042(a), Government Code, refers to a general residential operation for children with an intellectual disability that is licensed by the "Department of Family and Protective Services." The Department of Family and Protective Services' regulatory functions, including regulatory functions related to child care facilities, were transferred to the Health and Human Services Commission in accordance with Section 531.02011(3), Government Code, which is

executed law that expired September 1, 2023. Therefore, throughout this chapter, in instances relating to licensing of child care facilities, the revised law substitutes the commission for the Department of Family and Protective Services.

(2) Section 531.042(b), Government Code, refers to a patient or client in the conservatorship of "a health and human services agency." The Department of Family and Protective Services is not a health and human services agency, as defined by Section 531.001, Government Code, which is revised in this subtitle as Section 521.0001. However, the department is responsible for providing child protective services under Section 40.0025(b), Human Resources Code, and Chapters 262 and 263, Family Code, provide for the placement of children in the conservatorship of the department. Accordingly, the revised law adds a reference to the Department of Family and Protective Services.

Revised Law

Sec. 546.0054. COMMUNITY LIVING OPTIONS INFORMATION PROCESS FOR CERTAIN INDIVIDUALS WITH INTELLECTUAL DISABILITY. (a) In this section, "institution" means:

(1) a residential care facility the commission operates or maintains to provide 24-hour services, including residential services, to individuals with an intellectual disability; or

(2) an ICF-IID.

(b) In addition to providing information regarding care and support options as required by Section 546.0053, the commission shall implement a community living options information process in each institution to inform individuals with an intellectual disability who reside in the institution and the individuals' legally authorized representatives of alternative community living

options.

(c) The commission shall:

(1) at least annually provide the information required by Subsection (b) through the community living options information process; and

(2) provide the information at any other time on request by an individual with an intellectual disability who resides in an institution or the individual's legally authorized representative.

(d) If an individual with an intellectual disability residing in an institution or the individual's legally authorized representative indicates a desire to pursue an alternative community living option after receiving the information provided under this section, the commission shall refer the individual or the individual's legally authorized representative to the local intellectual and developmental disability authority. The local authority shall place the individual:

(1) in an alternative community living option, subject to the availability of funds; or

(2) on a waiting list for those options if for any reason the options are not available to the individual on or before the 30th day after the date the individual or the individual's legally authorized representative is referred to the local authority.

(e) The commission shall document in the records of each individual with an intellectual disability who resides in an institution:

(1) the information provided to the individual or the individual's legally authorized representative through the community living options information process; and

(2) the results of that process. (Gov. Code, Secs. 531.02442(a)(1-a), (b), (c), (d), (e).)

Source Law

Sec. 531.02442. COMMUNITY LIVING OPTIONS

INFORMATION PROCESS FOR CERTAIN PERSONS WITH AN INTELLECTUAL DISABILITY. (a) In this section:

(1-a) "Institution" means:

(A) a residential care facility operated or maintained by the department to provide 24-hour services, including residential services, to persons with an intellectual disability; or

(B) an ICF-IID, as defined by Section 531.002, Health and Safety Code.

(b) In addition to providing information regarding care and support options as required by Section 531.042, the department shall implement a community living options information process in each institution to inform persons with an intellectual disability who reside in the institution and their legally authorized representatives of alternative community living options.

(c) The department shall provide the information required by Subsection (b) through the community living options information process at least annually. The department shall also provide the information at any other time on request by a person with an intellectual disability who resides in an institution or the person's legally authorized representative.

(d) If a person with an intellectual disability residing in an institution or the person's legally authorized representative indicates a desire to pursue an alternative community living option after receiving the information provided under this section, the department shall refer the person or the person's legally authorized representative to the local intellectual and developmental disability authority. The local intellectual and developmental disability authority shall place the person in an alternative community living option, subject to the availability of funds, or on a waiting list for those options if the options are not available to the person for any reason on or before the 30th day after the date the person or the person's legally authorized representative is referred to the local intellectual and developmental disability authority.

(e) The department shall document in the records of each person with an intellectual disability who resides in an institution the information provided to the person or the person's legally authorized representative through the community living options information process and the results of that process.

Revisor's Note

(1) Section 531.02442(a)(1), Government Code, defines "department" as "the Department of Aging and Disability Services." The revised law omits the definition for the reason stated in the revisor's note to Section 546.0004. The omitted law reads:

> (1) "Department" means the Department of Aging and Disability Services.

(2) Section 531.02442(a)(1-a)(B), Government

Code, defines an "ICF-IID." Throughout this chapter, the revised law omits references to the definition of that term because it duplicates the chapter-wide definition for that term added to this chapter in Section 546.0001(1), which is applicable to the revised law.

(3) Section 531.02442(a)(2), Government Code, defines "legally authorized representative." The revised law omits the definition because it duplicates the subchapter-wide definition for that term added to this subchapter in Section 546.0051, which is applicable to the revised law. The omitted law reads:

> (2) "Legally authorized representative" has the meaning assigned by Section 241.151, Health and Safety Code.

(4) Section 531.02442(a)(3), Government Code, defines "local intellectual and developmental disability authority." The revised law omits the definition because it duplicates the chapter-wide definition for that term added to this chapter in Section 546.0001(1), which is applicable to the revised law. The omitted law reads:

> (3) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

Revised Law

Sec. 546.0055. IMPLEMENTATION OF COMMUNITY LIVING OPTIONS INFORMATION PROCESS AT STATE INSTITUTIONS FOR CERTAIN ADULT RESIDENTS. (a) In this section:

(1) "Adult resident" means an individual with an intellectual disability who:

(A) is at least 22 years of age; and

(B) resides in a state supported living center.

(2) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

(b) This section applies only to the community living options information process for an adult resident.

(c) The commission shall contract with local intellectual and developmental disability authorities to implement the community living options information process required by Section 546.0054 for an adult resident.

(d) The commission's contract with a local intellectual and developmental disability authority must:

(1) delegate to the local authority the commission's duties under Section 546.0054 with regard to implementing the community living options information process at a state supported living center;

(2) include performance measures designed to assist the commission in evaluating the effectiveness of the local authority in implementing the community living options information process; and

(3) ensure that the local authority provides service coordination and relocation services to an adult resident who chooses, is eligible for, and is recommended by the interdisciplinary team for a community living option to facilitate a timely, appropriate, and successful transition from the state supported living center to the community living option.

(e) The commission, with the advice and assistance of representatives of family members or legally authorized representatives of adult residents, individuals with an intellectual disability, state supported living centers, and local intellectual and developmental disability authorities, shall:

(1) develop an effective community living options information process;

(2) create uniform procedures for implementing the community living options information process; and

(3) minimize any potential conflict of interest regarding the community living options information process between a state supported living center and an adult resident, an adult

resident's legally authorized representative, or a local intellectual and developmental disability authority.

(f) A state supported living center shall:

(1) allow a local intellectual and developmental disability authority to participate in the interdisciplinary planning process involving the consideration of community living options for an adult resident;

(2) to the extent not otherwise prohibited by state or federal confidentiality laws, provide a local intellectual and developmental disability authority with access to an adult resident and an adult resident's records to assist the authority in implementing the community living options information process; and

(3) provide an adult resident or the adult resident's legally authorized representative with accurate information regarding the risks of moving the adult resident to a community living option. (Gov. Code, Secs. 531.02443(a)(1), (5), (b), (c), (d), (e), (f).)

Source Law

Sec. 531.02443. IMPLEMENTATION OF COMMUNITY LIVING OPTIONS INFORMATION PROCESS AT STATE INSTITUTIONS FOR CERTAIN ADULT RESIDENTS. (a) In this section:

(1) "Adult resident" means a person with an intellectual disability who:

(A) is at least 22 years of age; and

(B) resides in a state supported living center.

(5) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

(b) This section applies only to the community living options information process for an adult resident.

(c) The department shall contract with local intellectual and developmental disability authorities to implement the community living options information process required by Section 531.02442 for an adult resident.

(d) The contract with the local intellectual and developmental disability authority must:

(1) delegate to the local intellectual and developmental disability authority the department's duties under Section 531.02442 with regard to the implementation of the community living options information process at a state supported living center;

(2) include performance measures designed to assist the department in evaluating the

effectiveness of a local intellectual and developmental disability authority in implementing the community living options information process; and

(3) ensure that the local intellectual and developmental disability authority provides service coordination and relocation services to an adult resident who chooses, is eligible for, and is recommended by the interdisciplinary team for a community living option to facilitate a timely, appropriate, and successful transition from the state supported living center to the community living option.

(e) The department, with the advice and assistance of the interagency task force on ensuring appropriate care settings for persons with disabilities and representatives of family members or legally authorized representatives of adult residents, persons with an intellectual disability, state supported living centers, and local intellectual and developmental disability authorities, shall:

(1) develop an effective community living options information process;

(2) create uniform procedures for the implementation of the community living options information process; and

(3) minimize any potential conflict of interest regarding the community living options information process between a state supported living center and an adult resident, an adult resident's legally authorized representative, or a local intellectual and developmental disability authority.

(f) A state supported living center shall:

(1) allow a local intellectual and developmental disability authority to participate in the interdisciplinary planning process involving the consideration of community living options for an adult resident;

(2) to the extent not otherwise prohibited by state or federal confidentiality laws, provide a local intellectual and developmental disability authority with access to an adult resident and an adult resident's records to assist the authority in implementing the community living options information process; and

(3) provide the adult resident or the adult resident's legally authorized representative with accurate information regarding the risks of moving the adult resident to a community living option.

Revisor's Note

(1) Section 531.02443(a)(2), Government Code, defines "department" as "the Department of Aging and Disability Services." The revised law omits the definition for the reason stated in the revisor's note to Section 546.0004. The omitted law reads:

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

(2) Section 531.02443(a)(3), Government Code,

defines "legally authorized representative." The revised law omits the definition for the reason stated in Revisor's Note (1) to Section 546.0052. The omitted law reads:

> (3) "Legally authorized representative" has the meaning assigned by Section 241.151, Health and Safety Code.

(3) Section 531.02443(a)(4), Government Code, defines "local intellectual and developmental disability authority." The revised law omits the definition because it duplicates the chapter-wide definition for the term added to this chapter as Section 546.0001(1), which is applicable to the revised law. The omitted law reads:

> (4) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(4) Section 531.02443(e), Government Code, requires the Health and Human Services Commission to seek advice and assistance from the interagency task force on ensuring appropriate care settings for persons with disabilities, meaning the task force established under former Section 531.02441, Government Code. Section 531.02441, including the task force, expired on September 1, 2017, and because of the expiration, the revised law omits the reference to the task force.

Revised Law

Sec. 546.0056. VOUCHER PROGRAM FOR TRANSITIONAL LIVING ASSISTANCE FOR INDIVIDUALS WITH DISABILITIES. (a) In this section:

(1) "Institutional housing" means:

(A) an ICF-IID;

(B) a nursing facility;

(C) a state hospital, state supported living

center, or state center the commission maintains and manages;

(D) a general residential operation for children with an intellectual disability that the commission licenses; or

(E) a general residential operation.

(2) "Integrated housing" means housing in which an individual with a disability resides or may reside that is:

(A) located in the community; and

(B) not exclusively occupied by individuals with disabilities and their care providers.

(b) Subject to the availability of funds, the commission shall coordinate with the Texas Department of Housing and Community Affairs to develop a housing assistance program to assist individuals with disabilities in moving from institutional housing to integrated housing. In developing the program, the agencies shall address:

(1) eligibility requirements for assistance;

(2) the period during which an individual with a disability may receive assistance;

(3) the types of housing expenses the program will cover; and

(4) the locations at which the program will operate.

(c) Subject to the availability of funds, the commission shall administer the housing assistance program. The commission shall coordinate with the Texas Department of Housing and Community Affairs in:

(1) administering the program;

(2) determining the availability of funding from the United States Department of Housing and Urban Development; and

(3) obtaining that funding.

(d) The Texas Department of Housing and Community Affairs shall provide information to the commission as necessary to facilitate the administration of the housing assistance program. (Gov. Code, Sec. 531.059.)

Source Law

Sec. 531.059. VOUCHER PROGRAM FOR TRANSITIONAL LIVING ASSISTANCE FOR PERSONS WITH DISABILITIES. (a) In this section:

(1) "Institutional housing" means:

(A) an ICF-IID, as defined by Section 531.002, Health and Safety Code;

(B) a nursing facility;

(C) a state hospital, state supported living center, or state center maintained and managed by the Department of State Health Services or the Department of Aging and Disability Services;

(D) a general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services; or

(E) a general residential operation, as defined by Section 42.002, Human Resources Code.

(2) "Integrated housing" means housing in which a person with a disability resides or may reside that is found in the community but that is not exclusively occupied by persons with disabilities and their care providers.

(b) Subject to the availability of funds, the commission shall coordinate with the Texas Department of Housing and Community Affairs, the Department of State Health Services, and the Department of Aging and Disability Services to develop a housing assistance program to assist persons with disabilities in moving from institutional housing to integrated housing. In developing the program, the agencies shall address:

(1) eligibility requirements for assistance;

(2) the period during which a person with a disability may receive assistance;

(3) the types of housing expenses to be covered under the program; and

(4) the locations at which the program will be operated.

(c) Subject to the availability of funds, the Department of Aging and Disability Services shall administer the housing assistance program under this section. The department shall coordinate with the Texas Department of Housing and Community Affairs in administering the program, determining the availability of funding from the United States Department of Housing and Urban Development, and obtaining those funds.

(d) The Texas Department of Housing and Community Affairs and the Department of Aging and Disability Services shall provide information to the commission as necessary to facilitate the administration of the housing assistance program.

Revisor's Note

Section 531.059(b), Government Code, requires the Health and Human Services Commission to coordinate with agencies, including the "Department of State Health Services," to develop a housing assistance program. The Department of State Health Services'

client services functions were transferred to the Health and Human Services Commission in accordance with Section 531.0201(a)(2)(C), Government Code, which is executed law that expired September 1, 2023. Therefore, throughout this chapter, in instances relating to client services, the revised law substitutes the commission for the department.

Revised Law

Sec. 546.0057. TRANSITION SERVICES FOR YOUTH WITH DISABILITIES. (a) The executive commissioner shall monitor programs and services offered through health and human services agencies designed to assist youth with disabilities to transition from school-oriented living to:

(1) post-schooling activities;

(2) services for adults; or

(3) community living.

(b) In monitoring the programs and services, the executive commissioner shall:

(1) consider whether the programs or services result in positive outcomes in the employment, community integration, health, and quality of life of individuals with disabilities; and

(2) collect information regarding the outcomes of the transition process as necessary to assess the programs and services. (Gov. Code, Sec. 531.02445.)

Source Law

Sec. 531.02445. TRANSITION SERVICES FOR YOUTH WITH DISABILITIES. (a) The executive commissioner shall monitor programs and services offered through health and human services agencies designed to assist youth with disabilities to transition from school-oriented living to post-schooling activities, services for adults, or community living.

(b) In monitoring the programs and services, the executive commissioner shall:

(1) consider whether the programs or services result in positive outcomes in the employment, community integration, health, and quality of life of individuals with disabilities; and

(2) collect information regarding the outcomes of the transition process as necessary to assess the programs and services.

Revised Law

Sec. 546.0058. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES. (a) The commission shall quantify the amount of money the legislature appropriates that would have been spent during the remainder of a state fiscal biennium to care for an individual who resides in a nursing facility but who is leaving that facility before the end of the biennium to reside in the community with the assistance of community-based services.

(b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the executive commissioner shall direct, as appropriate:

(1) the comptroller, at the time an individual described by Subsection (a) leaves a nursing facility, to transfer an amount not to exceed the amount quantified under that subsection among the health and human services agencies and the commission as necessary to comply with this section; or

(2) the commission or a health and human services agency, at the time an individual described by Subsection (a) leaves a nursing facility, to transfer an amount not to exceed the amount quantified under that subsection within the agency's budget as necessary to comply with this section.

(c) The commission shall ensure that the amount transferred under this section is redirected by the commission or a health and human services agency, as applicable, to one or more community-based programs in the amount necessary to provide community-based services to the individual after the individual leaves a nursing facility. (Gov. Code, Sec. 531.092.)

Source Law

> Sec. 531.092. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES. (a) The commission shall quantify the amount of money appropriated by the legislature that would have been spent during the remainder of a state fiscal biennium to care for a person who lives in a nursing facility but who is leaving that facility before the end of the biennium to live in the community with the assistance of community-based services.
>
> (b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the

executive commissioner shall direct, as appropriate:

(1) the comptroller, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection among the health and human services agencies and the commission as necessary to comply with this section; or

(2) the commission or a health and human services agency, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection within the agency's budget as necessary to comply with this section.

(c) The commission shall ensure that the amount transferred under this section is redirected by the commission or health and human services agency, as applicable, to one or more community-based programs in the amount necessary to provide community-based services to the person after the person leaves the nursing facility.

SUBCHAPTER C. CONSUMER DIRECTION MODELS

Revised Law

Sec. 546.0101. DEFINITIONS. In this subchapter:

(1) "Consumer" means an individual who receives services through a consumer direction model the commission establishes under this subchapter.

(2) "Consumer direction model" means a service delivery model under which a consumer or the consumer's legally authorized representative exercises control over the development and implementation of the consumer's individual service plan or over the persons delivering the services directly to the consumer. The term includes the consumer-directed service option, the service responsibility option, and other types of service delivery models the commission develops under this subchapter.

(3) "Consumer-directed service option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative, as the employer, exercises control over:

(i) recruiting, hiring, managing, or dismissing persons providing services directly to the consumer; or

(ii) retaining contractors or vendors for other authorized program services; and

(B) the consumer-directed services agency serves

as fiscal agent and performs employer-related administrative functions for the consumer or the consumer's legally authorized representative, including payroll and filing tax and related reports.

(4) "Designated representative" means an adult volunteer appointed by a consumer or the consumer's legally authorized representative, as an employer, to perform all or part of the consumer's or the representative's duties as employer as approved by the consumer or the representative.

(5) "Legally authorized representative":

(A) means:

(i) a parent or legal guardian if the individual is a minor;

(ii) a legal guardian if the individual has been adjudicated as incapacitated to manage the individual's personal affairs; or

(iii) any other person authorized or required by law to act on the individual's behalf with regard to the individual's care; and

(B) does not include a designated representative.

(6) "Service responsibility option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative participates in selecting, training, and managing persons providing services directly to the consumer; and

(B) the provider agency, as the employer, performs employer-related administrative functions for the consumer or the consumer's legally authorized representative, including hiring and dismissing persons providing services directly to the consumer. (Gov. Code, Sec. 531.051(a).)

Source Law

Sec. 531.051. CONSUMER DIRECTION OF CERTAIN SERVICES FOR PERSONS WITH DISABILITIES AND ELDERLY PERSONS. (a) In this section:

(1) "Consumer" means a person who receives services through a consumer direction model established by the commission under this section.

(2) "Consumer direction" or "consumer direction model" means a service delivery model under which a consumer or the consumer's legally authorized representative exercises control over the development and implementation of the consumer's individual service plan or over the persons delivering the services directly to the consumer. The term includes the consumer-directed service option, the service responsibility option, and other types of service delivery models developed by the commission under this section.

(3) "Consumer-directed service option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative, as the employer, exercises control over:

(i) the recruitment, hiring, management, or dismissal of persons providing services directly to the consumer; or

(ii) the retention of contractors or vendors for other authorized program services; and

(B) the consumer-directed services agency serves as fiscal agent and performs employer-related administrative functions for the consumer or the consumer's legally authorized representative, including payroll and the filing of tax and related reports.

(4) "Designated representative" means an adult volunteer appointed by a consumer or the consumer's legally authorized representative, as an employer, to perform all or part of the consumer's or the representative's duties as employer as approved by the consumer or the representative.

(5) "Legally authorized representative":

(A) means:

(i) a parent or legal guardian if the person is a minor;

(ii) a legal guardian if the person has been adjudicated as incapacitated to manage the person's personal affairs; or

(iii) any other person authorized or required by law to act on behalf of the person with regard to the person's care; and

(B) does not include a designated representative.

(6) "Service responsibility option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative participates in the selection of, trains, and manages persons providing services directly to the consumer; and

(B) the provider agency, as the employer, performs employer-related administrative functions for the consumer or the consumer's legally authorized representative, including the hiring and dismissal of persons providing services directly to the consumer.

Revisor's Note

(1) Section 531.051(a), Government Code, provides definitions for "this section." Throughout

this subchapter, the revised law substitutes "this subchapter" for "this section" because this subchapter is substantially derived from Section 531.051. This subchapter also includes Section 531.0512, Government Code. That section is revised in this subchapter as Section 546.0106, and the defined terms are made applicable to that revised law. Because it is clear from the context that the defined terms have the same meaning in Section 531.0512, applying the defined terms to the revision of that section in the subchapter does not result in a substantive change.

(2) Section 531.051(a)(2), Government Code, defines the terms "consumer direction" and "consumer direction model" as meaning a service delivery model related to a consumer's service plan or the direction of services provided to a consumer. For clarity and consistency of terminology used within this subchapter, the revised law omits "consumer direction" and exclusively uses the term "consumer direction model" throughout the revised law.

Revised Law

Sec. 546.0102. IMPLEMENTATION OF CONSUMER DIRECTION MODELS. (a) The commission shall develop and oversee the implementation of consumer direction models under which an individual with a disability or an elderly individual who is receiving certain state-funded or Medicaid-funded services, or the individual's legally authorized representative, exercises control over:

(1) developing and implementing the individual's service plan; or

(2) the persons who directly deliver the services.

(b) The consumer direction models the commission establishes under this subchapter may be implemented in appropriate and suitable commission or health and human services agency

programs. (Gov. Code, Secs. 531.051(b), (d).)

Source Law

> (b) The commission shall develop and oversee the implementation of consumer direction models under which a person with a disability or an elderly person who is receiving certain state-funded or Medicaid-funded services, or the person's legally authorized representative, exercises control over the development and implementation of the person's individual service plan or over the persons who directly deliver the services.
>
> (d) The consumer direction models established under this section may be implemented in appropriate and suitable programs of the commission or a health and human services agency.

Revised Law

Sec. 546.0103. RULES. In adopting rules for consumer direction models, the executive commissioner shall:

(1) determine which services are appropriate and suitable for delivery through a consumer direction model;

(2) ensure that each consumer direction model is designed to comply with applicable federal and state laws;

(3) maintain procedures to ensure that a potential consumer or the consumer's legally authorized representative has adequate and appropriate information, including the responsibilities of a consumer or representative under each service delivery option, to make an informed choice among the types of consumer direction models;

(4) require each consumer or the consumer's legally authorized representative to sign a statement acknowledging receipt of the information required by Subdivision (3);

(5) maintain procedures to monitor delivery of services through a consumer direction model to ensure:

(A) adherence to existing applicable program standards;

(B) appropriate use of funds; and

(C) consumer satisfaction with the delivery of services;

(6) ensure that authorized program services that are

not being delivered to a consumer through a consumer direction model are provided by a provider agency the consumer or the consumer's legally authorized representative chooses; and

(7) set a timetable to complete the implementation of the consumer direction models. (Gov. Code, Sec. 531.051(c).)

Source Law

(c) In adopting rules for the consumer direction models, the executive commissioner shall:

(1) determine which services are appropriate and suitable for delivery through consumer direction;

(2) ensure that each consumer direction model is designed to comply with applicable federal and state laws;

(3) maintain procedures to ensure that a potential consumer or the consumer's legally authorized representative has adequate and appropriate information, including the responsibilities of a consumer or representative under each service delivery option, to make an informed choice among the types of consumer direction models;

(4) require each consumer or the consumer's legally authorized representative to sign a statement acknowledging receipt of the information required by Subdivision (3);

(5) maintain procedures to monitor delivery of services through consumer direction to ensure:

(A) adherence to existing applicable program standards;

(B) appropriate use of funds; and

(C) consumer satisfaction with the delivery of services;

(6) ensure that authorized program services that are not being delivered to a consumer through consumer direction are provided by a provider agency chosen by the consumer or the consumer's legally authorized representative; and

(7) set a timetable to complete the implementation of the consumer direction models.

Revised Law

Sec. 546.0104. APPLICABILITY OF CERTAIN NURSING LICENSURE REQUIREMENTS. Section 301.251(a), Occupations Code, does not apply to delivery of a service for which payment is provided under the consumer-directed service option developed under this subchapter if:

(1) the individual who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter

301, Occupations Code, that is revoked or suspended; and

(C) performs a service that is not expressly prohibited from delegation by the Texas Board of Nursing; and

(2) the consumer who receives the service:

(A) has a disability and the service would have been performed by the consumer or the consumer's legally authorized representative except for that disability; and

(B) is:

(i) capable of training the individual to properly perform the service and the consumer directs the individual to deliver the service; or

(ii) not capable of training the individual to properly perform the service, the consumer's legally authorized representative is capable of training the individual to properly perform the service, and the legally authorized representative directs the individual to deliver the service. (Gov. Code, Sec. 531.051(e).)

Source Law

(e) Section 301.251(a), Occupations Code, does not apply to delivery of a service for which payment is provided under the consumer-directed service option developed under this section if:

(1) the person who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter 301, Occupations Code, that is revoked or suspended; and

(C) performs a service that is not expressly prohibited from delegation by the Texas Board of Nursing; and

(2) the consumer who receives the service:

(A) has a disability and the service would have been performed by the consumer or the consumer's legally authorized representative except for that disability; and

(B) if:

(i) the consumer is capable of training the person in the proper performance of the service, the consumer directs the person to deliver the service; or

(ii) the consumer is not capable of training the person in the proper performance of the service, the consumer's legally authorized representative is capable of training the person in the proper performance of the service and directs the person to deliver the service.

Revised Law

Sec. 546.0105. LEGALLY AUTHORIZED REPRESENTATIVE SERVICE OVERSIGHT REQUIRED. If an individual delivers a service under Section 546.0104(2)(B)(ii), the legally authorized representative must be present when the service is performed or be immediately accessible to the individual who delivers the service. If the individual will perform the service when the representative is not present, the representative must observe the individual performing the service at least once to assure the representative that the individual can competently perform that service. (Gov. Code, Sec. 531.051(f).)

Source Law

> (f) If the person delivers the service under Subsection (e)(2)(B)(ii), the legally authorized representative must be present when the service is performed or be immediately accessible to the person who delivers the service. If the person will perform the service when the representative is not present, the representative must observe the person performing the service at least once to assure the representative that the person performing the service can competently perform that service.

Revised Law

Sec. 546.0106. PROCEDURE TO PROVIDE NOTICE TO MEDICAID RECIPIENTS. The commission shall:

(1) develop a procedure to:

(A) verify that a recipient or the recipient's parent or legal guardian is informed of the consumer direction model and provided the option to choose to receive care under that model; and

(B) if the individual declines to receive care under the consumer direction model, document the decision to decline; and

(2) ensure that each Medicaid managed care organization implements the procedure. (Gov. Code, Sec. 531.0512.)

Source Law

> Sec. 531.0512. NOTIFICATION REGARDING CONSUMER DIRECTION MODEL. The commission shall:
>
> (1) develop a procedure to:
>
> (A) verify that a Medicaid recipient

or the recipient's parent or legal guardian is informed regarding the consumer direction model and provided the option to choose to receive care under that model; and

(B) if the individual declines to receive care under the consumer direction model, document the declination; and

(2) ensure that each Medicaid managed care organization implements the procedure.

SUBCHAPTER D. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEM INITIATIVES AND GRANT PROGRAM

Revised Law

Sec. 546.0151. DEFINITION. In this subchapter, "community-based organization" includes:

(1) an area agency on aging;

(2) an independent living center;

(3) a municipality, county, or other local government;

(4) a nonprofit or for-profit organization; or

(5) a community mental health and intellectual disability center. (Gov. Code, Sec. 531.02481(f) (part).)

Source Law

(f) . . . A community-based organization includes:

(1) an area agency on aging;

(2) an independent living center;

(3) a municipality, county, or other local government;

(4) a nonprofit or for-profit organization; or

(5) a community mental health and intellectual disability center.

Revised Law

Sec. 546.0152. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEMS FOR LONG-TERM CARE SERVICES. (a) The commission shall assist communities in this state to develop comprehensive, community-based support and service delivery systems for long-term care services. At a community's request, the commission shall provide resources and assistance to the community to enable the community to:

(1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers that result from the policies and procedures of state health and human services agencies;

(2) develop a system of blended funds, consistent with federal law and the General Appropriations Act, to allow the community to customize services to fit individual community needs; and

(3) develop a local system of access and assistance to aid clients in accessing the full range of long-term care services.

(b) At the request of a community-based organization or a combination of community-based organizations, the commission may provide a grant to the organization or organizations in accordance with this subchapter.

(c) In implementing this subchapter, the commission shall consider models used in other service delivery systems. (Gov. Code, Secs. 531.02481(a), (d).)

Source Law

> Sec. 531.02481. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEMS FOR LONG-TERM CARE SERVICES. (a) The commission and the Department of Aging and Disability Services shall assist communities in this state in developing comprehensive, community-based support and service delivery systems for long-term care services. At the request of a community-based organization or combination of community-based organizations, the commission may provide a grant to the organization or combination of organizations in accordance with Subsection (g). At the request of a community, the commission shall provide resources and assistance to the community to enable the community to:
>
> (1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers that result from the policies and procedures of state health and human services agencies;
>
> (2) develop a system of blended funds, consistent with the requirements of federal law and the General Appropriations Act, to allow the community to customize services to fit individual community needs; and
>
> (3) develop a local system of access and assistance to aid clients in accessing the full range of long-term care services.
>
> (d) In implementing this section, the commission shall consider models used in other service delivery systems.

Revisor's Note

(1) Section 531.02481(a), Government Code, authorizes the Health and Human Services Commission to provide grants to a community-based organization or

combination of community-based organizations in accordance with "Subsection (g)." The revised law substitutes "this subchapter" for the quoted language because requirements imposed on the commission with respect to awarding grants under Section 531.02481 are not limited to Subsection (g). Section 531.02481, which is revised as Subchapter D of this chapter, imposes other requirements on the commission in awarding grants. In addition, Subsection (g) is revised as Sections 546.0156, 546.0157, 546.0158, and 546.0159 of this subchapter. Substituting "this subchapter" for "Subsection (g)" results in capturing all requirements applicable to the commission under Section 531.02481, including the requirements contained in Subsection (g).

(2) Section 531.02481(d), Government Code, requires the commission to consider other models in implementing "this section." The revised law substitutes "this subchapter" for "this section" because, as stated in Revisor's Note (1), the provisions of Section 531.02481 are revised as Subchapter D of this chapter. Throughout this subchapter, in this and similar contexts, the revised law is drafted accordingly.

Revised Law

Sec. 546.0153. AREA AGENCIES ON AGING: MINIMUM NUMBER. The executive commissioner shall assure the maintenance of no fewer than 28 area agencies on aging in order to assure the continuation of a local system of access and assistance that is sensitive to the aging population. (Gov. Code, Sec. 531.02481(e).)

Source Law

(e) The executive commissioner shall assure the maintenance of no fewer than 28 area agencies on aging in order to assure the continuation of a local system of access and assistance that is sensitive to the aging population.

Revised Law

Sec. 546.0154. PROPOSALS. A community-based organization or a combination of organizations may make a proposal under this subchapter. (Gov. Code, Sec. 531.02481(f) (part).)

Source Law

> (f) A community-based organization or a combination of organizations may make a proposal under this section. . . .

Revised Law

Sec. 546.0155. PROPOSAL REVIEW AND APPROVAL. (a) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval.

(b) The commission shall review the initiative to ensure that the initiative is:

(1) consistent with other similar programs offered in communities; and

(2) not duplicative of other services provided in the community. (Gov. Code, Sec. 531.02481(c).)

Source Law

> (c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval. The commission shall review the initiative to ensure that the initiative is consistent with other similar programs offered in communities and does not duplicate other services provided in the community.

Revised Law

Sec. 546.0156. STANDARD AND PRIORITY OF REVIEW. (a) In making a grant to a community-based organization, the commission shall evaluate the organization's proposal based on demonstrated need and the proposal's merit.

(b) The commission shall give priority to proposals that will use the Internet and related information technologies to provide to clients:

(1) referral services;

(2) other information regarding local long-term care

services; and

(3) needs assessments. (Gov. Code, Sec. 531.02481(g) (part).)

Source Law

(g) In making a grant to a community-based organization, the commission shall evaluate the organization's proposal based on demonstrated need and the merit of the proposal. . . . The commission shall give priority to proposals that will use the Internet and related information technologies to provide to clients referral services, other information regarding local long-term care services, and needs assessment. . . .

Revised Law

Sec. 546.0157. COMMUNITY-BASED ORGANIZATION MATCHING CONTRIBUTION REQUIRED. To receive a grant under this subchapter, a community-based organization must at least partially match the state grant with money or other resources obtained from a nongovernmental entity, from a local government, or if the community-based organization is a local government, from fees or taxes collected by the local government. The community-based organization may then combine the money or resources the organization obtains from a variety of federal, state, local, or private sources to accomplish the proposal's purpose. (Gov. Code, Sec. 531.02481(g) (part).)

Source Law

(g) . . . To receive a grant under this section, a community-based organization must at least partially match the state grant with money or other resources obtained from a nongovernmental entity, from a local government, or if the community-based organization is a local government, from fees or taxes collected by the local government. The community-based organization may then combine the money or resources the organization obtains from a variety of state, local, federal, or private sources to accomplish the purpose of the proposal. . . .

Revised Law

Sec. 546.0158. PROPOSALS INVOLVING MULTIPLE COMMUNITY-BASED ORGANIZATIONS. (a) If a combination of community-based organizations makes a proposal, the organizations must designate a single organization to receive and administer the grant.

(b) If a community-based organization receives a grant on behalf of a combination of community-based organizations or if the community-based organization's proposal involves coordination with other entities to accomplish the proposal's purpose, the commission may condition receipt of the grant on the organization's making a good faith effort to coordinate with other entities in the manner indicated in the proposal. (Gov. Code, Sec. 531.02481(g) (part).)

Source Law

> (g) . . . If a combination of community-based organizations makes a proposal, the combination must designate a single organization to receive and administer the grant. . . . If a community-based organization receives a grant on behalf of a combination of community-based organizations or if the community-based organization's proposal involved coordinating with other entities to accomplish the purpose of the proposal, the commission may condition receipt of the grant on the organization's making a good faith effort to coordinate with other entities in the manner indicated in the proposal.

Revised Law

Sec. 546.0159. GUIDELINES. The commission may adopt guidelines for proposals. (Gov. Code, Sec. 531.02481(g) (part).)

Source Law

> (g) . . . The commission may adopt guidelines for proposals under this subsection. . . .

Revised Law

Sec. 546.0160. CERTAIN AGENCIES' DUTY TO PROVIDE RESOURCES AND ASSISTANCE. At the commission's request, a health and human services agency shall provide resources and assistance to a community as necessary to perform the commission's duties under Section 546.0152(a). (Gov. Code, Sec. 531.02481(b).)

Source Law

> (b) At the request of the commission, a health and human services agency shall provide resources and assistance to a community as necessary to perform the commission's duties under Subsection (a).

SUBCHAPTER E. PERMANENCY PLANNING

Revised Law

Sec. 546.0201. DEFINITIONS. In this subchapter:

(1) "Child" means an individual with a developmental

disability who is younger than 22 years of age.

(2) "Community resource coordination group" means a coordination group established under the memorandum of understanding adopted under Subchapter D, Chapter 522.

(3) "Department" means the Department of Family and Protective Services.

(4) "Institution" means:

(A) an ICF-IID;

(B) a group home operated under the commission's authority, including a residential service provider under a Section 1915(c) waiver program that provides services at a residence other than the child's home or agency foster home;

(C) a nursing facility;

(D) a general residential operation for children with an intellectual disability that the commission licenses; or

(E) another residential arrangement other than a foster home that provides care to four or more children who are unrelated to each other.

(5) "Permanency planning" means a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship. (Gov. Code, Sec. 531.151; New.)

Source Law

Sec. 531.151. DEFINITIONS. In this subchapter:

(1) "Child" means a person with a developmental disability who is younger than 22 years of age.

(2) "Community resource coordination group" means a coordination group established under the memorandum of understanding adopted under Section 531.055.

(3) "Institution" means:

(A) an ICF-IID, as defined by Section 531.002, Health and Safety Code;

(B) a group home operated under the authority of the commission, including a residential service provider under a Medicaid waiver program authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended, that provides services at a residence other than the child's home or agency foster home;

(C) a nursing facility;

(D) a general residential operation for children with an intellectual disability that is licensed by the commission; or

(E) another residential arrangement other than a foster home as defined by Section 42.002, Human Resources Code, that provides care to four or more children who are unrelated to each other.

(4) "Permanency planning" means a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship.

Revisor's Note

(1) The revised law adds a subchapter-wide definition of "department," meaning the Department of Family and Protective Services, for drafting convenience and to eliminate frequent, unnecessary repetition of the term "Department of Family and Protective Services."

(2) Section 531.151(2), Government Code, refers to a coordination group established under a memorandum of understanding adopted under Section 531.055, Government Code. The provisions of Section 531.055 are revised in this subtitle as Subchapter D, Chapter 522, and the revised law is drafted accordingly.

(3) Section 531.151(3)(B), Government Code, refers to a "Medicaid waiver program authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n." Throughout this chapter, the revised law substitutes "Section 1915(c) waiver program" for the quoted language because "Section 1915(c) waiver program" is the defined term under Section 531.001, Government Code, which is revised in this subtitle as Section 521.0001 and applies to the revised law in this chapter.

(4) Section 531.151(3)(E), Government Code, refers to a foster home "as defined by Section 42.002, Human Resources Code." Section 42.002, Human Resources Code, formerly defined "foster home" to mean "a child-care facility that provides care for not more

than six children for 24 hours a day." However, Chapter 317 (H.B. 7), Acts of the 85th Legislature, Regular Session, 2017, amended Section 42.002 to remove that definition, effectively repealing that definition from the section. Therefore, the revised law omits the cross-reference to Section 42.002.

Revised Law

Sec. 546.0202. POLICY STATEMENT. It is the policy of this state to strive to ensure that the basic needs for safety, security, and stability are met for each child in this state. A successful family is the most efficient and effective way to meet those needs. This state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible. (Gov. Code, Sec. 531.152.)

Source Law

> Sec. 531.152. POLICY STATEMENT. It is the policy of the state to strive to ensure that the basic needs for safety, security, and stability are met for each child in Texas. A successful family is the most efficient and effective way to meet those needs. The state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible.

Revised Law

Sec. 546.0203. DEVELOPMENT OF PERMANENCY PLAN PROCEDURES. (a) To further the policy stated in Section 546.0202 and except as provided by Subsection (b), the commission and each appropriate health and human services agency shall develop procedures to ensure that a permanency plan is developed for each child:

(1) who resides in an institution in this state on a temporary or long-term basis; or

(2) with respect to whom the commission or appropriate health and human services agency is notified in advance that institutional care is sought.

(b) The department shall develop a permanency plan as required by this subchapter for each child who resides in an institution in this state for whom the department has been appointed permanent managing conservator. The department is not required to develop a permanency plan under this subchapter for a child for whom the department has been appointed temporary managing conservator, but may incorporate the requirements of this subchapter in a permanency plan developed for the child under Section 263.3025, Family Code.

(c) In developing procedures under Subsection (a), the commission and other appropriate health and human services agencies shall develop to the extent possible uniform procedures applicable to each of the agencies and each child who is the subject of a permanency plan that promote efficiency for the agencies and stability for each child.

(d) In implementing permanency planning procedures, the commission shall:

(1) delegate the commission's duty to develop a permanency plan to a local intellectual and developmental disability authority or enter into a memorandum of understanding with the local intellectual and developmental disability authority to develop the permanency plan for each child who resides in an institution in this state or with respect to whom the commission is notified in advance that institutional care is sought;

(2) contract with a private entity, other than an entity that provides long-term institutional care, to develop a permanency plan for a child who resides in an institution in this state or with respect to whom the commission is notified in advance that institutional care is sought; or

(3) perform the commission's duties regarding permanency planning procedures using commission personnel.

(e) A contract or memorandum of understanding under Subsection (d) must include performance measures by which the commission may evaluate the effectiveness of permanency planning

efforts of a local intellectual and developmental disability authority or a private entity.

(f) In implementing permanency planning procedures, the commission shall engage in appropriate activities in addition to those required by Subsection (d) to minimize the potential conflicts of interest that, in developing the plan, may exist or arise between:

(1) the institution in which the child resides or in which institutional care is sought for the child; and

(2) the best interest of the child.

(g) The commission and the department may solicit and accept gifts, grants, and donations to support the development of permanency plans for children residing in institutions by individuals or organizations not employed by or affiliated with those institutions.

(h) A health and human services agency that contracts with a private entity under Subsection (d) to develop a permanency plan shall ensure that the entity is provided:

(1) training regarding the permanency planning philosophy described by Section 546.0201; and

(2) available resources that will assist a child residing in an institution in making a successful transition to a community-based residence. (Gov. Code, Sec. 531.153.)

Source Law

Sec. 531.153. DEVELOPMENT OF PERMANENCY PLAN. (a) To further the policy stated in Section 531.152 and except as provided by Subsection (b), the commission and each appropriate health and human services agency shall develop procedures to ensure that a permanency plan is developed for each child who resides in an institution in this state on a temporary or long-term basis or with respect to whom the commission or appropriate health and human services agency is notified in advance that institutional care is sought.

(b) The Department of Family and Protective Services shall develop a permanency plan as required by this subchapter for each child who resides in an institution in this state for whom the department has been appointed permanent managing conservator. The department is not required to develop a permanency plan under this subchapter for a child for whom the department has been appointed temporary managing conservator, but may incorporate the requirements of

this subchapter in a permanency plan developed for the child under Section 263.3025, Family Code.

(c) In developing procedures under Subsection (a), the commission and other appropriate health and human services agencies shall develop to the extent possible uniform procedures applicable to each of the agencies and each child who is the subject of a permanency plan that promote efficiency for the agencies and stability for each child.

(d) In implementing permanency planning procedures under Subsection (a) to develop a permanency plan for each child, the Department of Aging and Disability Services shall:

(1) delegate the department's duty to develop a permanency plan to a local intellectual and developmental disability authority, as defined by Section 531.002, Health and Safety Code, or enter into a memorandum of understanding with the local intellectual and developmental disability authority to develop the permanency plan for each child who resides in an institution in this state or with respect to whom the department is notified in advance that institutional care is sought;

(2) contract with a private entity, other than an entity that provides long-term institutional care, to develop a permanency plan for a child who resides in an institution in this state or with respect to whom the department is notified in advance that institutional care is sought; or

(3) perform the department's duties regarding permanency planning procedures using department personnel.

(d-1) A contract or memorandum of understanding under Subsection (d) must include performance measures by which the Department of Aging and Disability Services may evaluate the effectiveness of a local intellectual and developmental disability authority's or private entity's permanency planning efforts.

(d-2) In implementing permanency planning procedures under Subsection (a) to develop a permanency plan for each child, the Department of Aging and Disability Services shall engage in appropriate activities in addition to those required by Subsection (d) to minimize the potential conflicts of interest that, in developing the plan, may exist or arise between:

(1) the institution in which the child resides or in which institutional care is sought for the child; and

(2) the best interest of the child.

(e) The commission, the Department of Aging and Disability Services, and the Department of Family and Protective Services may solicit and accept gifts, grants, and donations to support the development of permanency plans for children residing in institutions by individuals or organizations not employed by or affiliated with those institutions.

(f) A health and human services agency that contracts with a private entity under Subsection (d) to develop a permanency plan shall ensure that the entity is provided training regarding the permanency planning philosophy under Section 531.151 and available resources that will assist a child residing in an institution in making a successful transition to a community-based residence.

Revisor's Note

Section 531.153(d)(1), Government Code, references a definition for a "local intellectual and developmental disability authority." Throughout this chapter, the revised law omits references to the definition of that term because it duplicates the chapter-wide definition for that term added to this chapter as Section 546.0001(1), which is applicable to the revised law.

Revised Law

Sec. 546.0204. PERMANENCY PLANNING FOR CERTAIN CHILDREN. (a) Notwithstanding Section 546.0201, in this section, "institution" has the meaning assigned by Section 242.002, Health and Safety Code.

(b) The commission and each appropriate health and human services agency shall develop procedures to ensure that permanency planning is provided for each child:

(1) residing in an institution in this state on a temporary or long-term basis; or

(2) for whom institutional care is sought. (Gov. Code, Secs. 531.0245(a), (b)(1).)

Source Law

Sec. 531.0245. PERMANENCY PLANNING FOR CERTAIN CHILDREN. (a) The commission and each appropriate health and human services agency shall develop procedures to ensure that permanency planning is provided for each child residing in an institution in this state on a temporary or long-term basis or for whom institutional care is sought.

(b) In this section:

(1) "Institution" has the meaning assigned by Section 242.002, Health and Safety Code.

Revisor's Note

(1) Section 531.0245(b)(2), Government Code, defines "permanency planning." The revised law omits the definition because it duplicates the definition of that same term in Section 546.0201(5), which applies to this section. The omitted law reads:

(2) "Permanency planning" has the meaning assigned by Section 531.151.

(2) Section 531.0245, Government Code, is revised as Section 546.0204 in Subchapter E, Chapter 546, of the revised law. Subchapter E is predominately derived from Subchapter D-1, Chapter 531, Government Code. Section 531.151, Government Code, revised as Section 546.0201 of the revised law, provides subchapter-wide definitions applicable to the revised subchapter, including Section 531.0245. Section 531.0245, which is not contained in Subchapter D-1, uses some of the same terms defined in Section 531.151, including "institution," "permanency planning," and "child," and, in the case of "institution," provides a different, narrower definition of the term. To preserve the separate meanings of the term "institution," the revised law adds "[n]otwithstanding Section 546.0201" to the revised definition of the term. With respect to the other terms, "permanency planning" and "child," because it is clear from the context that those terms have the same meanings in Section 531.0245, applying those terms to the revision of that section in this subchapter does not result in a substantive change.

Revised Law

Sec. 546.0205. INSTITUTION TO ASSIST WITH PERMANENCY PLANNING EFFORTS. An institution in which a child resides shall assist with providing effective permanency planning for the child by:

(1) cooperating with the health and human services agency, local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan; and

(2) participating in meetings to review the child's permanency plan as requested by a health and human services agency,

local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan. (Gov. Code, Sec. 531.1531.)

Source Law

> Sec. 531.1531. ASSISTANCE WITH PERMANENCY PLANNING EFFORTS. An institution in which a child resides shall assist with providing effective permanency planning for the child by:
>
> (1) cooperating with the health and human services agency, local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan; and
>
> (2) participating in meetings to review the child's permanency plan as requested by a health and human services agency, local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan.

Revised Law

Sec. 546.0206. IMPLEMENTATION SYSTEM: LOCAL PERMANENCY PLANNING SITES. The commission shall develop an implementation system that initially consists of four or more local sites and that is designed to coordinate planning for a permanent living arrangement and relationship for a child with a family. In developing the system, the commission shall:

(1) include criteria to identify children who need permanency plans;

(2) require the establishment of a permanency plan for each child who resides outside the child's family or for whom care or protection is sought in an institution;

(3) include a process to determine the agency or entity responsible for developing and overseeing implementation of a child's permanency plan;

(4) identify, blend, and use funds from all available sources to provide customized services and programs to implement a child's permanency plan;

(5) clarify and expand the role of a local community resource coordination group in ensuring accountability for a child who resides in an institution or who is at risk of being placed in an institution;

(6) require reporting of each placement or potential placement of a child in an institution or other living arrangement outside of the child's home; and

(7) assign in each local permanency planning site area a single gatekeeper for all children in the area for whom placement in an institution through a state-funded program is sought with authority to ensure that:

(A) family members of each child are aware of:

(i) intensive services that could prevent placement of the child in an institution; and

(ii) available placement options; and

(B) permanency planning is initiated for each child. (Gov. Code, Sec. 531.158.)

Source Law

Sec. 531.158. LOCAL PERMANENCY PLANNING SITES. The commission shall develop an implementation system that consists initially of four or more local sites and that is designed to coordinate planning for a permanent living arrangement and relationship for a child with a family. In developing the system, the commission shall:

(1) include criteria to identify children who need permanency plans;

(2) require the establishment of a permanency plan for each child who lives outside the child's family or for whom care or protection is sought in an institution;

(3) include a process to determine the agency or entity responsible for developing and overseeing implementation of a child's permanency plan;

(4) identify, blend, and use funds from all available sources to provide customized services and programs to implement a child's permanency plan;

(5) clarify and expand the role of a local community resource coordination group in ensuring accountability for a child who resides in an institution or who is at risk of being placed in an institution;

(6) require reporting of each placement or potential placement of a child in an institution or other living arrangement outside of the child's home; and

(7) assign in each local permanency planning site area a single gatekeeper for all children in the area for whom placement in an institution through a program funded by the state is sought with authority to ensure that:

(A) family members of each child are aware of:

(i) intensive services that could prevent placement of the child in an institution; and

(ii) available placement options; and

(B) permanency planning is initiated for each child.

Revised Law

Sec. 546.0207. DESIGNATION OF VOLUNTEER ADVOCATE. (a) The commission shall designate an individual, including a member of a community-based organization, to serve as a volunteer advocate for a child residing in an institution to assist in developing a permanency plan for the child if:

(1) the child's parent or guardian requests the assistance of an advocate;

(2) the institution in which the child is placed cannot locate the child's parent or guardian; or

(3) the child resides in an institution the commission operates.

(b) The individual designated to serve as the child's volunteer advocate may be:

(1) an individual the child's parent or guardian selects, except that the individual may not be employed by or under a contract with the institution in which the child resides;

(2) an adult relative of the child; or

(3) a child advocacy group representative.

(c) The commission shall provide to each individual designated to serve as a child's volunteer advocate information regarding permanency planning under this subchapter. (Gov. Code, Sec. 531.156.)

Source Law

Sec. 531.156. DESIGNATION OF ADVOCATE. (a) The Department of Aging and Disability Services shall designate a person, including a member of a community-based organization, to serve as a volunteer advocate for a child residing in an institution to assist in developing a permanency plan for the child if:

(1) the child's parent or guardian requests the assistance of an advocate;

(2) the institution in which the child is placed cannot locate the child's parent or guardian; or

(3) the child resides in an institution operated by the department.

(b) The person designated to serve as the child's volunteer advocate under this section may be:

(1) a person selected by the child's parent or guardian, except that the person may not be employed by or under a contract with the institution in which the child resides;

(2) an adult relative of the child; or

(3) a representative of a child advocacy group.

(c) The Department of Aging and Disability Services shall provide to each person designated to serve as a child's volunteer advocate information regarding permanency planning under this subchapter.

Revised Law

Sec. 546.0208. PREADMISSION NOTICE AND INFORMATION. (a) The requirements of this section do not apply to a request to place a child in an institution if the child:

(1) is involved in an emergency situation, as defined by rules the executive commissioner adopts; or

(2) has been committed to an institution under:

(A) Chapter 46B, Code of Criminal Procedure; or

(B) Chapter 55, Family Code.

(b) The executive commissioner by rule shall develop and implement a system by which the commission ensures that, for each child with respect to whom the commission or a local intellectual and developmental disability authority is notified of a request for placement in an institution, the child's parent or guardian is fully informed before the child is placed in the institution of all community-based services and any other service and support options for which the child may be eligible. The system must be designed to ensure that the commission provides the information through:

(1) a local intellectual and developmental disability authority;

(2) any private entity that has knowledge and expertise regarding the needs of and full spectrum of care options available to children with disabilities as well as the philosophy and purpose of permanency planning; or

(3) a commission employee.

(c) The commission shall develop comprehensive information consistent with the policy stated in Section 546.0202 to explain to a parent or guardian considering placing a child in an institution:

(1) options for community-based services;

(2) the benefits to the child of residing in a family or community setting;

(3) that the child's placement in an institution is considered temporary in accordance with Section 546.0215; and

(4) that an ongoing permanency planning process is required under this subchapter and other state law.

(d) An institution in which a child's parent or guardian is considering placing the child may provide the information required under Subsection (b), but the information must also be provided by a local intellectual and developmental disability authority, private entity, or employee of the commission as required by that subsection.

(e) Except as otherwise provided by this subsection and Subsection (a), the commission shall ensure that, not later than the 14th working day after the date the commission is notified of a request for a child's placement in an institution, the child's parent or guardian is provided the information described by Subsections (b) and (c). The commission may provide the information after the 14th working day after the date the commission is notified of the request if the child's parent or guardian waives the requirement that the information be provided within the period otherwise required by this subsection. (Gov. Code, Sec. 531.1521.)

Source Law

Sec. 531.1521. PREADMISSION INFORMATION. (a) The executive commissioner by rule shall develop and implement a system by which the Department of Aging and Disability Services ensures that, for each child with respect to whom the department or a local intellectual and developmental disability authority is notified of a request for placement in an institution, the child's parent or guardian is fully informed before the child is placed in the institution of all community-based services and any other service and support options for which the child may be eligible. The system must be designed to ensure that the department provides the information through:

(1) a local intellectual and developmental disability authority;

(2) any private entity that has knowledge and expertise regarding the needs of and full spectrum of care options available to children with disabilities as well as the philosophy and purpose of

permanency planning; or

(3) a department employee.

(b) An institution in which a child's parent or guardian is considering placing the child may provide information required under Subsection (a), but the information must also be provided by a local intellectual and developmental disability authority, private entity, or employee of the Department of Aging and Disability Services as required by Subsection (a).

(c) The Department of Aging and Disability Services shall develop comprehensive information consistent with the policy stated in Section 531.152 to explain to a parent or guardian considering placing a child in an institution:

(1) options for community-based services;

(2) the benefits to the child of living in a family or community setting;

(3) that the placement of the child in an institution is considered temporary in accordance with Section 531.159; and

(4) that an ongoing permanency planning process is required under this subchapter and other state law.

(d) Except as otherwise provided by this subsection and Subsection (e), the Department of Aging and Disability Services shall ensure that, not later than the 14th working day after the date the department is notified of a request for the placement of a child in an institution, the child's parent or guardian is provided the information described by Subsections (a) and (c). The department may provide the information after the 14th working day after the date the department is notified of the request if the child's parent or guardian waives the requirement that the information be provided within the period otherwise required by this subsection.

(e) The requirements of this section do not apply to a request for the placement of a child in an institution if the child:

(1) is involved in an emergency situation, as defined by rules adopted by the executive commissioner; or

(2) has been committed to an institution under Chapter 46B, Code of Criminal Procedure, or Chapter 55, Family Code.

Revisor's Note

Section 531.1521, Government Code, requires the Health and Human Services Commission to provide certain information to the parent or guardian considering placing a child in an institution, including that the child's placement is considered temporary in accordance with "Section 531.159." Section 531.159 is revised in this chapter as Sections 546.0215, 546.0216, 546.0217, and 546.0222. The relevant provisions relating to the temporary placement of a child in an institution are revised as

Section 546.0215 of this chapter, and the revised law is drafted accordingly.

Revised Law

Sec. 546.0209. REQUIREMENTS OF PARENT OR GUARDIAN ON CHILD'S ADMISSION TO CERTAIN INSTITUTIONS. On the admission of a child to an institution described by Section 546.0201(4)(A), (B), or (D), the commission shall require the child's parent or guardian to submit:

(1) an admission form that includes:

(A) the parent's or guardian's:

(i) name, address, and telephone number;

(ii) driver's license number and state of issuance or personal identification card number the Department of Public Safety issued; and

(iii) place of employment and the employer's address and telephone number; and

(B) the name, address, and telephone number of a relative of the child or other individual whom the commission or institution may contact in an emergency, a statement indicating the relation between that individual and the child, and at the parent's or guardian's option:

(i) that individual's driver's license number and state of issuance or personal identification card number the Department of Public Safety issued; and

(ii) the name, address, and telephone number of that individual's employer; and

(2) a signed acknowledgment of responsibility stating that the parent or guardian agrees to:

(A) notify the institution in which the child is placed of any changes to the information submitted under Subdivision (1)(A); and

(B) make reasonable efforts to participate in the child's life and in planning activities for the child. (Gov. Code, Sec. 531.1533.)

Source Law

Sec. 531.1533. REQUIREMENTS ON ADMISSIONS OF CHILDREN TO CERTAIN INSTITUTIONS. On the admission of a child to an institution described by Section 531.151(3)(A), (B), or (D), the Department of Aging and Disability Services shall require the child's parent or guardian to submit:

(1) an admission form that includes:

(A) the parent's or guardian's:

(i) name, address, and telephone number;

(ii) driver's license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(iii) place of employment and the employer's address and telephone number; and

(B) the name, address, and telephone number of a relative of the child or other person whom the department or institution may contact in an emergency, a statement indicating the relation between that person and the child, and at the parent's or guardian's option, that person's:

(i) driver's license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer; and

(2) a signed acknowledgment of responsibility stating that the parent or guardian agrees to:

(A) notify the institution in which the child is placed of any changes to the information submitted under Subdivision (1)(A); and

(B) make reasonable efforts to participate in the child's life and in planning activities for the child.

Revised Law

Sec. 546.0210. DUTIES OF CERTAIN INSTITUTIONS: NOTIFICATION REQUIREMENTS AND PARENT OR GUARDIAN ACCOMMODATIONS. (a) This section applies only to an institution described by Section 546.0201(4)(A), (B), or (D).

(b) An institution described by Section 546.0201(4)(A) or (B) shall notify the local intellectual and developmental disability authority for the region in which the institution is located of a request for a child's placement in the institution. An institution described by Section 546.0201(4)(D) shall notify the commission of a request for a child's placement in the institution.

(c) An institution must make reasonable accommodations to promote the participation of the parent or guardian of a child residing in the institution in all planning and decision-making regarding the child's care, including participation in:

(1) the initial development of the child's permanency plan and periodic review of the plan;

(2) an annual review and reauthorization of the child's service plan;

(3) routine interdisciplinary team meetings;

(4) decision-making regarding the child's medical care; and

(5) decision-making and other activities involving the child's health and safety.

(d) Reasonable accommodations that an institution must make include:

(1) conducting a meeting in person or by telephone, as mutually agreed upon by the institution and the parent or guardian;

(2) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the institution and the parent or guardian;

(3) if a parent or guardian has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.), including providing an accessible meeting location or a sign language interpreter, as applicable; and

(4) providing a language interpreter, if applicable.

(e) Except as otherwise provided by Subsection (f):

(1) an ICF-IID must:

(A) attempt to notify the parent or guardian of a child who resides in the ICF-IID in writing of a periodic permanency planning meeting or annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian; and

(2) a nursing facility must:

(A) attempt to notify the parent or guardian of a child who resides in the facility in writing of an annual service

plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian.

(f) If an emergency situation involving a child residing in an ICF-IID or nursing facility occurs, the ICF-IID or nursing facility, as applicable, must:

(1) attempt to notify the child's parent or guardian as soon as possible; and

(2) request a response from the parent or guardian.

(g) If a child's parent or guardian does not respond to the notice provided under Subsection (e) or (f), the ICF-IID or nursing facility, as applicable, must attempt to locate the parent or guardian by contacting another individual whose information was provided by the parent or guardian under Section 546.0209(1)(B).

(h) Not later than the 30th day after the date an ICF-IID or nursing facility determines that the ICF-IID or nursing facility is unable to locate a child's parent or guardian for participation in activities listed under Subsection (e)(1) or (2), the ICF-IID or nursing facility must notify the commission of that determination and request that the commission initiate a search for the child's parent or guardian. (Gov. Code, Sec. 531.164.)

Source Law

Sec. 531.164. DUTIES OF CERTAIN INSTITUTIONS. (a) This section applies only to an institution described by Section 531.151(3)(A), (B), or (D).

(b) An institution described by Section 531.151(3)(A) or (B) shall notify the local intellectual and developmental disability authority for the region in which the institution is located of a request for placement of a child in the institution. An institution described by Section 531.151(3)(D) shall notify the Department of Aging and Disability Services of a request for placement of a child in the institution.

(c) An institution must make reasonable accommodations to promote the participation of the parent or guardian of a child residing in the institution in all planning and decision-making regarding the child's care, including participation in:

(1) the initial development of the child's permanency plan and periodic review of the plan;

(2) an annual review and reauthorization

of the child's service plan;

(3) decision-making regarding the child's medical care;

(4) routine interdisciplinary team meetings; and

(5) decision-making and other activities involving the child's health and safety.

(d) Reasonable accommodations that an institution must make under this section include:

(1) conducting a meeting in person or by telephone, as mutually agreed upon by the institution and the parent or guardian;

(2) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the institution and the parent or guardian;

(3) if a parent or guardian has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.), including providing an accessible meeting location or a sign language interpreter, as applicable; and

(4) providing a language interpreter, if applicable.

(e) Except as otherwise provided by Subsection (f):

(1) an ICF-IID must:

(A) attempt to notify the parent or guardian of a child who resides in the ICF-IID in writing of a periodic permanency planning meeting or annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian; and

(2) a nursing facility must:

(A) attempt to notify the parent or guardian of a child who resides in the facility in writing of an annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian.

(f) If an emergency situation involving a child residing in an ICF-IID or nursing facility occurs, the ICF-IID or nursing facility, as applicable, must:

(1) attempt to notify the child's parent or guardian as soon as possible; and

(2) request a response from the parent or guardian.

(g) If a child's parent or guardian does not respond to a notice under Subsection (e) or (f), the ICF-IID or nursing facility, as applicable, must attempt to locate the parent or guardian by contacting another person whose information was provided by the parent or guardian under Section 531.1533(1)(B).

(h) Not later than the 30th day after the date an ICF-IID or nursing facility determines that it is unable to locate a child's parent or guardian for participation in activities listed under Subsection (e)(1) or (2), the ICF-IID or nursing facility must notify the Department of Aging and Disability Services of that determination and request that the department initiate a search for the child's parent or guardian.

Revised Law

Sec. 546.0211. NOTIFICATION OF PLACEMENT REQUIRED. (a) Not later than the third day after the date a child is initially placed in an institution, the institution shall notify:

(1) the commission, if the child is placed in a nursing facility;

(2) the local intellectual and developmental disability authority for the region in which the institution is located, if the child:

(A) is placed in an ICF-IID; or

(B) is placed by a child protective services agency in a general residential operation for children with an intellectual disability that the commission licenses;

(3) the community resource coordination group in the county of residence of the child's parent or guardian;

(4) if the child is at least three years of age, the school district for the area in which the institution is located; and

(5) if the child is less than three years of age, the local early childhood intervention program for the area in which the institution is located.

(b) The commission shall notify the local intellectual and developmental disability authority of a child's placement in a nursing facility if the child is known or suspected to have an intellectual disability or another disability for which the child may receive services through the commission. (Gov. Code, Sec. 531.154.)

Source Law

Sec. 531.154. NOTIFICATION REQUIRED. (a) Not later than the third day after the date a child is initially placed in an institution, the institution shall notify:

(1) the Department of Aging and Disability Services, if the child is placed in a nursing facility;

(2) the local intellectual and developmental disability authority, as defined by Section 531.002, Health and Safety Code, where the institution is located, if the child:

(A) is placed in an ICF-IID, as

defined by Section 531.002, Health and Safety Code; or

(B) is placed by a child protective services agency in a general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services;

(3) the community resource coordination group in the county of residence of a parent or guardian of the child;

(4) if the child is at least three years of age, the school district for the area in which the institution is located; and

(5) if the child is less than three years of age, the local early childhood intervention program for the area in which the institution is located.

(b) The Department of Aging and Disability Services shall notify the local intellectual and developmental disability authority, as defined by Section 531.002, Health and Safety Code, of a child's placement in a nursing facility if the child is known or suspected to have an intellectual disability or another disability for which the child may receive services through the Department of Aging and Disability Services.

Revised Law

Sec. 546.0212. NOTICE TO PARENT OR GUARDIAN REGARDING PLACEMENT OPTIONS AND SERVICES. Each entity receiving notice of a child's initial placement in an institution under Section 546.0211 may contact the child's parent or guardian to ensure that the parent or guardian is aware of:

(1) services and support that could provide alternatives to placing the child in the institution;

(2) available placement options; and

(3) opportunities for permanency planning. (Gov. Code, Sec. 531.155.)

Source Law

Sec. 531.155. OFFER OF SERVICES. Each entity receiving notice of the initial placement of a child in an institution under Section 531.154 may contact the child's parent or guardian to ensure that the parent or guardian is aware of:

(1) services and support that could provide alternatives to placement of the child in the institution;

(2) available placement options; and

(3) opportunities for permanency planning.

Revised Law

Sec. 546.0213. PLACEMENT ON WAIVER PROGRAM WAITING LIST. A state agency that receives notice of a child's placement in an institution shall ensure that, on or before the third day after the

date the agency is notified of the child's placement in the institution, the child is also placed on a waiting list for Section 1915(c) waiver program services appropriate to the child's needs. (Gov. Code, Sec. 531.157.)

Source Law

> Sec. 531.157. COMMUNITY-BASED SERVICES. A state agency that receives notice of a child's placement in an institution shall ensure that, on or before the third day after the date the agency is notified of the child's placement in the institution, the child is also placed on a waiting list for waiver program services under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended, appropriate to the child's needs.

Revised Law

Sec. 546.0214. INTERFERENCE WITH PERMANENCY PLANNING EFFORTS. An entity that provides information to a child's parent or guardian relating to permanency planning shall refrain from providing the child's parent or guardian with inaccurate or misleading information regarding the risks of moving the child to another facility or community setting. (Gov. Code, Sec. 531.1532.)

Source Law

> Sec. 531.1532. INTERFERENCE WITH PERMANENCY PLANNING EFFORTS. An entity that provides information to a child's parent or guardian relating to permanency planning shall refrain from providing the child's parent or guardian with inaccurate or misleading information regarding the risks of moving the child to another facility or community setting.

Revised Law

Sec. 546.0215. INITIAL PLACEMENT OF CHILD IN INSTITUTION AND PLACEMENT EXTENSIONS. (a) The chief executive officer of each appropriate health and human services agency or the officer's designee must approve a child's placement in an institution. The child's initial placement in the institution is temporary and may not exceed six months unless the appropriate chief executive officer or the officer's designee approves an extension of an additional six months after conducting a review of documented permanency planning efforts to unite the child with a family in a permanent living arrangement.

(b) After the initial six-month extension of a child's

placement in an institution approved under Subsection (a), the chief executive officer or the officer's designee shall conduct a review of the child's placement in the institution at least semiannually to determine whether continuing that placement is warranted. If, based on the review, the chief executive officer or the officer's designee determines that an additional extension is warranted, the officer or the officer's designee shall recommend to the executive commissioner that the child continue residing in the institution.

(c) On receipt of a recommendation made under Subsection (b), the executive commissioner, the executive commissioner's designee, or another person with whom the commission contracts shall conduct a review of the child's placement. Based on the results of the review, the executive commissioner or the executive commissioner's designee may approve a six-month extension of the child's placement if the extension is appropriate.

(d) A child may continue residing in an institution after the six-month extension approved under Subsection (c) only if the chief executive officer of the appropriate health and human services agency or the officer's designee makes subsequent recommendations as provided by Subsection (b) for each additional six-month extension and the executive commissioner or the executive commissioner's designee approves each extension as provided by Subsection (c). (Gov. Code, Secs. 531.159(b), (c), (d).)

Source Law

> (b) The chief executive officer of each appropriate health and human services agency or the officer's designee must approve the placement of a child in an institution. The initial placement of the child in the institution is temporary and may not exceed six months unless the appropriate chief executive officer or the officer's designee approves an extension of an additional six months after conducting a review of documented permanency planning efforts to unite the child with a family in a permanent living arrangement. After the initial six-month extension of a child's placement in an institution approved under this subsection, the chief executive officer or the officer's designee shall conduct a review of the child's placement in the institution at least semiannually to determine whether a continuation of that placement is warranted. If, based on the

review, the chief executive officer or the officer's designee determines that an additional extension is warranted, the officer or the officer's designee shall recommend to the executive commissioner that the child continue residing in the institution.

(c) On receipt of a recommendation made under Subsection (b) for an extension of a child's placement, the executive commissioner, the executive commissioner's designee, or another person with whom the commission contracts shall conduct a review of the child's placement. Based on the results of the review, the executive commissioner or the executive commissioner's designee may approve a six-month extension of the child's placement if the extension is appropriate.

(d) The child may continue residing in the institution after the six-month extension approved under Subsection (c) only if the chief executive officer of the appropriate health and human services agency or the officer's designee makes subsequent recommendations as provided by Subsection (b) for each additional six-month extension and the executive commissioner or the executive commissioner's designee approves each extension as provided by Subsection (c).

Revised Law

Sec. 546.0216. REVIEW OF CERTAIN PLACEMENT DATA. (a) The executive commissioner or the executive commissioner's designee shall conduct a semiannual review of data received from health and human services agencies regarding all children who reside in institutions in this state.

(b) The executive commissioner, the executive commissioner's designee, or a person with whom the commission contracts shall also review the recommendations of the chief executive officer of each appropriate health and human services agency or the officer's designee if the officer or the officer's designee repeatedly recommends that children continue residing in an institution. (Gov. Code, Sec. 531.159(e).)

Source Law

(e) The executive commissioner or the executive commissioner's designee shall conduct a semiannual review of data received from health and human services agencies regarding all children who reside in institutions in this state. The executive commissioner, the executive commissioner's designee, or a person with whom the commission contracts shall also review the recommendations of the chief executive officers of each appropriate health and human services agency or the officer's designee if the officer or the officer's designee repeatedly recommends that children continue residing in an institution.

Revised Law

Sec. 546.0217. PROCEDURES FOR PLACEMENT REVIEWS. The executive commissioner by rule shall develop procedures for conducting the reviews required by Sections 546.0215(c) and (d) and 546.0216. (Gov. Code, Sec. 531.159(f) (part).)

Source Law

> (f) The executive commissioner by rule shall develop procedures by which to conduct the reviews required by Subsections (c), (d), and (e). . . .

Revisor's Note

Section 531.159(f), Government Code, authorizes the Health and Human Services Commission to seek certain input from the work group on children's long-term services, health services, and mental health services established under Section 22.035, Human Resources Code. Section 22.035, including the work group, expired on September 1, 2017, and because of the expiration, the revised law omits the reference to the work group and that section. The omitted law reads:

> (f) . . . In developing the procedures, the commission may seek input from the work group on children's long-term services, health services, and mental health services established under Section 22.035, Human Resources Code.

Revised Law

Sec. 546.0218. ANNUAL REAUTHORIZATION OF PLANS OF CARE FOR CERTAIN CHILDREN. (a) The executive commissioner shall adopt rules under which the commission requires a nursing facility in which a child resides to request from the child's parent or guardian a written reauthorization of the child's plan of care.

(b) The rules must require that the written reauthorization be requested annually. (Gov. Code, Sec. 531.1591.)

Source Law

> Sec. 531.1591. ANNUAL REAUTHORIZATION OF PLANS OF CARE FOR CERTAIN CHILDREN. (a) The executive commissioner shall adopt rules under which the Department of Aging and Disability Services requires a nursing facility in which a child resides to request from the child's parent or guardian a written

reauthorization of the child's plan of care.

(b) The rules adopted under this section must require that the written reauthorization be requested annually.

Revised Law

Sec. 546.0219. TRANSFER OF CHILD BETWEEN INSTITUTIONS. (a) This section applies only to an institution described by Section 546.0201(4)(A), (B), or (D) in which a child resides.

(b) Before transferring a child who is 17 years of age or younger, or a child who is at least 18 years of age and for whom a guardian has been appointed, from one institution to another institution, the institution in which the child resides must attempt to obtain consent for the transfer from the child's parent or guardian unless the transfer is in response to an emergency situation, as defined by rules the executive commissioner adopts. (Gov. Code, Sec. 531.166.)

Source Law

Sec. 531.166. TRANSFER OF CHILD BETWEEN INSTITUTIONS. (a) This section applies only to an institution described by Section 531.151(3)(A), (B), or (D) in which a child resides.

(b) Before transferring a child who is 17 years of age or younger, or a child who is at least 18 years of age and for whom a guardian has been appointed, from one institution to another institution, the institution in which the child resides must attempt to obtain consent for the transfer from the child's parent or guardian unless the transfer is in response to an emergency situation, as defined by rules adopted by the executive commissioner.

Revised Law

Sec. 546.0220. COMPLIANCE WITH PERMANENCY PLAN REQUIREMENTS AS PART OF INSPECTION, SURVEY, OR INVESTIGATION. As part of each inspection, survey, or investigation of an institution, including a nursing facility, a general residential operation for children with an intellectual disability that the commission licenses, or an ICF-IID, in which a child resides, the agency or the agency's designee shall determine the extent to which the nursing facility, general residential operation, or ICF-IID is complying with the permanency planning requirements under this subchapter. (Gov. Code, Sec. 531.160.)

Source Law

Sec. 531.160. INSPECTIONS. As part of each inspection, survey, or investigation of an institution, including a nursing facility, general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services, or ICF-IID, as defined by Section 531.002, Health and Safety Code, in which a child resides, the agency or the agency's designee shall determine the extent to which the nursing facility, general residential operation, or ICF-IID is complying with the permanency planning requirements under this subchapter.

Revised Law

Sec. 546.0221. SEARCH FOR CHILD'S PARENT OR GUARDIAN. (a) The commission shall develop and implement a process by which the commission, on receipt of notification under Section 546.0210(h) that a child's parent or guardian cannot be located, conducts a search for the parent or guardian. If, on the first anniversary of the date the commission receives the notification under that subsection, the commission has been unsuccessful in locating the parent or guardian, the commission shall refer the case to:

(1) the department's child protective services division if the child is 17 years of age or younger; or

(2) the department's adult protective services division if the child is 18 years of age or older.

(b) On receipt of a referral under Subsection (a)(1), the department's child protective services division shall exercise intense due diligence in attempting to locate the child's parent or guardian. If the division is unable to locate the child's parent or guardian, the department shall file a suit affecting the parent-child relationship requesting an order appointing the department as the child's temporary managing conservator.

(c) A child is considered abandoned for purposes of the Family Code if the child's parent or guardian cannot be located following the department's exercise of intense due diligence in attempting to locate the parent or guardian.

(d) On receipt of a referral under Subsection (a)(2), the department's adult protective services division shall notify the

court that appointed the child's guardian that the guardian cannot be located. (Gov. Code, Sec. 531.165.)

Source Law

> Sec. 531.165. SEARCH FOR PARENT OR GUARDIAN OF A CHILD. (a) The Department of Aging and Disability Services shall develop and implement a process by which the department, on receipt of notification under Section 531.164(h) that a child's parent or guardian cannot be located, conducts a search for the parent or guardian. If, on the first anniversary of the date the department receives the notification under Section 531.164(h), the department has been unsuccessful in locating the parent or guardian, the department shall refer the case to:
>
> (1) the child protective services division of the Department of Family and Protective Services if the child is 17 years of age or younger; or
>
> (2) the adult protective services division of the Department of Family and Protective Services if the child is 18 years of age or older.
>
> (b) On receipt of a referral under Subsection (a)(1), the child protective services division of the Department of Family and Protective Services shall exercise intense due diligence in attempting to locate the child's parent or guardian. If the division is unable to locate the child's parent or guardian, the department shall file a suit affecting the parent-child relationship requesting an order appointing the department as the child's temporary managing conservator.
>
> (c) A child is considered abandoned for purposes of the Family Code if the child's parent or guardian cannot be located following the exercise of intense due diligence in attempting to locate the parent or guardian by the Department of Family and Protective Services under Subsection (b).
>
> (d) On receipt of a referral under Subsection (a)(2), the adult protective services division of the Department of Family and Protective Services shall notify the court that appointed the child's guardian that the guardian cannot be located.

Revised Law

Sec. 546.0222. DOCUMENTATION OF ONGOING PERMANENCY PLANNING EFFORTS. The commission and each appropriate health and human services agency shall require a person who develops a permanency plan for a child residing in an institution to identify and document in the child's permanency plan all ongoing permanency planning efforts at least semiannually to ensure that, as soon as possible, the child will benefit from a permanent living arrangement with an enduring and nurturing parental relationship. (Gov. Code, Sec. 531.159(a).)

Source Law

Sec. 531.159. MONITORING OF PERMANENCY PLANNING EFFORTS. (a) The commission and each appropriate health and human services agency shall require a person who develops a permanency plan for a child residing in an institution to identify and document in the child's permanency plan all ongoing permanency planning efforts at least semiannually to ensure that, as soon as possible, the child will benefit from a permanent living arrangement with an enduring and nurturing parental relationship.

Revised Law

Sec. 546.0223. ACCESS TO RECORDS. Each institution in which a child resides shall allow the following to have access to the child's records to assist in complying with the requirements of this subchapter:

(1) the commission;

(2) appropriate health and human services agencies; and

(3) to the extent not otherwise prohibited by state or federal confidentiality laws, a local intellectual and developmental disability authority or private entity that enters into a contract or memorandum of understanding under Section 546.0203(d) to develop a permanency plan for the child. (Gov. Code, Sec. 531.161.)

Source Law

Sec. 531.161. ACCESS TO RECORDS. Each institution in which a child resides shall allow the following to have access to the child's records to assist in complying with the requirements of this subchapter:

(1) the commission;

(2) appropriate health and human services agencies; and

(3) to the extent not otherwise prohibited by state or federal confidentiality laws, a local intellectual and developmental disability authority or private entity that enters into a contract or memorandum of understanding under Section 531.153(d) to develop a permanency plan for the child.

Revised Law

Sec. 546.0224. COLLECTION OF INFORMATION REGARDING INVOLVEMENT OF CERTAIN PARENTS AND GUARDIANS. (a) The commission shall collect and maintain aggregate information regarding the involvement of parents and guardians of children residing in

institutions described by Sections 546.0201(4)(A), (B), and (D) in the lives of and planning activities relating to those children. The commission shall obtain input from stakeholders concerning the types of information most useful in assessing the involvement of those parents and guardians.

(b) The commission shall make the aggregate information available to the public on request. (Gov. Code, Sec. 531.167.)

Source Law

> Sec. 531.167. COLLECTION OF INFORMATION REGARDING INVOLVEMENT OF CERTAIN PARENTS AND GUARDIANS. (a) The Department of Aging and Disability Services shall collect and maintain aggregate information regarding the involvement of parents and guardians of children residing in institutions described by Sections 531.151(3)(A), (B), and (D) in the lives of and planning activities relating to those children. The department shall obtain input from stakeholders concerning the types of information that are most useful in assessing the involvement of those parents and guardians.
>
> (b) The Department of Aging and Disability Services shall make the aggregate information available to the public on request.

Revised Law

Sec. 546.0225. REPORTING SYSTEMS: SEMIANNUAL REPORTING. (a) For each of the local permanency planning sites, the commission shall develop a reporting system under which each appropriate health and human services agency responsible for permanency planning under this subchapter is required to semiannually provide to the commission:

(1) the number of permanency plans the agency develops for children residing in institutions or children at risk of being placed in institutions;

(2) progress achieved in implementing permanency plans;

(3) the number of children the agency serves residing in institutions;

(4) the number of children the agency serves at risk of being placed in an institution served by the local permanency planning sites;

(5) the number of children the agency serves reunited

with their families or placed with alternate permanent families; and

(6) cost data related to developing and implementing permanency plans.

(b) The executive commissioner shall submit to the governor and the committees of the senate and the house of representatives having primary jurisdiction over health and human services agencies a semiannual report on:

(1) the number of children residing in institutions in this state and the number of those children for whom a recommendation has been made for a transition to a community-based residence but who have not yet made that transition;

(2) the circumstances of each child described by Subdivision (1), including the type of institution and name of the institution in which the child resides, the child's age, the residence of the child's parents or guardians, and the length of time during which the child has resided in the institution;

(3) the number of permanency plans developed for children residing in institutions in this state, progress achieved in implementing those plans, and barriers to implementing those plans;

(4) the number of children who previously resided in an institution in this state and have made the transition to a community-based residence;

(5) the number of children who previously resided in an institution in this state and have been reunited with their families or placed with alternate families;

(6) the community supports that resulted in the successful placement of children described by Subdivision (5) with alternate families; and

(7) the community supports that are unavailable but necessary to address the needs of children who continue to reside in an institution in this state after being recommended to make a transition from the institution to an alternate family or

community-based residence. (Gov. Code, Sec. 531.162.)

Source Law

Sec. 531.162. PERMANENCY REPORTING. (a) For each of the local permanency planning sites, the commission shall develop a reporting system under which each appropriate health and human services agency responsible for permanency planning under this subchapter is required to provide to the commission semiannually:

(1) the number of permanency plans developed by the agency for children residing in institutions or children at risk of being placed in institutions;

(2) progress achieved in implementing permanency plans;

(3) the number of children served by the agency residing in institutions;

(4) the number of children served by the agency at risk of being placed in an institution served by the local permanency planning sites;

(5) the number of children served by the agency reunited with their families or placed with alternate permanent families; and

(6) cost data related to the development and implementation of permanency plans.

(b) The executive commissioner shall submit a semiannual report to the governor and the committees of each house of the legislature that have primary oversight jurisdiction over health and human services agencies regarding:

(1) the number of children residing in institutions in this state and, of those children, the number for whom a recommendation has been made for a transition to a community-based residence but who have not yet made that transition;

(2) the circumstances of each child described by Subdivision (1), including the type of institution and name of the institution in which the child resides, the child's age, the residence of the child's parents or guardians, and the length of time in which the child has resided in the institution;

(3) the number of permanency plans developed for children residing in institutions in this state, the progress achieved in implementing those plans, and barriers to implementing those plans;

(4) the number of children who previously resided in an institution in this state and have made the transition to a community-based residence;

(5) the number of children who previously resided in an institution in this state and have been reunited with their families or placed with alternate families;

(6) the community supports that resulted in the successful placement of children described by Subdivision (5) with alternate families; and

(7) the community supports that are unavailable but necessary to address the needs of children who continue to reside in an institution in this state after being recommended to make a transition from the institution to an alternate family or community-based residence.

Revised Law

Sec. 546.0226. EFFECT ON OTHER LAW. This subchapter does

not affect responsibilities imposed by federal or other state law on a physician or other professional. (Gov. Code, Sec. 531.163.)

Source Law

Sec. 531.163. EFFECT ON OTHER LAW. This subchapter does not affect responsibilities imposed by federal or other state law on a physician or other professional.

SUBCHAPTER F. FAMILY-BASED ALTERNATIVES FOR CHILDREN

Revised Law

Sec. 546.0251. DEFINITIONS. In this subchapter:

(1) "Child" means an individual younger than 22 years of age who:

(A) has a physical or developmental disability; or

(B) is medically fragile.

(2) "Family-based alternative" means a family setting in which the family provider or providers are specially trained to provide support and in-home care to children with disabilities or children who are medically fragile.

(3) "Family-based alternatives system" means the system of family-based alternatives required under this subchapter.

(4) "Institution" means any congregate care facility, including:

(A) a nursing facility;

(B) an ICF-IID;

(C) a group home operated by the commission; and

(D) a general residential operation for children with an intellectual disability that the commission licenses.

(5) "Waiver services" means services provided under:

(A) the medically dependent children (MDCP) waiver program;

(B) the community living assistance and support services (CLASS) waiver program;

(C) the home and community-based services (HCS)

waiver program;

(D) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(E) any other Section 1915(c) waiver program that provides long-term care services to children. (Gov. Code, Sec. 531.060(c); New.)

Source Law

(c) In this section:

(1) "Child" means a person younger than 22 years of age who has a physical or developmental disability or who is medically fragile.

(2) "Family-based alternative" means a family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(3) "Institution" means any congregate care facility, including:

(A) a nursing facility;

(B) an ICF-IID, as defined by Section 531.002, Health and Safety Code;

(C) a group home operated by the Department of Aging and Disability Services; and

(D) a general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services.

(4) "Waiver services" means services provided under:

(A) the Medically Dependent Children Program (MDCP);

(B) the Community Living Assistance and Support Services (CLASS) waiver program;

(C) the Home and Community-based Services (HCS) waiver program;

(D) the Deaf Blind with Multiple Disabilities (DBMD) waiver program; and

(E) any other Section 1915(c) waiver program that provides long-term care services for children.

Revisor's Note

(1) Section 531.060(c), Government Code, provides definitions for "this section." The revised law substitutes "this subchapter" for "this section" because the provisions of Section 531.060 are revised as Subchapter F of this chapter. Throughout this subchapter, in this and similar contexts, the revised law is drafted accordingly.

(2) The revised law adds the definition of "family-based alternatives system" for drafting

convenience and to avoid frequent, unnecessary repetition of the substance of the definition.

(3) Section 531.060(c)(4)(A), Government Code, refers to the "Medically Dependent Children Program (MDCP)." The revised law substitutes "medically dependent children (MDCP) waiver program" for "Medically Dependent Children Program (MDCP)" because that is the more commonly used name for the waiver program.

Revised Law

Sec. 546.0252. FAMILY-BASED ALTERNATIVES SYSTEM: PURPOSE, IMPLEMENTATION, AND ADMINISTRATION. (a) The purpose of the family-based alternatives system is to further this state's policy of providing for a child's basic needs for safety, security, and stability by ensuring that a child becomes a part of a successful permanent family as soon as possible.

(b) In achieving the purpose described by Subsection (a), the family-based alternatives system is intended to operate in a manner that recognizes that parents are a valued and integral part of the process established under the system. The system must:

(1) encourage parents to participate in all decisions affecting their children; and

(2) respect the authority of parents, other than parents whose parental rights have been terminated, to make decisions regarding their children.

(c) The commission shall begin implementing the family-based alternatives system in areas of this state with high numbers of children who reside in institutions.

(d) The family-based alternatives system may be administered in cooperation with public and private entities. (Gov. Code, Secs. 531.060(a), (b), (f), (h).)

Source Law

Sec. 531.060. FAMILY-BASED ALTERNATIVES FOR CHILDREN. (a) The purpose of the system of family-based alternatives required by this section is

to further the state's policy of providing for a child's basic needs for safety, security, and stability through ensuring that a child becomes a part of a successful permanent family as soon as possible.

(b) In achieving the purpose described by Subsection (a), the system is intended to be operated in a manner that recognizes that parents are a valued and integral part of the process established under the system. The system shall encourage parents to participate in all decisions affecting their children and shall respect the authority of parents, other than parents whose parental rights have been terminated, to make decisions regarding their children.

(f) The commission shall begin implementation of the system in areas of this state with high numbers of children who reside in institutions.

(h) The system may be administered in cooperation with public and private entities.

Revised Law

Sec. 546.0253. FAMILY-BASED ALTERNATIVES SYSTEM DESIGN REQUIREMENTS. (a) The family-based alternatives system must provide for:

(1) recruiting and training alternative families to provide services for children;

(2) comprehensively assessing each child in need of services and each alternative family available to provide services, as necessary to identify the most appropriate alternative family for the child's placement;

(3) providing to a child's parents or guardian information regarding the availability of a family-based alternative;

(4) identifying each child residing in an institution and offering support services, including waiver services, that would enable the child to return to the child's birth family or be placed in a family-based alternative; and

(5) determining through a child's permanency plan other circumstances in which the child must be offered waiver services, including circumstances in which changes in an institution's status affect the child's placement or the quality of services the child receives.

(b) In complying with the requirement imposed by Subsection (a)(3), the commission shall ensure that the procedures for

providing information to parents or a guardian permit and encourage the participation of an individual who is not affiliated with the institution in which the child resides or with an institution in which the child could be placed.

(c) In designing the family-based alternatives system, the commission shall consider and, when appropriate, incorporate current research and recommendations developed by other public and private entities involved in analyzing public policy relating to children residing in institutions. (Gov. Code, Secs. 531.060(i), (j), (m).)

Source Law

(i) The system must provide for:

(1) recruiting and training alternative families to provide services for children;

(2) comprehensively assessing each child in need of services and each alternative family available to provide services, as necessary to identify the most appropriate alternative family for placement of the child;

(3) providing to a child's parents or guardian information regarding the availability of a family-based alternative;

(4) identifying each child residing in an institution and offering support services, including waiver services, that would enable the child to return to the child's birth family or be placed in a family-based alternative; and

(5) determining through a child's permanency plan other circumstances in which the child must be offered waiver services, including circumstances in which changes in an institution's status affect the child's placement or the quality of services received by the child.

(j) In complying with the requirement imposed by Subsection (i)(3), the commission shall ensure that the procedures for providing information to parents or a guardian permit and encourage the participation of an individual who is not affiliated with the institution in which the child resides or with an institution in which the child could be placed.

(m) In designing the system, the commission shall consider and, when appropriate, incorporate current research and recommendations developed by other public and private entities involved in analyzing public policy relating to children residing in institutions.

Revised Law

Sec. 546.0254. MEDICAID WAIVER PROGRAM ALIGNMENT. As necessary to implement this subchapter, the commission shall:

(1) ensure that an appropriate number of openings for

waiver services that become available as a result of funding for transferring individuals with disabilities into community-based services are made available to both children and adults;

(2) ensure that service definitions applicable to waiver services are modified as necessary to permit the provision of waiver services through family-based alternatives;

(3) ensure that procedures are implemented for making a level of care determination for each child and identifying the most appropriate waiver service for the child, including procedures under which the commission's director of long-term care, after considering any preference of the child's birth family or alternative family, resolves disputes among agencies about the most appropriate waiver service; and

(4) require that the health and human services agency responsible for providing a specific waiver service to a child also assume responsibility for identifying any necessary transition activities or services. (Gov. Code, Sec. 531.060(n).)

Source Law

(n) As necessary to implement this section, the commission shall:

(1) ensure that an appropriate number of openings for waiver services that become available as a result of funding for the purpose of transferring persons with disabilities into community-based services are made available to both children and adults;

(2) ensure that service definitions applicable to waiver services are modified as necessary to permit the provision of waiver services through family-based alternatives;

(3) ensure that procedures are implemented for making a level of care determination for each child and identifying the most appropriate waiver service for the child, including procedures under which the director of long-term care for the commission, after considering any preference of the child's birth family or alternative family, resolves disputes among agencies about the most appropriate waiver service; and

(4) require that the health and human services agency responsible for providing a specific waiver service to a child also assume responsibility for identifying any necessary transition activities or services.

Revised Law

Sec. 546.0255. COMMUNITY ORGANIZATION ELIGIBILITY;

CONTRACT AND REQUIREMENTS. (a) The commission shall contract with a community organization, including a faith-based community organization, or a nonprofit organization to develop and implement a family-based alternatives system under which a child who cannot reside with the child's birth family may receive necessary services in a family-based alternative instead of an institution. For purposes of this subsection, a community organization, including a faith-based community organization, or a nonprofit organization does not include:

(1) a governmental entity; or

(2) a quasi-governmental entity to which a state agency delegates authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

(b) To be eligible for the contract under Subsection (a), an organization must possess knowledge regarding the support needs of children with disabilities and their families.

(c) The contracted organization may subcontract for one or more components of implementing the family-based alternatives system with:

(1) community organizations, including faith-based community organizations;

(2) nonprofit organizations;

(3) governmental entities; or

(4) quasi-governmental entities described by Subsection (a)(2). (Gov. Code, Secs. 531.060(d), (e).)

Source Law

(d) The commission shall contract with a community organization, including a faith-based community organization, or a nonprofit organization for the development and implementation of a system under which a child who cannot reside with the child's birth family may receive necessary services in a family-based alternative instead of an institution. To be eligible for the contract under this subsection, an organization must possess knowledge regarding the support needs of children with disabilities and their families. For purposes of this subsection, a community organization, including a faith-based community organization, or a nonprofit organization

does not include:

(1) any governmental entity; or

(2) any quasi-governmental entity to which a state agency delegates its authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

(e) The contractor may subcontract for one or more components of implementation of the system with:

(1) community organizations, including faith-based community organizations;

(2) nonprofit organizations;

(3) governmental entities; or

(4) quasi-governmental entities to which state agencies delegate authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

Revised Law

Sec. 546.0256. PLACEMENT OPTIONS. (a) In placing a child in a family-based alternative, the family-based alternatives system may use a variety of placement options, including a shared parenting arrangement between the alternative family and the child's birth family. Regardless of the option used, a family-based alternative placement must be designed as a long-term arrangement, except in cases in which the child's birth family chooses to return the child to their home.

(b) Adoption of the child by the child's alternative family is an available option in cases in which the child's birth family's parental rights have been terminated. (Gov. Code, Sec. 531.060(k).)

Source Law

(k) In placing a child in a family-based alternative, the system may use a variety of placement options, including an arrangement in which shared parenting occurs between the alternative family and the child's birth family. Regardless of the option used, a family-based alternative placement must be designed to be a long-term arrangement, except in cases in which the child's birth family chooses to return the child to their home. In cases in which the birth family's parental rights have been terminated, adoption of the child by the child's alternative family is an available option.

Revised Law

Sec. 546.0257. AGENCY COOPERATION. Each affected health and human services agency shall:

(1) cooperate with the contracted organization and any subcontractors; and

(2) take all action necessary to implement the

family-based alternatives system and comply with the requirements of this subchapter. (Gov. Code, Sec. 531.060(g) (part).)

Source Law

> (g) Each affected health and human services agency shall cooperate with the contractor and any subcontractors and take all action necessary to implement the system and comply with the requirements of this section. . . .

Revised Law

Sec. 546.0258. DISPUTE RESOLUTION. The commission has final authority to make any decisions and resolve any disputes regarding the family-based alternatives system. (Gov. Code, Sec. 531.060(g) (part).)

Source Law

> (g) . . . The commission has final authority to make any decisions and resolve any disputes regarding the system.

Revised Law

Sec. 546.0259. GIFTS, GRANTS, AND DONATIONS. The commission or the contracted organization may solicit and accept gifts, grants, and donations to support the family-based alternatives system's functions under this subchapter. (Gov. Code, Sec. 531.060(l).)

Source Law

> (l) The commission or the contractor may solicit and accept gifts, grants, and donations to support the system's functions under this section.

Revised Law

Sec. 546.0260. ANNUAL REPORT. Not later than January 1 of each year, the commission shall report to the legislature on the implementation of the family-based alternatives system. The report must include a statement of:

(1) the number of children currently receiving care in an institution;

(2) the number of children placed in a family-based alternative under the system during the preceding year;

(3) the number of children who left an institution during the preceding year under an arrangement other than a

family-based alternative under the system or for another reason unrelated to the availability of a family-based alternative under the system;

(4) the number of children waiting for an available placement in a family-based alternative under the system; and

(5) the number of alternative families trained and available to accept placement of a child under the system. (Gov. Code, Sec. 531.060(o).)

Source Law

(o) Not later than January 1 of each year, the commission shall report to the legislature on the implementation of the system. The report must include a statement of:

(1) the number of children currently receiving care in an institution;

(2) the number of children placed in a family-based alternative under the system during the preceding year;

(3) the number of children who left an institution during the preceding year under an arrangement other than a family-based alternative under the system or for another reason unrelated to the availability of a family-based alternative under the system;

(4) the number of children waiting for an available placement in a family-based alternative under the system; and

(5) the number of alternative families trained and available to accept placement of a child under the system.

SUBCHAPTER G. LONG-TERM CARE INSTITUTIONS AND FACILITIES

Revised Law

Sec. 546.0301. PROCEDURES TO REVIEW CONDUCT RELATED TO CERTAIN INSTITUTIONS AND FACILITIES. The commission shall adopt procedures to review:

(1) citations or penalties assessed for a violation of a rule or law against an institution or facility licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, considering:

(A) the number of violations by geographic region;

(B) the patterns of violations in each region; and

(C) the outcomes following the assessment of a citation or penalty; and

(2) the performance of duties by employees and agents of a state agency responsible for licensing, inspecting, surveying, or investigating institutions and facilities licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, related to:

(A) complaints the commission receives; or

(B) any standards or rules violated by an employee or agent of a state agency. (Gov. Code, Sec. 531.056.)

Source Law

> Sec. 531.056. REVIEW OF SURVEY PROCESS IN CERTAIN INSTITUTIONS AND FACILITIES. (a) The commission shall adopt procedures to review:
>
> (1) citations or penalties assessed for a violation of a rule or law against an institution or facility licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, considering:
>
> (A) the number of violations by geographic region;
>
> (B) the patterns of violations in each region; and
>
> (C) the outcomes following the assessment of a penalty or citation; and
>
> (2) the performance of duties by employees and agents of a state agency responsible for licensing, inspecting, surveying, or investigating institutions and facilities licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, related to:
>
> (A) complaints received by the commission; or
>
> (B) any standards or rules violated by an employee or agent of a state agency.

Revised Law

Sec. 546.0302. ISSUANCE OF MATERIALS TO CERTAIN LONG-TERM CARE FACILITIES. The executive commissioner shall:

(1) review the commission's methods for issuing informational letters, policy updates, policy clarifications, and other related materials to an entity licensed under Chapter 103, Human Resources Code, or Chapter 242, 247, 248A, or 252, Health and Safety Code; and

(2) develop and implement more efficient methods to issue those materials, as appropriate. (Gov. Code, Sec. 531.0585.)

Source Law

> Sec. 531.0585. ISSUANCE OF MATERIALS TO CERTAIN LONG-TERM CARE FACILITIES. The executive commissioner shall review the commission's methods for issuing informational letters, policy updates, policy clarifications, and other related materials to an entity licensed under Chapter 103, Human Resources Code, or Chapter 242, 247, 248A, or 252, Health and Safety Code, and develop and implement more efficient methods to issue those materials as appropriate.

SUBCHAPTER H. INCENTIVE PAYMENT PROGRAM FOR CERTAIN NURSING FACILITIES

Revised Law

Sec. 546.0351. DEFINITIONS. In this subchapter:

(1) "Incentive payment program" means the program established under this subchapter.

(2) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term care services, as defined by Section 22.0011, Human Resources Code, to recipients. (Gov. Code, Sec. 531.912(a); New.)

Source Law

> Sec. 531.912. COMMON PERFORMANCE MEASUREMENTS AND PAY-FOR-PERFORMANCE INCENTIVES FOR CERTAIN NURSING FACILITIES. (a) In this section, "nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term care services, as defined by Section 22.0011, Human Resources Code, to Medicaid recipients.

Revisor's Note

(1) The revised law adds the definition of "incentive payment program" for drafting convenience and to avoid frequent, unnecessary repetition of the substance of the definition.

(2) Section 531.912, Government Code, refers to "Medicaid recipients." Throughout this chapter, the revised law substitutes "recipient" for the quoted language for clarity and consistency in the

terminology used within the chapter and because "recipient" is the defined term under Section 546.0001, which is applicable to the revised law.

Revised Law

Sec. 546.0352. INCENTIVE PAYMENT PROGRAM. (a) If feasible, the executive commissioner by rule may establish an incentive payment program for nursing facilities that choose to participate. The program must be designed to improve the quality of care and services provided to recipients.

(b) Subject to Section 546.0354, the incentive payment program may provide incentive payments in accordance with this section to encourage facilities to participate in the program.

(c) The executive commissioner may:

(1) determine the amount of any incentive payment under the incentive payment program; and

(2) enter into a contract with a qualified person, as the executive commissioner determines, for the following services related to the program:

(A) data collection;

(B) data analysis; and

(C) technical support. (Gov. Code, Secs. 531.912(b), (e).)

Source Law

(b) If feasible, the executive commissioner by rule may establish an incentive payment program for nursing facilities that choose to participate. The program must be designed to improve the quality of care and services provided to Medicaid recipients. Subject to Subsection (f), the program may provide incentive payments in accordance with this section to encourage facilities to participate in the program.

(e) The executive commissioner may:

(1) determine the amount of any incentive payment under the program; and

(2) enter into a contract with a qualified person, as determined by the executive commissioner, for the following services related to the program:

(A) data collection;

(B) data analysis; and

(C) technical support.

Revised Law

Sec. 546.0353. COMMON PERFORMANCE MEASURES. (a) In establishing an incentive payment program, the executive commissioner shall adopt common performance measures to be used in evaluating nursing facilities that are related to structure, process, and outcomes that positively correlate to nursing facility quality and improvement. The common performance measures:

(1) must be:

(A) recognized by the executive commissioner as valid indicators of the overall quality of care recipients receive; and

(B) designed to encourage and reward evidence-based practices among nursing facilities; and

(2) may include measures of:

(A) quality of care, as determined by clinical performance ratings published by the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency;

(B) direct-care staff retention and turnover;

(C) recipient satisfaction, including the satisfaction of recipients who are short-term and long-term facility residents, and family satisfaction, as determined by the Consumer Assessment of Healthcare Providers and Systems Nursing Home Surveys relied on by the Centers for Medicare and Medicaid Services;

(D) employee satisfaction and engagement;

(E) the incidence of preventable acute care emergency room services use;

(F) regulatory compliance;

(G) level of person-centered care; and

(H) direct-care staff training, including a facility's use of independent distance learning programs for continuously training direct-care staff.

(b) The executive commissioner shall maximize the use of

available information technology and limit the number of performance measures adopted under this section to achieve administrative cost efficiency and avoid an unreasonable administrative burden on participating nursing facilities. (Gov. Code, Secs. 531.912(c), (d).)

Source Law

(c) In establishing an incentive payment program under this section, the executive commissioner shall, subject to Subsection (d), adopt common performance measures to be used in evaluating nursing facilities that are related to structure, process, and outcomes that positively correlate to nursing facility quality and improvement. The common performance measures:

(1) must be:

(A) recognized by the executive commissioner as valid indicators of the overall quality of care received by Medicaid recipients; and

(B) designed to encourage and reward evidence-based practices among nursing facilities; and

(2) may include measures of:

(A) quality of care, as determined by clinical performance ratings published by the federal Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency;

(B) direct-care staff retention and turnover;

(C) recipient satisfaction, including the satisfaction of recipients who are short-term and long-term residents of facilities, and family satisfaction, as determined by the Nursing Home Consumer Assessment of Healthcare Providers and Systems surveys relied upon by the federal Centers for Medicare and Medicaid Services;

(D) employee satisfaction and engagement;

(E) the incidence of preventable acute care emergency room services use;

(F) regulatory compliance;

(G) level of person-centered care; and

(H) direct-care staff training, including a facility's utilization of independent distance learning programs for the continuous training of direct-care staff.

(d) The executive commissioner shall maximize the use of available information technology and limit the number of performance measures adopted under Subsection (c) to achieve administrative cost efficiency and avoid an unreasonable administrative burden on participating nursing facilities.

Revisor's Note

Section 531.912(c)(2)(C), Government Code, refers to the "Nursing Home Consumer Assessment of Healthcare Providers and Systems surveys." The revised

law substitutes "Consumer Assessment of Healthcare Providers and Systems Nursing Home Surveys" for consistency in the terminology used within state law and by the federal government.

Revised Law

Sec. 546.0354. SUBJECT TO APPROPRIATIONS. The commission may make incentive payments under an incentive payment program only if money is appropriated for that purpose. (Gov. Code, Sec. 531.912(f).)

Source Law

(f) The commission may make incentive payments under the program only if money is appropriated for that purpose.

SUBCHAPTER I. MEDICAID GENERALLY

Revised Law

Sec. 546.0401. MEDICAID LONG-TERM CARE SYSTEM. (a) The commission shall ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds.

(b) The commission shall also make every effort to improve the quality of care for recipients of Medicaid long-term care services by:

(1) evaluating the need for expanding the provider base for consumer-directed services and, if the commission identifies a demand for that expansion, encouraging area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with the commission;

(2) ensuring that all recipients who reside in a nursing facility are provided information about end-of-life care options and the importance of planning for end-of-life care; and

(3) developing policies to encourage a recipient who resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an

appropriate continuum of care. (Gov. Code, Sec. 531.083.)

Source Law

> Sec. 531.083. MEDICAID LONG-TERM CARE SYSTEM. The commission shall ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds. The commission shall also make every effort to improve the quality of care for recipients of Medicaid long-term care services by:
>
> (1) evaluating the need for expanding the provider base for consumer-directed services and, if the commission identifies a demand for that expansion, encouraging area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with the Department of Aging and Disability Services;
>
> (2) ensuring that all recipients who reside in a nursing facility are provided information about end-of-life care options and the importance of planning for end-of-life care; and
>
> (3) developing policies to encourage a recipient who resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an appropriate continuum of care.

Revised Law

Sec. 546.0402. ADMINISTRATION AND DELIVERY OF CERTAIN WAIVER PROGRAMS; PUBLIC INPUT. (a) To the extent authorized by law, the commission shall make uniform the functions relating to the administration and delivery of Section 1915(c) waiver programs, including:

(1) rate-setting;

(2) the applicability and use of service definitions;

(3) quality assurance; and

(4) intake data elements.

(b) Subsection (a) does not apply to functions of a Section 1915(c) waiver program that is operated in conjunction with a federally funded state Medicaid program that is authorized under Section 1915(b) of the Social Security Act (42 U.S.C. Section 1396n(b)).

(c) The commission shall ensure that information on individuals seeking to obtain services from Section 1915(c) waiver programs is maintained in a single computerized database that is accessible to staff of each of the state agencies administering

those programs.

(d) In complying with the requirements of this section, the commission shall regularly consult with and obtain input from:

(1) consumers and family members;

(2) providers;

(3) advocacy groups;

(4) state agencies that administer a Section 1915(c) waiver program; and

(5) other interested persons. (Gov. Code, Secs. 531.0218, 531.02191.)

Source Law

Sec. 531.0218. LONG-TERM CARE MEDICAID PROGRAMS. (a) To the extent authorized by state and federal law, the commission shall make uniform the functions relating to the administration and delivery of Section 1915(c) waiver programs, including:

(1) rate-setting;

(2) the applicability and use of service definitions;

(3) quality assurance; and

(4) intake data elements.

(b) Subsection (a) does not apply to functions of a Section 1915(c) waiver program that is operated in conjunction with a federally funded program of the state under Medicaid that is authorized under Section 1915(b) of the federal Social Security Act (42 U.S.C. Section 1396n(b)).

(c) The commission shall ensure that information on individuals seeking to obtain services from Section 1915(c) waiver programs is maintained in a single computerized database that is accessible to staff of each of the state agencies administering those programs.

Sec. 531.02191. PUBLIC INPUT. In complying with the requirements of Section 531.0218, the commission shall regularly consult with and obtain input from:

(1) consumers and family members;

(2) providers;

(3) advocacy groups;

(4) state agencies that administer a Section 1915(c) waiver program; and

(5) other interested persons.

Revised Law

Sec. 546.0403. RECOVERY OF CERTAIN ASSISTANCE; MEDICAID ACCOUNT. (a) The executive commissioner shall ensure that Section 1917(b)(1) of the Social Security Act (42 U.S.C. Section 1396p(b)(1)) is implemented under Medicaid.

(b) The Medicaid account is an account in the general

revenue fund. Any funds recovered by implementing the provisions of Section 1917(b)(1) of the Social Security Act (42 U.S.C. Section 1396p(b)(1)) must be deposited in the Medicaid account. Money in the account may be appropriated only to fund long-term care, including community-based care and facility-based care. (Gov. Code, Sec. 531.077.)

Source Law

Sec. 531.077. RECOVERY OF CERTAIN ASSISTANCE. (a) The executive commissioner shall ensure that Medicaid implements 42 U.S.C. Section 1396p(b)(1).

(b) The Medicaid account is an account in the general revenue fund. Any funds recovered by implementing 42 U.S.C. Section 1396p(b)(1) shall be deposited in the Medicaid account. Money in the account may be appropriated only to fund long-term care, including community-based care and facility-based care.

SUBCHAPTER J. MEDICAID WAIVER PROGRAMS

Revised Law

Sec. 546.0451. COMPETITIVE AND INTEGRATED EMPLOYMENT INITIATIVE FOR CERTAIN RECIPIENTS; BIENNIAL REPORT. (a) This section applies to an individual receiving services under:

(1) any of the following Section 1915(c) waiver programs:

(A) the home and community-based services (HCS) waiver program;

(B) the Texas home living (TxHmL) waiver program;

(C) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) the community living assistance and support services (CLASS) waiver program; and

(2) the STAR+PLUS home and community-based services (HCBS) waiver program established under Section 1115, Social Security Act (42 U.S.C. Section 1315).

(b) The executive commissioner by rule shall develop a uniform process that complies with the policy adopted under Section 546.0003 to:

(1) assess the goals of and competitive and integrated

employment opportunities and related employment services available to an individual to whom this section applies; and

(2) use the identified goals and available opportunities and services to direct the individual's plan of care at the time the plan is developed or renewed.

(c) The entity responsible for developing and renewing the plan of care for an individual to whom this section applies shall use the uniform process developed under Subsection (b) to assess the individual's goals, opportunities, and services described by that subsection and incorporate those goals, opportunities, and services into the individual's plan of care.

(d) The executive commissioner by rule shall:

(1) identify strategies to increase the number of individuals receiving employment services from the Texas Workforce Commission or through the waiver program in which an individual is enrolled;

(2) determine a reasonable number of individuals who indicate a desire to work to receive employment services and ensure those individuals:

(A) have received employment services during the state fiscal biennium ending August 31, 2023, or during the period beginning September 1, 2023, and ending December 31, 2023, from the Texas Workforce Commission or through the waiver program in which an individual is enrolled; or

(B) are receiving employment services on December 31, 2023, from the Texas Workforce Commission or through the waiver program in which an individual is enrolled; and

(3) ensure each individual who indicates a desire to work is referred to receive employment services from the Texas Workforce Commission or through the waiver program in which the individual is enrolled.

(e) Not later than December 31 of each even-numbered year, the executive commissioner shall prepare and submit to the governor, lieutenant governor, speaker of the house of

representatives, and legislature a written report that outlines:

(1) the number of individuals to whom this section applies who are receiving employment services in accordance with rules adopted under this section;

(2) whether the employment services described by Subdivision (1) are provided by the Texas Workforce Commission, through the waiver program in which an individual is enrolled, or both; and

(3) the number of individuals to whom this section applies who have obtained competitive and integrated employment, categorized by waiver program and, if applicable, an individual's level of care. (Gov. Code, Sec. 531.02448.)

Source Law

Sec. 531.02448. COMPETITIVE AND INTEGRATED EMPLOYMENT INITIATIVE FOR CERTAIN MEDICAID RECIPIENTS. (a) This section applies to an individual receiving services under:

(1) any of the following waiver programs established under Section 1915(c), Social Security Act (42 U.S.C. Section 1396n(c)):

(A) the home and community-based services (HCS) waiver program;

(B) the Texas home living (TxHmL) waiver program;

(C) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) the community living assistance and support services (CLASS) waiver program; and

(2) the STAR+PLUS home and community-based services (HCBS) waiver program established under Section 1115, Social Security Act (42 U.S.C. Section 1315).

(b) The executive commissioner by rule shall develop a uniform process that complies with the policy adopted under Section 531.02447 to:

(1) assess the goals of and competitive and integrated employment opportunities and related employment services available to an individual to whom this section applies; and

(2) use the identified goals and available opportunities and services to direct the individual's plan of care at the time the plan is developed or renewed.

(c) The entity responsible for the development and renewal of the plan of care for an individual to whom this section applies shall use the uniform process the executive commissioner develops to assess the individual's goals, opportunities, and services described by Subsection (b) and incorporate those goals, opportunities, and services into the plan of care.

(d) The executive commissioner by rule shall:

(1) identify strategies to increase the number of individuals who are receiving employment

services from the Texas Workforce Commission or through the waiver program in which an individual is enrolled;

(2) determine a reasonable number of individuals who indicate a desire to work to receive employment services and ensure those individuals:

(A) have received employment services during the state fiscal biennium ending August 31, 2023, or during the period beginning September 1, 2023, and ending December 31, 2023, from the Texas Workforce Commission or through the waiver program in which an individual is enrolled; or

(B) are receiving employment services on December 31, 2023, from the Texas Workforce Commission or through the waiver program in which an individual is enrolled; and

(3) ensure each individual who indicates a desire to work is referred to receive employment services from the Texas Workforce Commission or through the waiver program in which the individual is enrolled.

(e) Not later than December 31 of each even-numbered year, the executive commissioner shall prepare and submit to the governor, lieutenant governor, speaker of the house of representatives, and legislature a written report that outlines:

(1) the number of individuals to whom this section applies who are receiving employment services in accordance with rules adopted under this section;

(2) whether the employment services described by Subdivision (1) are provided by the Texas Workforce Commission, through the waiver program in which an individual is enrolled, or both; and

(3) the number of individuals to whom this section applies who have obtained competitive and integrated employment, categorized by waiver program and, if applicable, an individual's level of care.

Revised Law

Sec. 546.0452. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER PROGRAMS. (a) In this section, "legally authorized representative" has the meaning assigned by Section 546.0101.

(b) The commission shall consider developing risk management criteria under home and community-based services waiver programs designed to allow individuals eligible to receive services under the programs to assume greater choice and responsibility over the services and supports the individuals receive.

(c) The commission shall ensure that any risk management criteria developed include:

(1) a requirement that if an individual who will be provided services and supports has a legally authorized representative, the representative is involved in determining which services and supports the individual will receive; and

(2) a requirement that if services or supports are declined, the decision to decline is clearly documented. (Gov. Code, Sec. 531.0515.)

Source Law

Sec. 531.0515. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER PROGRAMS. (a) In this section, "legally authorized representative" has the meaning assigned by Section 531.051.

(b) The commission shall consider developing risk management criteria under home and community-based services waiver programs designed to allow individuals eligible to receive services under the programs to assume greater choice and responsibility over the services and supports the individuals receive.

(c) The commission shall ensure that any risk management criteria developed under this section include:

(1) a requirement that if an individual to whom services and supports are to be provided has a legally authorized representative, the representative be involved in determining which services and supports the individual will receive; and

(2) a requirement that if services or supports are declined, the decision to decline is clearly documented.

Revisor's Note

Section 531.0515(a), Government Code, defines "legally authorized representative" as having the meaning assigned by Section 531.051, Government Code. The substantive provision of Section 531.051 defining "legally authorized representative" is revised in this chapter as part of Section 546.0101. The revised law is drafted accordingly.

Revised Law

Sec. 546.0453. PROTOCOL FOR MAINTAINING CONTACT INFORMATION OF INDIVIDUALS INTERESTED IN MEDICAID WAIVER PROGRAMS. The commission shall develop a protocol in the office of the ombudsman to improve the capture and updating of contact information for an individual who contacts the office of the ombudsman regarding Medicaid waiver programs or services. (Gov. Code, Sec. 531.0501(d).)

Source Law

(d) The commission shall develop a protocol in the office of the ombudsman to improve the capture and

updating of contact information for an individual who contacts the office of the ombudsman regarding Medicaid waiver programs or services.

Revised Law

Sec. 546.0454. INTEREST LIST MANAGEMENT FOR CERTAIN MEDICAID WAIVER PROGRAMS. (a) This section applies only to the following waiver programs:

(1) the community living assistance and support services (CLASS) waiver program;

(2) the home and community-based services (HCS) waiver program;

(3) the deaf-blind with multiple disabilities (DBMD) waiver program;

(4) the Texas home living (TxHmL) waiver program;

(5) the medically dependent children (MDCP) waiver program; and

(6) the STAR+PLUS home and community-based services (HCBS) program.

(b) The commission, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052, the state Medicaid managed care advisory committee, and interested stakeholders, shall develop a questionnaire to be completed by or on behalf of an individual who requests to be placed on or is currently on an interest list for a waiver program.

(c) The questionnaire developed under Subsection (b) must, at a minimum, request the following information about an individual seeking or receiving services under a waiver program:

(1) contact information for the individual or the individual's parent or other legally authorized representative;

(2) the individual's general demographic information;

(3) the individual's living arrangement;

(4) the types of assistance the individual requires;

(5) the individual's current caregiver supports and circumstances that may cause the individual to lose those supports;

and

(6) when the delivery of services under a waiver program should begin to ensure the individual's health and welfare and that the individual receives services and supports in the least restrictive setting possible.

(d) If an individual is on a waiver program's interest list and the individual or the individual's parent or other legally authorized representative does not respond to a written or verbal request made by the commission to update information concerning the individual or otherwise fails to maintain contact with the commission, the commission:

(1) shall designate the individual's status on the interest list as inactive until the individual or the individual's parent or other legally authorized representative notifies the commission that the individual is still interested in receiving services under the waiver program; and

(2) at the time the individual or the individual's parent or other legally authorized representative provides notice to the commission under Subdivision (1), shall designate the individual's status on the interest list as active and restore the individual to the position on the list that corresponds with the date the individual was initially placed on the list.

(e) The commission's designation of an individual's status on an interest list as inactive under Subsection (d) may not result in the removal of the individual from that list or any other waiver program interest list.

(f) Not later than September 1 of each year, the commission shall provide to the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052, or, if that advisory committee is abolished, an appropriate stakeholder advisory committee, as determined by the executive commissioner, the number of individuals, including individuals whose status is designated as inactive by the commission, who are on an interest list to receive services under a

waiver program. (Gov. Code, Sec. 531.06011.)

Source Law

Sec. 531.06011. CERTAIN MEDICAID WAIVER PROGRAMS: INTEREST LIST MANAGEMENT. (a) This section applies only with respect to the following waiver programs:

(1) the community living assistance and support services (CLASS) waiver program;

(2) the home and community-based services (HCS) waiver program;

(3) the deaf-blind with multiple disabilities (DBMD) waiver program;

(4) the Texas home living (TxHmL) waiver program;

(5) the medically dependent children (MDCP) waiver program; and

(6) the STAR+PLUS home and community-based services (HCBS) program.

(b) The commission, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, the state Medicaid managed care advisory committee, and interested stakeholders, shall develop a questionnaire to be completed by or on behalf of an individual who requests to be placed on or is currently on an interest list for a waiver program.

(c) The questionnaire developed under Subsection (b) must, at a minimum, request the following information about an individual seeking or receiving services under a waiver program:

(1) contact information for the individual or the individual's parent or other legally authorized representative;

(2) the individual's general demographic information;

(3) the individual's living arrangement;

(4) the types of assistance the individual requires;

(5) the individual's current caregiver supports and circumstances that may cause the individual to lose those supports; and

(6) when the delivery of services under a waiver program should begin to ensure the individual's health and welfare and that the individual receives services and supports in the least restrictive setting possible.

(d) If an individual is on a waiver program's interest list and the individual or the individual's parent or other legally authorized representative does not respond to a written or verbal request made by the commission to update information concerning the individual or otherwise fails to maintain contact with the commission, the commission:

(1) shall designate the individual's status on the interest list as inactive until the individual or the individual's parent or other legally authorized representative notifies the commission that the individual is still interested in receiving services under the waiver program; and

(2) at the time the individual or the individual's parent or other legally authorized representative provides notice to the commission under Subdivision (1), shall designate the individual's status on the interest list as active and restore the individual to the position on the list that

corresponds with the date the individual was initially placed on the list.

(e) The commission's designation of an individual's status on an interest list as inactive under Subsection (d) may not result in the removal of the individual from that list or any other waiver program interest list.

(f) Not later than September 1 of each year, the commission shall provide to the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, or, if that advisory committee is abolished, an appropriate stakeholder advisory committee, as determined by the executive commissioner, the number of individuals, including individuals whose status is designated as inactive by the commission, who are on an interest list to receive services under a waiver program.

Revised Law

Sec. 546.0455. INTEREST LIST MANAGEMENT FOR CERTAIN CHILDREN ENROLLED IN MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM. (a) This section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) A legally authorized representative of a child who is notified by the commission that the child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forgo the hearing, may request that the commission:

(1) return the child to the interest list for the program unless the child is ineligible due to the child's age; or

(2) place the child on the interest list for another Section 1915(c) waiver program.

(c) At the time a child's legally authorized representative makes a request under Subsection (b), the commission shall:

(1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically

dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other individuals on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection (a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other individuals on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other individuals on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date the child was initially placed on the interest list for the other waiver program.

(d) Notwithstanding Subsection (c)(1)(B) or (c)(2), a child may be placed on an interest list for a Section 1915(c) waiver program in the position described by those subsections only if the child has previously been placed on the interest list for that waiver program.

(e) At the time the commission provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forgo the hearing, the commission shall inform the representative in writing about:

(1) the options under this section for placing the

child on an interest list; and

(2) the process for applying for the Medicaid buy-in program for children with disabilities implemented under Section 532.0353. (Gov. Code, Sec. 531.0601.)

Source Law

Sec. 531.0601. LONG-TERM CARE SERVICES WAIVER PROGRAM INTEREST LISTS. (a) This section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) A legally authorized representative of a child who is notified by the commission that the child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, may request that the commission:

(1) return the child to the interest list for the program unless the child is ineligible due to the child's age; or

(2) place the child on the interest list for another Section 1915(c) waiver program.

(c) At the time a child's legally authorized representative makes a request under Subsection (b), the commission shall:

(1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection (a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date the child was initially placed on the interest list for the other waiver program.

(d) Notwithstanding Subsection (c)(1)(B) or (c)(2), a child may be placed on an interest list for a Section 1915(c) waiver program in the position

described by those subsections only if the child has previously been placed on the interest list for that waiver program.

(e) At the time the commission provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, the commission shall inform the representative in writing about:

(1) the options under this section for placing the child on an interest list; and

(2) the process for applying for the Medicaid buy-in program for children with disabilities implemented under Section 531.02444.

Revised Law

Sec. 546.0456. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM; INTEREST LIST PLACEMENT. (a) Notwithstanding any other law and to the extent allowed by federal law, in determining a child's eligibility for the medically dependent children (MDCP) waiver program, the deaf-blind with multiple disabilities (DBMD) waiver program, or a "Money Follows the Person" demonstration project, the commission shall consider whether the child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or

(2) receives Medicaid hospice or palliative care services.

(b) If the commission determines a child is eligible for a waiver program under Subsection (a), the child's enrollment in the applicable program is contingent on the availability of a slot in the program. If a slot is not immediately available, the commission shall place the child in the first position on the interest list for the medically dependent children (MDCP) waiver program or deaf-blind with multiple disabilities (DBMD) waiver program, as applicable. (Gov. Code, Sec. 531.0603.)

Source Law

Sec. 531.0603. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM. (a)

Notwithstanding any other law and to the extent allowed by federal law, in determining eligibility of a child for the medically dependent children (MDCP) waiver program, the deaf-blind with multiple disabilities (DBMD) waiver program, or a "Money Follows the Person" demonstration project, the commission shall consider whether the child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or

(2) receives Medicaid hospice or palliative care services.

(b) If the commission determines a child is eligible for a waiver program under Subsection (a), the child's enrollment in the applicable program is contingent on the availability of a slot in the program. If a slot is not immediately available, the commission shall place the child in the first position on the interest list for the medically dependent children (MDCP) waiver program or deaf-blind with multiple disabilities (DBMD) waiver program, as applicable.

SUBCHAPTER K. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM

Revised Law

Sec. 546.0501. LIMITATION ON NURSING FACILITY LEVEL OF CARE REQUIREMENT. To the extent allowed by federal law, the commission may not require that a child reside in a nursing facility for an extended period of time to meet the nursing facility level of care required for the child to be determined eligible for the medically dependent children (MDCP) waiver program. (Gov. Code, Sec. 531.0604.)

Source Law

Sec. 531.0604. MEDICALLY DEPENDENT CHILDREN PROGRAM ELIGIBILITY REQUIREMENTS; NURSING FACILITY LEVEL OF CARE. To the extent allowed by federal law, the commission may not require that a child reside in a nursing facility for an extended period of time to meet the nursing facility level of care required for the child to be determined eligible for the medically dependent children (MDCP) waiver program.

Revised Law

Sec. 546.0502. CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections 546.0102(b) and 546.0103(1), a consumer direction model implemented under Subchapter C, including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program must allow for the delivery of all services and supports available under that program through consumer direction. (Gov. Code, Sec.

531.0511.)

Source Law

> Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER PROGRAM: CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections 531.051(c)(1) and (d), a consumer direction model implemented under Section 531.051, including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program must allow for the delivery of all services and supports available under that program through consumer direction.

Revised Law

Sec. 546.0503. ASSESSMENTS AND REASSESSMENTS. (a) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides for review the results of the initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall ensure that providing the results does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services.

(b) The commission shall require the signature of a parent or legally authorized representative to verify the parent's or representative's receipt of the results of the initial assessment or reassessment from the care coordinator. A Medicaid managed care organization may not delay the delivery of care pending the signature.

(c) The commission shall provide to a parent or legally authorized representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.

(d) This section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal

process, the Medicaid fair hearing process, or the external medical review process. (Gov. Code, Sec. 531.0602.)

Source Law

> Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM ASSESSMENTS AND REASSESSMENTS. (a) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides the results of the initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver program for review. The commission shall ensure the provision of the results does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services.
>
> (b) The commission shall require the parent's or representative's signature to verify the parent or representative received the results of the initial assessment or reassessment from the care coordinator under Subsection (a). A Medicaid managed care organization may not delay the delivery of care pending the signature.
>
> (c) The commission shall provide a parent or representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.
>
> (d) This section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal process, the Medicaid fair hearing process, or the external medical review process.

Revised Law

Sec. 546.0504. QUALITY MONITORING BY EXTERNAL QUALITY REVIEW ORGANIZATION. The commission, based on the state's external quality review organization's initial report on the STAR Kids managed care program, shall determine whether the findings of the report necessitate additional data and research to improve the program. If the commission determines additional data and research are needed, the commission, through the external quality review organization, may:

(1) conduct annual surveys of recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;

(2) conduct annual focus groups with recipients

described by Subdivision (1) or their representatives on issues identified through:

(A) the Consumer Assessment of Healthcare Providers and Systems;

(B) other external quality review organization activities; or

(C) stakeholders; and

(3) in consultation with the STAR Kids Managed Care Advisory Committee and as frequently as feasible, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as the collaborative innovation improvement network. (Gov. Code, Sec. 531.06021(a).)

Source Law

Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM QUALITY MONITORING; REPORT. (a) The commission, based on the state's external quality review organization's initial report on the STAR Kids managed care program, shall determine whether the findings of the report necessitate additional data and research to improve the program. If the commission determines additional data and research are needed, the commission, through the external quality review organization, may:

(1) conduct annual surveys of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;

(2) conduct annual focus groups with recipients described by Subdivision (1) or their representatives on issues identified through:

(A) the Consumer Assessment of Healthcare Providers and Systems;

(B) other external quality review organization activities; or

(C) stakeholders, including the STAR Kids Managed Care Advisory Committee described by Section 533.00254; and

(3) in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254 and as frequently as feasible, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as the collaborative innovation improvement network.

Revisor's Note

Sections 531.06021(a)(2)(C) and (a)(3), Government Code, refer to the STAR Kids Managed Care Advisory Committee "described by Section 533.00254." The revised law omits the reference to the provision

establishing the committee because that provision expired December 31, 2023, which was prior to the effective date of the revision.

Revised Law

Sec. 546.0505. QUARTERLY REPORT. Not later than the 30th day after the last day of each state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for recipients receiving benefits under the medically dependent children (MDCP) waiver program:

(1) enrollment in the Medicaid buy-in for children program implemented under Section 532.0353;

(2) requests relating to interest list placements under Section 546.0455;

(3) use of the Medicaid escalation help line established under Subchapter R, Chapter 540, if the help line was operational during the applicable state fiscal quarter;

(4) use of, requests for, and outcomes of the external medical review procedure established under Section 532.0404; and

(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition. (Gov. Code, Sec. 531.06021(b).)

Source Law

(b) Not later than the 30th day after the last day of each state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program:

(1) enrollment in the Medicaid buy-in for children program implemented under Section 531.02444;

(2) requests relating to interest list placements under Section 531.0601;

(3) use of the Medicaid escalation help line established under Section 533.00253, if the help line was operational during the applicable state fiscal quarter;

(4) use of, requests for, and outcomes of the external medical review procedure established under Section 531.024164; and

(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition.

Revisor's Note

Section 531.06021(b)(3), Government Code, refers to the Medicaid escalation help line established under Section 533.00253, Government Code. The provisions of Section 533.00253 are revised in this subtitle as Subchapter R, Chapter 540, and the revised law is drafted accordingly.

SUBCHAPTER L. QUALITY ASSURANCE FEE PROGRAM

Revised Law

Sec. 546.0551. QUALITY ASSURANCE FEE FOR CERTAIN MEDICAID WAIVER PROGRAM SERVICES. (a) In this section, "gross receipts" means money received as compensation for services under an intermediate care facility for individuals with an intellectual disability waiver program, such as a home and community services waiver or a community living assistance and support services waiver. The term does not include:

(1) a charitable contribution;

(2) revenues received for services or goods other than waivers; or

(3) any money received from consumers or their families as reimbursement for services or goods not normally covered under a waiver program.

(b) The executive commissioner by rule shall modify the quality assurance fee program under Subchapter H, Chapter 252, Health and Safety Code, by providing for a quality assurance fee program that imposes a quality assurance fee on persons providing services under a home and community services waiver or a community living assistance and support services waiver.

(c) The executive commissioner shall establish the fee at an

amount that will produce annual revenues of not more than six percent of the total annual gross receipts in this state.

(d) The executive commissioner shall adopt rules governing:

(1) the reporting required to compute and collect the fee and the manner and times of collecting the fee; and

(2) the administration of the fee, including the imposition of penalties for a violation of the rules.

(e) Fees collected under this section must be deposited in the waiver program quality assurance fee account. (Gov. Code, Sec. 531.078.)

Source Law

Sec. 531.078. QUALITY ASSURANCE FEES ON CERTAIN WAIVER PROGRAM SERVICES. (a) In this section, "gross receipts" means money received as compensation for services under an intermediate care facility for individuals with an intellectual disability waiver program such as a home and community services waiver or a community living assistance and support services waiver. The term does not include a charitable contribution, revenues received for services or goods other than waivers, or any money received from consumers or their families as reimbursement for services or goods not normally covered by the waivers.

(b) The executive commissioner by rule shall modify the quality assurance fee program under Subchapter H, Chapter 252, Health and Safety Code, by providing for a quality assurance fee program that imposes a quality assurance fee on persons providing services under a home and community services waiver or a community living assistance and support services waiver.

(c) The executive commissioner shall establish the fee at an amount that will produce annual revenues of not more than six percent of the total annual gross receipts in this state.

(d) The executive commissioner shall adopt rules governing:

(1) the reporting required to compute and collect the fee and the manner and times of collecting the fee; and

(2) the administration of the fee, including the imposition of penalties for a violation of the rules.

(e) Fees collected under this section shall be deposited in the waiver program quality assurance fee account.

Revised Law

Sec. 546.0552. WAIVER PROGRAM QUALITY ASSURANCE FEE ACCOUNT. (a) The waiver program quality assurance fee account is a dedicated account in the general revenue fund. The account is exempt from the application of Section 403.095.

(b) The account consists of fees collected under Section 546.0551.

(c) Subject to legislative appropriation and state and federal law, money in the account may be appropriated only to the commission to:

(1) increase reimbursement rates paid under:

(A) the home and community services waiver program; or

(B) the community living assistance and support services (CLASS) waiver program; or

(2) offset allowable expenses under Medicaid. (Gov. Code, Sec. 531.079.)

Source Law

Sec. 531.079. WAIVER PROGRAM QUALITY ASSURANCE FEE ACCOUNT. (a) The waiver program quality assurance fee account is a dedicated account in the general revenue fund. The account is exempt from the application of Section 403.095.

(b) The account consists of fees collected under Section 531.078.

(c) Subject to legislative appropriation and state and federal law, money in the account may be appropriated only to the Department of Aging and Disability Services to increase reimbursement rates paid under the home and community services waiver program or the community living assistance and support services waiver program or to offset allowable expenses under Medicaid.

Revisor's Note

Section 531.079(c), Government Code, refers to the "community living assistance and support services waiver program." The revised law substitutes "community living assistance and support services (CLASS) waiver program" for "community living assistance and support services waiver program" for clarity and consistency in the terminology used within the Government Code.

Revised Law

Sec. 546.0553. REIMBURSEMENT UNDER CERTAIN MEDICAID WAIVER PROGRAMS. Subject to legislative appropriation and state and federal law, the commission shall use money from the waiver program

quality assurance fee account, together with any federal money available to match money from the account, to increase reimbursement rates paid under:

(1) the home and community services waiver program; or

(2) the community living assistance and support services (CLASS) waiver program. (Gov. Code, Sec. 531.080.)

Source Law

> Sec. 531.080. REIMBURSEMENT OF WAIVER PROGRAMS. Subject to legislative appropriation and state and federal law, the Department of Aging and Disability Services shall use money from the waiver program quality assurance fee account, together with any federal money available to match money from the account, to increase reimbursement rates paid under the home and community services waiver program or the community living assistance and support services waiver program.

Revised Law

Sec. 546.0554. INVALIDITY; FEDERAL MONEY. If any portion of Section 546.0551, 546.0552, or 546.0553 is held invalid by a final order of a court that is not subject to appeal, or if the commission determines that the imposition of the quality assurance fee and the expenditure of the money collected as provided by those sections will not entitle this state to receive additional federal money under Medicaid, the commission shall:

(1) stop collecting the quality assurance fee; and

(2) not later than the 30th day after the date the commission stops collecting the quality assurance fee, return any money collected under Section 546.0551, but not spent under Section 546.0553, to the persons who paid the fees in proportion to the total amount paid by those persons. (Gov. Code, Sec. 531.081.)

Source Law

> Sec. 531.081. INVALIDITY; FEDERAL FUNDS. If any portion of Sections 531.078-531.080 is held invalid by a final order of a court that is not subject to appeal, or if the commission determines that the imposition of the quality assurance fee and the expenditure of the money collected as provided by those sections will not entitle this state to receive additional federal money under Medicaid, the commission shall:
>
> (1) stop collection of the quality assurance fee; and
>
> (2) not later than the 30th day after the

date the collection of the quality assurance fee is stopped, return any money collected under Section 531.078, but not spent under Section 531.080, to the persons who paid the fees in proportion to the total amount paid by those persons.

Revised Law

Sec. 546.0555. EXPIRATION OF QUALITY ASSURANCE FEE PROGRAM. If Subchapter H, Chapter 252, Health and Safety Code, expires, this subchapter expires on the same date. (Gov. Code, Sec. 531.082.)

Source Law

Sec. 531.082. EXPIRATION OF QUALITY ASSURANCE FEE ON WAIVER PROGRAMS. If Subchapter H, Chapter 252, Health and Safety Code, expires, this section and Sections 531.078-531.081 expire on the same date.

SUBCHAPTER M. VOLUNTEER ADVOCATE PROGRAM FOR CERTAIN ELDERLY INDIVIDUALS

Revised Law

Sec. 546.0601. DEFINITIONS. In this subchapter:

(1) "Designated caregiver" means:

(A) a person designated as a caregiver by an elderly individual receiving services from or under the direction of the commission or a health and human services agency; or

(B) a court-appointed guardian of an elderly individual receiving services from or under the direction of the commission or a health and human services agency.

(2) "Elderly individual" means an individual who is at least 60 years of age.

(3) "Program" means the volunteer advocate program created under this subchapter for elderly individuals receiving services from or under the direction of the commission or a health and human services agency.

(4) "Volunteer advocate" means a person who successfully completes the volunteer advocate curriculum described by Section 546.0602(2). (Gov. Code, Sec. 531.057(a).)

Source Law

Sec. 531.057. VOLUNTEER ADVOCATE PROGRAM FOR THE ELDERLY. (a) In this section:

(1) "Designated caregiver" means:

(A) a person designated as a caregiver by an elderly individual receiving services

from or under the direction of the commission or a health and human services agency; or

(B) a court-appointed guardian of an elderly individual receiving services from or under the direction of the commission or a health and human services agency.

(2) "Elderly" means individuals who are at least 60 years of age.

(3) "Program" means the volunteer advocate program created under this section for the elderly receiving services from or under the direction of the commission or a health and human services agency.

(4) "Volunteer advocate" means a person who successfully completes the volunteer advocate curriculum described by Subsection (c)(2).

Revisor's Note

Section 531.057(a)(2), Government Code, provides a definition for "elderly." The revised law substitutes "elderly individual" for the defined term because it is clear from the context that the terms are synonymous and "elderly individual" is more commonly used throughout the section.

Revised Law

Sec. 546.0602. PROGRAM PRINCIPLES. The program must adhere to the following principles:

(1) the intent of the program is to evaluate, through the operation of pilot projects, whether providing the services of a trained volunteer advocate selected by an elderly individual or the individual's designated caregiver is effective in achieving the following goals:

(A) extend the time the elderly individual can remain in an appropriate home setting;

(B) maximize the efficiency of services delivered to the elderly individual by focusing on services needed to sustain family caregiving;

(C) protect the elderly individual by providing a knowledgeable third party to review the quality of care and services delivered to the individual and the care options available to the individual and the individual's family; and

(D) facilitate communication between the elderly individual or the individual's designated caregiver and providers

of health care and other services;

(2) a volunteer advocate curriculum must be maintained that incorporates best practices as determined and recognized by a professional organization recognized in the elder health care field;

(3) the use of pro bono assistance from qualified professionals must be maximized in modifying the volunteer advocate curriculum and the program;

(4) trainers must be certified on the ability to deliver training;

(5) training shall be offered through multiple community-based organizations; and

(6) participation in the program is voluntary and must be initiated by an elderly individual or the individual's designated caregiver. (Gov. Code, Sec. 531.057(c).)

Source Law

(c) The program shall adhere to the following principles:

(1) the intent of the program is to evaluate, through operation of pilot projects, whether providing the services of a trained volunteer advocate selected by an elderly individual or the individual's designated caregiver is effective in achieving the following goals:

(A) extend the time the elderly individual can remain in an appropriate home setting;

(B) maximize the efficiency of services delivered to the elderly individual by focusing on services needed to sustain family caregiving;

(C) protect the elderly individual by providing a knowledgeable third party to review the quality of care and services delivered to the individual and the care options available to the individual and the individual's family; and

(D) facilitate communication between the elderly individual or the individual's designated caregiver and providers of health care and other services;

(2) a volunteer advocate curriculum must be maintained that incorporates best practices as determined and recognized by a professional organization recognized in the elder health care field;

(3) the use of pro bono assistance from qualified professionals must be maximized in modifying the volunteer advocate curriculum and the program;

(4) trainers must be certified on the ability to deliver training;

(5) training shall be offered through multiple community-based organizations; and

(6) participation in the program is voluntary and must be initiated by the elderly individual or the individual's designated caregiver.

Revisor's Note

Section 531.057(c), Government Code, outlines certain principles that the volunteer advocate program "shall" adhere to. The revised law substitutes "must" for "shall" because the term "shall" imposes a duty on an actor and the term "must" is more commonly used when no duty is imposed on an actor and the sentence's subject is an inanimate object.

Revised Law

Sec. 546.0603. AGREEMENTS WITH NONPROFIT ORGANIZATIONS; ORGANIZATION ELIGIBILITY. The executive commissioner may enter into agreements with appropriate nonprofit organizations to provide services under the program. A nonprofit organization is eligible to provide services under the program if the organization:

(1) has significant experience in providing services to elderly individuals;

(2) has the capacity to provide training and supervision for individuals interested in serving as volunteer advocates; and

(3) meets any other criteria prescribed by the executive commissioner. (Gov. Code, Sec. 531.057(d).)

Source Law

(d) The executive commissioner may enter into agreements with appropriate nonprofit organizations for the provision of services under the program. A nonprofit organization is eligible to provide services under the program if the organization:
(1) has significant experience in providing services to elderly individuals;
(2) has the capacity to provide training and supervision for individuals interested in serving as volunteer advocates; and
(3) meets any other criteria prescribed by the executive commissioner.

Revised Law

Sec. 546.0604. FUNDING. (a) The commission shall fund the program, including the design and evaluation of pilot projects, modification of the volunteer advocate curriculum, and training of

volunteers, through existing appropriations to the commission.

(b) Notwithstanding Subsection (a), the commission may accept gifts, grants, or donations for the program from any source to:

(1) carry out the design of the program;

(2) develop criteria for evaluating any proposed pilot projects operated under the program;

(3) modify a volunteer advocate training curriculum;

(4) conduct training for volunteer advocates; and

(5) develop a request for offers to conduct any proposed pilot projects under the program. (Gov. Code, Secs. 531.057(e), (f).)

Source Law

> (e) The commission shall fund the program, including the design and evaluation of pilot projects, modification of the volunteer advocate curriculum, and training of volunteers, through existing appropriations to the commission.
>
> (f) Notwithstanding Subsection (e), the commission may accept gifts, grants, or donations for the program from any public or private source to:
>
> (1) carry out the design of the program;
>
> (2) develop criteria for evaluation of any proposed pilot projects operated under the program;
>
> (3) modify a volunteer advocate training curriculum;
>
> (4) conduct training for volunteer advocates; and
>
> (5) develop a request for offers to conduct any proposed pilot projects under the program.

Revisor's Note

> Section 531.057(f), Government Code, refers to the acceptance of gifts, grants, or donations from any "public or private" source. The revised law omits "public or private" as unnecessary because the term "source" includes by its own terms both public and private sources.

Revised Law

Sec. 546.0605. RULES. The executive commissioner may adopt rules as necessary to implement the program. (Gov. Code, Sec. 531.057(g).)

Source Law

(g) The executive commissioner may adopt rules as necessary to implement the program.

SUBCHAPTER N. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT PROGRAM

Revised Law

Sec. 546.0651. DEFINITION. In this subchapter, "pilot program" means the pilot program established under this subchapter. (New.)

Revisor's Note

The revised law adds the definition of "pilot program" for drafting convenience and to avoid frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 546.0652. PILOT PROGRAM. The commission shall collaborate with the STAR Kids Managed Care Advisory Committee, recipients, family members of children with complex medical conditions, children's health care advocates, Medicaid managed care organizations, and other stakeholders to develop and implement a pilot program that is substantially similar to the program described by Section 3, Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), to provide coordinated care through a health home to children with complex medical conditions. (Gov. Code, Sec. 531.0605(a).)

Source Law

Sec. 531.0605. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT PROGRAM. (a) The commission shall collaborate with the STAR Kids Managed Care Advisory Committee, Medicaid recipients, family members of children with complex medical conditions, children's health care advocates, Medicaid managed care organizations, and other stakeholders to develop and implement a pilot program that is substantially similar to the program described by Section 3, Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), to provide coordinated care through a health home to children with complex medical conditions.

Revised Law

Sec. 546.0653. FEDERAL GUIDANCE AND FUNDING. The

commission shall seek guidance from the Centers for Medicare and Medicaid Services and the United States Department of Health and Human Services regarding the design of the program and, based on the guidance, may actively seek and apply for federal funding to implement the program. (Gov. Code, Sec. 531.0605(b).)

Source Law

> (b) The commission shall seek guidance from the Centers for Medicare and Medicaid Services and the United States Department of Health and Human Services regarding the design of the program and, based on the guidance, may actively seek and apply for federal funding to implement the program.

Revised Law

Sec. 546.0654. REPORT. Not later than December 31, 2024, the commission shall prepare and submit to the legislature a report that includes:

(1) a summary of the commission's implementation of the pilot program; and

(2) if the pilot program has been operating for a period sufficient to obtain necessary data:

(A) a summary of the commission's evaluation of the effect of the pilot program on the coordination of care for children with complex medical conditions; and

(B) a recommendation as to whether the pilot program should be continued, expanded, or terminated. (Gov. Code, Sec. 531.0605(c).)

Source Law

> (c) Not later than December 31, 2024, the commission shall prepare and submit a report to the legislature that includes:
>
> (1) a summary of the commission's implementation of the pilot program; and
>
> (2) if the pilot program has been operating for a period sufficient to obtain necessary data, a summary of the commission's evaluation of the effect of the pilot program on the coordination of care for children with complex medical conditions and a recommendation as to whether the pilot program should be continued, expanded, or terminated.

Revised Law

Sec. 546.0655. EXPIRATION. The pilot program terminates and this subchapter expires September 1, 2025. (Gov. Code, Sec.

531.0605(d).)

Source Law

(d) The pilot program terminates and this section expires September 1, 2025.

SUBCHAPTER O. MORTALITY REVIEW FOR CERTAIN INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITY

Revised Law

Sec. 546.0701. DEFINITION. In this subchapter, "contracted organization" means an entity that contracts with the commission to provide the services described by Section 546.0702(b). (Gov. Code, Sec. 531.8501.)

Source Law

Sec. 531.8501. DEFINITION. In this subchapter, "contracted organization" means an entity that contracts with the commission for the provision of services as described by Section 531.851(c).

Revised Law

Sec. 546.0702. MORTALITY REVIEW SYSTEM. (a) The executive commissioner shall establish an independent mortality review system to review the death of an individual with an intellectual or developmental disability who, at the time of the individual's death or at any time during the 24-hour period preceding the individual's death:

(1) resided in or received services from:

(A) an ICF-IID operated or licensed by the commission or a community center; or

(B) the ICF-IID component of the Rio Grande State Center; or

(2) received services through a Section 1915(c) waiver program for individuals who are eligible for ICF-IID services.

(b) The executive commissioner shall contract with an institution of higher education or a health care organization or association with experience in conducting research-based mortality studies to conduct independent mortality reviews of individuals with an intellectual or developmental disability. The contract must require the contracted organization to form a review team

consisting of:

(1) a physician with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(2) a registered nurse with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(3) a clinician or other professional with expertise in the delivery of services and supports for individuals with an intellectual or developmental disability; and

(4) any other appropriate individual as the executive commissioner provides.

(c) A review under this subchapter must be conducted:

(1) in addition to any review conducted by the facility in which the individual resided or the facility, agency, or provider from which the individual received services; and

(2) after any investigation of alleged or suspected abuse, neglect, or exploitation is completed.

(d) To ensure consistency across mortality review systems, a review under this subchapter must collect information consistent with the information required to be collected by another independent mortality review process established specifically for individuals with an intellectual or developmental disability.

(e) The executive commissioner shall adopt rules regarding the manner in which the death of an individual described by Subsection (a) must be reported to the contracted organization by a facility or waiver program provider described by that subsection. (Gov. Code, Sec. 531.851.)

Source Law

Sec. 531.851. MORTALITY REVIEW. (a) The executive commissioner shall establish an independent mortality review system to review the death of a person with an intellectual or developmental disability who, at the time of the person's death or at any time during the 24-hour period before the person's death:

(1) resided in or received services from:

(A) an ICF-IID operated or licensed by the Department of Aging and Disability Services or a

community center; or

(B) the ICF-IID component of the Rio Grande State Center; or

(2) received services through a Section 1915(c) waiver program for individuals who are eligible for ICF-IID services.

(b) A review under this subchapter must be conducted in addition to any review conducted by the facility in which the person resided or the facility, agency, or provider from which the person received services. A review under this subchapter must be conducted after any investigation of alleged or suspected abuse, neglect, or exploitation is completed.

(c) The executive commissioner shall contract with an institution of higher education or a health care organization or association with experience in conducting research-based mortality studies to conduct independent mortality reviews of persons with an intellectual or developmental disability. The contract must require the contracted organization to form a review team consisting of:

(1) a physician with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(2) a registered nurse with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(3) a clinician or other professional with expertise in the delivery of services and supports for individuals with an intellectual or developmental disability; and

(4) any other appropriate person as provided by the executive commissioner.

(d) The executive commissioner shall adopt rules regarding the manner in which the death of a person described by Subsection (a) must be reported to the contracted organization by a facility or waiver program provider described by that subsection.

(e) To ensure consistency across mortality review systems, a review under this section must collect information consistent with the information required to be collected by any other independent mortality review process established specifically for persons with an intellectual or developmental disability.

Revisor's Note

Section 531.851(e), Government Code, refers to a mortality review conducted "under this section." For consistency of terminology and because the provisions related to the mortality review being referred to are contained in the revised subchapter, the revised law substitutes "subchapter" for "section."

Revised Law

Sec. 546.0703. ACCESS TO INFORMATION AND RECORDS. (a) A contracted organization may request information and records regarding a deceased individual as necessary to carry out the

organization's duties. The requested information and records may include:

(1) medical, dental, and mental health care information; and

(2) information and records maintained by any state or local government agency, including:

(A) a birth certificate;

(B) law enforcement investigative data;

(C) medical examiner investigative data;

(D) juvenile court records;

(E) parole and probation information and records; and

(F) adult or child protective services information and records.

(b) On request of the contracted organization, the custodian of the relevant information and records relating to a deceased individual shall provide those records to the organization at no charge. (Gov. Code, Sec. 531.852.)

Source Law

> Sec. 531.852. ACCESS TO INFORMATION. (a) A contracted organization may request information and records regarding a deceased person as necessary to carry out the contracted organization's duties. Records and information that may be requested under this section include:
>
> (1) medical, dental, and mental health care information; and
>
> (2) information and records maintained by any state or local government agency, including:
>
> (A) a birth certificate;
>
> (B) law enforcement investigative data;
>
> (C) medical examiner investigative data;
>
> (D) juvenile court records;
>
> (E) parole and probation information and records; and
>
> (F) adult or child protective services information and records.
>
> (b) On request of the contracted organization, the custodian of the relevant information and records relating to a deceased person shall provide those records to the contracted organization at no charge.

Revised Law

Sec. 546.0704. MORTALITY REVIEW REPORTS. Subject to

Section 546.0705, a contracted organization shall submit:

(1) to the commission, the Department of Family and Protective Services, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report of the findings of the mortality review; and

(2) semiannually to the governor, the lieutenant governor, the speaker of the house of representatives, and the standing committees of the senate and house of representatives with primary jurisdiction over the commission, the department, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report that contains:

(A) aggregate information regarding the deaths for which the organization performed an independent mortality review;

(B) trends in the causes of death the organization identifies; and

(C) any suggestions for system-wide improvements to address conditions that contributed to deaths reviewed by the organization. (Gov. Code, Sec. 531.853.)

Source Law

Sec. 531.853. MORTALITY REVIEW REPORT. Subject to Section 531.854, a contracted organization shall submit:

(1) to the Department of Aging and Disability Services, the Department of Family and Protective Services, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report of the findings of the mortality review; and

(2) semiannually to the governor, the lieutenant governor, the speaker of the house of representatives, and the standing committees of the senate and house of representatives with primary jurisdiction over the Department of Aging and Disability Services, the Department of Family and Protective Services, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report that contains:

(A) aggregate information regarding the deaths for which the contracted organization performed an independent mortality review;

(B) trends in the causes of death identified by the contracted organization; and

(C) any suggestions for system-wide

improvements to address conditions that contributed to deaths reviewed by the contracted organization.

Revised Law

Sec. 546.0705. USE AND PUBLICATION RESTRICTIONS; CONFIDENTIALITY. (a) The commission may use or publish information under this subchapter only to advance statewide practices regarding the treatment and care of individuals with an intellectual or developmental disability. A summary of the data in the contracted organization's reports or a statistical compilation of data reports may be released by the commission for general publication if the summary or statistical compilation does not contain any information that would permit the identification of an individual or that is confidential or privileged under this subchapter or other state or federal law.

(b) Information and records acquired by the contracted organization in the exercise of the organization's duties under this subchapter:

(1) are confidential and exempt from disclosure under Chapter 552; and

(2) may be disclosed only as necessary to carry out the organization's duties.

(c) The identity of:

(1) an individual whose death was reviewed in accordance with this subchapter is confidential and may not be revealed; and

(2) a health care provider or the name of a facility or agency that provided services to or was the residence of an individual whose death was reviewed in accordance with this subchapter is confidential and may not be revealed.

(d) Reports, information, statements, memoranda, and other information furnished under this subchapter to the contracted organization and any findings or conclusions resulting from a review by the organization are privileged.

(e) A contracted organization's report of the findings of the independent mortality review conducted under this subchapter

and any records the organization develops relating to the review:

(1) are confidential and privileged;

(2) are not subject to discovery or subpoena; and

(3) may not be introduced into evidence in any civil, criminal, or administrative proceeding.

(f) A member of the contracted organization's review team may not testify or be required to testify in a civil, criminal, or administrative proceeding as to observations, factual findings, or conclusions that were made in conducting a review under this subchapter. (Gov. Code, Sec. 531.854.)

Source Law

Sec. 531.854. USE AND PUBLICATION RESTRICTIONS; CONFIDENTIALITY. (a) The commission may use or publish information under this subchapter only to advance statewide practices regarding the treatment and care of individuals with an intellectual or developmental disability. A summary of the data in the contracted organization's reports or a statistical compilation of data reports may be released by the commission for general publication if the summary or statistical compilation does not contain any information that would permit the identification of an individual or that is confidential or privileged under this subchapter or other state or federal law.

(b) Information and records acquired by the contracted organization in the exercise of its duties under this subchapter are confidential and exempt from disclosure under the open records law, Chapter 552, and may be disclosed only as necessary to carry out the contracted organization's duties.

(c) The identity of a person whose death was reviewed in accordance with this subchapter is confidential and may not be revealed.

(d) The identity of a health care provider or the name of a facility or agency that provided services to or was the residence of a person whose death was reviewed in accordance with this subchapter is confidential and may not be revealed.

(e) Reports, information, statements, memoranda, and other information furnished under this subchapter to the contracted organization and any findings or conclusions resulting from a review by the contracted organization are privileged.

(f) A contracted organization's report of the findings of the independent mortality review conducted under this subchapter and any records developed by the contracted organization relating to the review:

(1) are confidential and privileged;

(2) are not subject to discovery or subpoena; and

(3) may not be introduced into evidence in any civil, criminal, or administrative proceeding.

(g) A member of the contracted organization's review team may not testify or be required to testify in a civil, criminal, or administrative proceeding as to observations, factual findings, or conclusions that

were made in conducting a review under this subchapter.

Revised Law

Sec. 546.0706. LIMITATION ON LIABILITY. A health care provider or other person is not civilly or criminally liable for furnishing information to the contracted organization or to the commission for use by the organization in accordance with this subchapter unless the person acted in bad faith or knowingly provided false information to the organization or the commission. (Gov. Code, Sec. 531.855.)

Source Law

Sec. 531.855. LIMITATION ON LIABILITY. A health care provider or other person is not civilly or criminally liable for furnishing information to the contracted organization or to the commission for use by the contracted organization in accordance with this subchapter unless the person acted in bad faith or knowingly provided false information to the contracted organization or the commission.

CHAPTER 547. MENTAL HEALTH AND SUBSTANCE USE SERVICES

SUBCHAPTER A. DELIVERY OF MENTAL HEALTH AND SUBSTANCE USE SERVICES

Sec. 547.0001. EVALUATION OF CERTAIN CONTRACTORS AND SUBCONTRACTORS . . . . . 943

Sec. 547.0002. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE . . . . . 945

Sec. 547.0003. RULES GOVERNING PEER SPECIALISTS . . . . . 947

Sec. 547.0004. VETERAN SUICIDE PREVENTION ACTION PLAN . . . 949

Sec. 547.0005. LOCAL MENTAL HEALTH AUTHORITY GROUP REGIONAL STRATEGIES; ANNUAL REPORT . . . . 952

SUBCHAPTER B. TEXAS SYSTEM OF CARE FRAMEWORK

Sec. 547.0051. DEFINITIONS . . . . . 954

Sec. 547.0052. TEXAS SYSTEM OF CARE FRAMEWORK . . . . . 955

Sec. 547.0053. IMPLEMENTATION . . . . . 957

Sec. 547.0054. TECHNICAL ASSISTANCE FOR LOCAL SYSTEMS OF CARE . . . . . 957

SUBCHAPTER C. SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCES

Sec. 547.0101. DEFINITIONS . . . . . 957

Sec. 547.0102. EVALUATIONS BY COMMUNITY RESOURCE COORDINATION GROUPS . . . . . 959
Sec. 547.0103. SUMMARY REPORT BY COMMISSION . . . . . 960
Sec. 547.0104. AGENCY IMPLEMENTATION OF RECOMMENDATIONS . . . . . 961
SUBCHAPTER D. STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL
Sec. 547.0151. DEFINITION . . . . . 962
Sec. 547.0152. PURPOSE . . . . . 962
Sec. 547.0153. COMPOSITION OF COUNCIL . . . . . 962
Sec. 547.0154. PRESIDING OFFICER . . . . . 964
Sec. 547.0155. MEETINGS . . . . . 965
Sec. 547.0156. POWERS AND DUTIES . . . . . 965
Sec. 547.0157. SUICIDE PREVENTION SUBCOMMITTEE; SUICIDE DATA REPORTS . . . . . 966
SUBCHAPTER E. BEHAVIORAL HEALTH GRANT PROGRAMS GENERALLY
Sec. 547.0201. STREAMLINING PROCESS FOR AWARDING BEHAVIORAL HEALTH GRANTS . . . . . 967
SUBCHAPTER F. MATCHING GRANT PROGRAM FOR CERTAIN COMMUNITY MENTAL HEALTH PROGRAMS ASSISTING INDIVIDUALS EXPERIENCING MENTAL ILLNESS
Sec. 547.0251. DEFINITION . . . . . 967
Sec. 547.0252. MATCHING GRANT PROGRAM . . . . . 967
Sec. 547.0253. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS . . . . . 968
Sec. 547.0254. SELECTION OF RECIPIENTS; APPLICATIONS AND PROPOSALS . . . . . 969
Sec. 547.0255. LOCAL MENTAL HEALTH AUTHORITY INVOLVEMENT . . . . . 970
Sec. 547.0256. USE OF GRANTS AND MATCHING AMOUNTS . . . . . 971
Sec. 547.0257. DISTRIBUTING AND ALLOCATING APPROPRIATED MONEY . . . . . 972
Sec. 547.0258. RULES . . . . . 973
Sec. 547.0259. BIENNIAL REPORT . . . . . 973

SUBCHAPTER G. MATCHING GRANT PROGRAM FOR COMMUNITY MENTAL HEALTH PROGRAMS ASSISTING VETERANS AND THEIR FAMILIES
Sec. 547.0301. DEFINITION . . . . . 974
Sec. 547.0302. MATCHING GRANT PROGRAM . . . . . 974
Sec. 547.0303. MATCHING CONTRIBUTIONS REQUIRED . . . . . 974
Sec. 547.0304. MATCHING GRANT CONDITIONS: SINGLE COUNTIES . . . . . 975
Sec. 547.0305. MATCHING GRANT CONDITIONS: MULTIPLE COUNTIES . . . . . 976
Sec. 547.0306. SELECTION OF RECIPIENTS; APPLICATIONS AND PROPOSALS . . . . . 977
Sec. 547.0307. USE OF GRANTS AND MATCHING AMOUNTS . . . . . 978
Sec. 547.0308. DISTRIBUTING AND ALLOCATING APPROPRIATED MONEY . . . . . 978
Sec. 547.0309. RULES . . . . . 979
SUBCHAPTER H. MATCHING GRANT PROGRAM FOR CERTAIN COMMUNITY COLLABORATIVES TO REDUCE INVOLVEMENT OF INDIVIDUALS WITH MENTAL ILLNESS IN CRIMINAL JUSTICE SYSTEM
Sec. 547.0351. DEFINITION . . . . . 979
Sec. 547.0352. MATCHING GRANT PROGRAM . . . . . 979
Sec. 547.0353. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS . . . . . 980
Sec. 547.0354. COMMUNITY COLLABORATIVE ELIGIBILITY; CERTAIN GRANTS PROHIBITED . . . . . 981
Sec. 547.0355. PETITION REQUIRED; CONTENTS . . . . . 982
Sec. 547.0356. REVIEW OF PETITION BY COMMISSION . . . . . 983
Sec. 547.0357. USE OF GRANT MONEY AND MATCHING FUNDS . . . . 983
Sec. 547.0358. REPORT BY COMMUNITY COLLABORATIVE . . . . . 984
Sec. 547.0359. INSPECTIONS . . . . . 985
Sec. 547.0360. ALLOCATING APPROPRIATED MONEY . . . . . 985
SUBCHAPTER I. MATCHING GRANT PROGRAM FOR COMMUNITY COLLABORATIVE IN MOST POPULOUS COUNTY TO REDUCE INVOLVEMENT OF INDIVIDUALS WITH MENTAL ILLNESS IN CRIMINAL JUSTICE SYSTEM
Sec. 547.0401. DEFINITION . . . . . 986

Sec. 547.0402. MATCHING GRANT PROGRAM . . . . . 986
Sec. 547.0403. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS . . . . . 987
Sec. 547.0404. COMMUNITY COLLABORATIVE ELIGIBILITY . . . . . 988
Sec. 547.0405. DISTRIBUTION OF GRANT . . . . . 988
Sec. 547.0406. USE OF GRANT MONEY AND MATCHING FUNDS . . . . 989
Sec. 547.0407. REPORT BY COMMUNITY COLLABORATIVE . . . . . 990
Sec. 547.0408. INSPECTIONS . . . . . 990

CHAPTER 547. MENTAL HEALTH AND SUBSTANCE USE SERVICES

SUBCHAPTER A. DELIVERY OF MENTAL HEALTH AND SUBSTANCE USE SERVICES

Revised Law

Sec. 547.0001. EVALUATION OF CERTAIN CONTRACTORS AND SUBCONTRACTORS. (a) To ensure the appropriate delivery of mental health and substance use services, the commission shall regularly evaluate program contractors and subcontractors that provide or arrange services for individuals enrolled in:

(1) the Medicaid managed care program; and

(2) the child health plan program.

(b) The commission shall monitor:

(1) penetration rates as those rates relate to mental health and substance use services provided by or through contractors and subcontractors;

(2) utilization rates as those rates relate to mental health and substance use services provided by or through contractors and subcontractors; and

(3) provider networks used by contractors and subcontractors to provide mental health or substance use services. (Gov. Code, Sec. 531.0225.)

Source Law

Sec. 531.0225. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES. (a) To ensure appropriate delivery of mental health and substance abuse services, the commission shall regularly evaluate program contractors and subcontractors that provide or arrange for the services for persons enrolled in:

(1) the Medicaid managed care program; and

(2) the state child health plan program.

(b) The commission shall monitor:

(1) penetration rates, as they relate to mental health and substance abuse services provided by or through contractors and subcontractors;

(2) utilization rates, as they relate to mental health and substance abuse services provided by or through contractors and subcontractors; and

(3) provider networks used by contractors and subcontractors to provide mental health or substance abuse services.

Revisor's Note

(1) Section 531.0225, Government Code, refers to "substance abuse" services. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), published by the American Psychiatric Association to assist in classifying mental disorders, combines the categories of substance abuse and substance dependence into a single disorder referred to as "substance use disorder." Therefore, throughout this chapter, the revised law substitutes "substance use" for "substance abuse" to reflect modern terminology regarding the disorder.

(2) Section 531.0225(a), Government Code, refers to services for "persons" enrolled in certain programs. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), applicable to this code.

(3) Section 531.0225(a)(2), Government Code, refers to the "state child health plan program." The revised law substitutes "child health plan program" for "state child health plan program" for clarity and consistency in the terminology used within the chapter and because "child health plan program" is the defined term under Section 531.001, Government Code, which is revised in this subtitle as Section 521.0001, and

applies to the revised law in this chapter.

Revised Law

Sec. 547.0002. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE. (a) In this section, "ombudsman" means the individual designated under this section by the executive commissioner as the ombudsman for behavioral health access to care unless the context requires otherwise.

(b) The executive commissioner shall designate an ombudsman for behavioral health access to care.

(c) The ombudsman is administratively attached to the commission's office of the ombudsman established under Section 523.0255.

(d) The commission may use an alternate title for the ombudsman in consumer-facing materials if the commission determines that an alternate title would benefit consumer understanding or access.

(e) The ombudsman serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

(f) The ombudsman shall:

(1) interact with consumers and behavioral health care providers regarding concerns or complaints to help the consumers and providers resolve behavioral health care access issues;

(2) identify, track, and help report potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to quantitative and nonquantitative treatment limitations;

(3) report concerns, complaints, and potential violations described by Subdivision (2) to the appropriate

regulatory or oversight agency;

(4) receive and report concerns and complaints relating to inappropriate care or mental health commitment;

(5) provide appropriate information to help consumers obtain behavioral health care;

(6) develop appropriate points of contact for referrals to other state and federal agencies; and

(7) provide appropriate information to help consumers or providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies.

(g) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive the reports of concerns, complaints, and potential violations described by Subsection (f)(2) from the ombudsman, consumers, or behavioral health care providers. (Gov. Code, Sec. 531.02251.)

Source Law

Sec. 531.02251. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE. (a) In this section, "ombudsman" means the individual designated as the ombudsman for behavioral health access to care.

(b) The executive commissioner shall designate an ombudsman for behavioral health access to care.

(c) The ombudsman is administratively attached to the office of the ombudsman for the commission.

(d) The commission may use an alternate title for the ombudsman in consumer-facing materials if the commission determines that an alternate title would be beneficial to consumer understanding or access.

(e) The ombudsman serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

(f) The ombudsman shall:

(1) interact with consumers and behavioral health care providers with concerns or complaints to help the consumers and providers resolve behavioral health care access issues;

(2) identify, track, and help report potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to quantitative and nonquantitative treatment limitations;

(3) report concerns, complaints, and potential violations described by Subdivision (2) to the appropriate regulatory or oversight agency;

(4) receive and report concerns and complaints relating to inappropriate care or mental health commitment;

(5) provide appropriate information to help consumers obtain behavioral health care;

(6) develop appropriate points of contact for referrals to other state and federal agencies; and

(7) provide appropriate information to help consumers or providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies.

(h) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations described by Subsection (f)(2) from the ombudsman, consumers, or behavioral health care providers.

Revised Law

Sec. 547.0003. RULES GOVERNING PEER SPECIALISTS. (a) With input from mental health and substance use peer specialists, the commission shall develop and the executive commissioner shall adopt:

(1) rules establishing training requirements for peer specialists to provide services to individuals with mental illness or individuals with substance use conditions;

(2) rules establishing certification and supervision requirements for peer specialists;

(3) rules defining the scope of services that peer specialists may provide;

(4) rules distinguishing peer services from other services that a person must hold a license to provide; and

(5) any other rules necessary to protect the health and safety of individuals receiving peer services.

(b) The executive commissioner may not adopt rules under this section that preclude the provision of mental health rehabilitative services under 25 T.A.C. Chapter 416, Subchapter A, as that subchapter existed on January 1, 2017. (Gov. Code, Secs. 531.0999(a), (f).)

Source Law

Sec. 531.0999. PEER SPECIALISTS. (a) With input from mental health and substance use peer specialists and the work group described by Subsection (b), the commission shall develop and the executive commissioner shall adopt:

(1) rules that establish training requirements for peer specialists so that they are

able to provide services to persons with mental illness or services to persons with substance use conditions;

(2) rules that establish certification and supervision requirements for peer specialists;

(3) rules that define the scope of services that peer specialists may provide;

(4) rules that distinguish peer services from other services that a person must hold a license to provide; and

(5) any other rules necessary to protect the health and safety of persons receiving peer services.

(f) The executive commissioner may not adopt rules under Subsection (a) that preclude the provision of mental health rehabilitative services under 25 T.A.C. Chapter 416, Subchapter A, as that subchapter existed on January 1, 2017.

Revisor's Note

Sections 531.0999(b), (c), (d), and (e), Government Code, refer to a stakeholder work group established to provide input on rules adopted under Section 531.0999(a), Government Code. These provisions are omitted from the revised law because the work group to which they refer no longer exists. Section 533.0999(e), Government Code, provides that the work group is automatically abolished following the adoption of rules under Section 531.0999(a), Government Code. According to 43 Tex. Reg. 8573 (2018), the Health and Human Services Commission adopted rules on December 28, 2018, which became effective on January 1, 2019. The omitted law reads:

> (b) The commission shall establish a stakeholder work group to provide input for the adoption of rules under Subsection (a). The work group is composed of the following stakeholders appointed by the executive commissioner:
>
> (1) one representative of each organization that certifies mental health and substance use peer specialists in this state;
>
> (2) three representatives of organizations that employ mental health and substance use peer specialists;
>
> (3) one mental health peer specialist who works in an urban area;
>
> (4) one mental health peer specialist who works in a rural area;
>
> (5) one substance use peer specialist who works in an urban area;
>
> (6) one substance use peer

specialist who works in a rural area;

(7) one person who trains mental health peer specialists;

(8) one person who trains substance use peer specialists;

(9) three representatives of mental health and addiction licensed health care professional groups who supervise mental health and substance use peer specialists;

(10) to the extent possible, not more than three persons with personal experience recovering from mental illness, substance use conditions, or co-occurring mental illness and substance use conditions; and

(11) any other persons considered appropriate by the executive commissioner.

(c) The executive commissioner shall appoint one member of the work group to serve as presiding officer.

(d) The work group shall meet once every month.

(e) The work group is automatically abolished on the adoption of rules under Subsection (a).

Revised Law

Sec. 547.0004. VETERAN SUICIDE PREVENTION ACTION PLAN. (a) The commission, in collaboration with the Texas Coordinating Council for Veterans Services, the United States Department of Veterans Affairs, the Service Members, Veterans, and their Families Technical Assistance Center Implementation Academy of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, veteran advocacy groups, health care providers, and any other organization or interested party the commission considers appropriate, shall develop a comprehensive action plan to increase access to and availability of professional veteran health services to prevent veteran suicides.

(b) The action plan must:

(1) identify opportunities for raising awareness of and providing resources for veteran suicide prevention;

(2) identify opportunities to increase access to veteran mental health services;

(3) identify funding resources to provide accessible, affordable veteran mental health services;

(4) provide measures to expand public-private partnerships to ensure access to quality, timely mental health services;

(5) provide for proactive outreach measures to reach veterans needing care;

(6) provide for peer-to-peer service coordination, including training, certification, recertification, and continuing education for peer coordinators; and

(7) address suicide prevention awareness, measures, and training regarding veterans involved in the justice system.

(c) The commission shall make specific long-term statutory, administrative, and budget-related recommendations to the legislature and the governor regarding the policy initiatives and reforms necessary to implement the action plan developed under this section. The initiatives and reforms in the long-term plan must be fully implemented by September 1, 2027.

(d) The commission shall include in the commission's strategic plan under Chapter 2056 the plans for implementing the long-term recommendations under Subsection (c).

(e) This section expires September 1, 2027. (Gov. Code, Secs. 531.0925(a), (b), (c) (part), (d), (e).)

Source Law

Sec. 531.0925. VETERAN SUICIDE PREVENTION ACTION PLAN. (a) The commission, in collaboration with the Texas Coordinating Council for Veterans Services, the United States Department of Veterans Affairs, the Service Members, Veterans, and Their Families Technical Assistance Center Implementation Academy of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, veteran advocacy groups, medical providers, and any other organization or interested party the commission considers appropriate, shall develop a comprehensive action plan to increase access to and availability of professional veteran health services to prevent veteran suicides.

(b) The action plan must:

(1) identify opportunities for raising awareness of and providing resources for veteran suicide prevention;

(2) identify opportunities to increase access to veteran mental health services;

(3) identify funding resources to provide accessible, affordable veteran mental health

services;

(4) provide measures to expand public-private partnerships to ensure access to quality, timely mental health services;

(5) provide for proactive outreach measures to reach veterans needing care;

(6) provide for peer-to-peer service coordination, including training, certification, recertification, and continuing education for peer coordinators; and

(7) address suicide prevention awareness, measures, and training regarding veterans involved in the justice system.

(c) The commission shall make specific short-term and long-term statutory, administrative, and budget-related recommendations to the legislature and the governor regarding the policy initiatives and reforms necessary to implement the action plan developed under this section. . . . The initiatives and reforms in the long-term plan must be fully implemented by September 1, 2027.

(d) The commission shall include in its strategic plan under Chapter 2056 the plans for implementation of the short-term and long-term recommendations under Subsection (c).

(e) This section expires September 1, 2027.

Revisor's Note

(1) Section 531.0925(a), Government Code, requires the commission to collaborate with "medical providers." The revised law substitutes "health care providers" for "medical providers" because, in context, the terms have the same meaning and "health care providers" is the more commonly used term.

(2) Section 531.0925(c), Government Code, requires the Health and Human Services Commission to make specific short-term and long-term recommendations to the legislature and the governor regarding policy initiatives and reforms necessary to implement a veteran suicide prevention action plan. That subsection also requires the commission to fully implement the short-term recommendations not later than September 1, 2021, and to begin implementing the long-term recommendations not later than September 1, 2021. The commission has fully implemented the short-term plan and has begun implementing the long-term plan. Therefore, the revised law omits those requirements as executed. The omitted law

reads:

> (c) . . . The short-term recommendations must include a plan for state implementation beginning not later than September 1, 2019. The initiatives and reforms in the short-term plan must be fully implemented by September 1, 2021. The long-term recommendations must include a plan for state implementation beginning not later than September 1, 2021. . . .

(3) Section 531.0925(d), Government Code, requires the Health and Human Services Commission to include in the commission's strategic plan under Chapter 2056, Government Code, the commission's plans for implementing the short-term recommendations under Section 531.0925(c). The commission included the short-term recommendations in the commission's July 2020 strategic plan. Therefore, the reference to the "short-term plan" is omitted as executed.

Revised Law

Sec. 547.0005. LOCAL MENTAL HEALTH AUTHORITY GROUP REGIONAL STRATEGIES; ANNUAL REPORT. (a) In this section, "local mental health authority group" means a group of local mental health authorities established by the commission under Chapter 963 (S.B. 633), Acts of the 86th Legislature, Regular Session, 2019.

(b) The commission shall require each local mental health authority group to meet at least quarterly to collaborate on planning and implementing regional strategies to reduce:

(1) costs to local governments of providing services to individuals experiencing a mental health crisis;

(2) transportation to mental health facilities of individuals served by an authority that is a member of the group;

(3) incarceration of individuals with mental illness in county jails located in an area served by an authority that is a member of the group; and

(4) visits by individuals with mental illness at hospital emergency rooms located in an area served by an authority that is a member of the group.

(c) The commission shall use federal funds in accordance with state and federal guidelines to implement this section.

(d) The commission, in coordination with each local mental health authority group, shall annually update the mental health services development plan that was initially developed by the commission and each local mental health authority group under Chapter 963 (S.B. 633), Acts of the 86th Legislature, Regular Session, 2019. The commission and each group's updated plan must include a description of:

(1) actions taken by the group to implement regional strategies in the plan; and

(2) new regional strategies identified by the group to reduce the circumstances described by Subsection (b), including the estimated number of outpatient and inpatient beds necessary to meet the goals of each group's regional strategy.

(e) Not later than December 1 of each year, the commission shall produce and publish on the commission's Internet website a report containing the most recent version of each mental health services development plan developed by the commission and a local mental health authority group. (Gov. Code, Sec. 531.0222.)

Source Law

Sec. 531.0222. LOCAL MENTAL HEALTH AUTHORITY GROUP REGIONAL PLANNING. (a) In this section, "local mental health authority group" means a group of local mental health authorities established by the commission under Chapter 963 (S.B. 633), Acts of the 86th Legislature, Regular Session, 2019.

(b) The commission shall require each local mental health authority group to meet at least quarterly to collaborate on planning and implementing regional strategies to reduce:

(1) costs to local governments of providing services to persons experiencing a mental health crisis;

(2) transportation to mental health facilities of persons served by an authority that is a member of the group;

(3) incarceration of persons with mental illness in county jails that are located in an area served by an authority that is a member of the group; and

(4) visits by persons with mental illness at hospital emergency rooms located in an area served by an authority that is a member of the group.

(c) The commission shall use federal funds in accordance with state and federal guidelines to

implement this section.

(d) The commission, in coordination with each local mental health authority group, shall annually update the mental health services development plan that was initially developed by the commission and each local mental health authority group under Chapter 963 (S.B. 633), Acts of the 86th Legislature, Regular Session, 2019. The commission and each group's updated plan must include a description of:

(1) actions taken by the group to implement regional strategies in the plan; and

(2) new regional strategies identified by the group to reduce the circumstances described by Subsection (b), including the estimated number of outpatient and inpatient beds necessary to meet the goals of each group's regional strategy.

(e) Not later than December 1 of each year, the commission shall produce and publish on its Internet website a report containing the most recent version of each mental health services development plan developed by the commission and a local mental health authority group.

SUBCHAPTER B. TEXAS SYSTEM OF CARE FRAMEWORK

Revised Law

Sec. 547.0051. DEFINITIONS. In this subchapter:

(1) "Minor" means an individual younger than 18 years of age.

(2) "Serious emotional disturbance" means a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment that substantially interferes with or limits an individual's role or ability to function in family, school, or community activities.

(3) "System of care framework" means a framework for collaboration among state agencies, minors who have a serious emotional disturbance or are at risk of developing a serious emotional disturbance, and the families of those minors that improves access to services and delivers effective community-based services that are family-driven, youth- or young adult-guided, and culturally and linguistically competent. (Gov. Code, Sec. 531.251(a).)

Source Law

Sec. 531.251. TEXAS SYSTEM OF CARE FRAMEWORK.

(a) In this section:

(1) "Minor" means an individual younger than 18 years of age.

(2) "Serious emotional disturbance" means a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment

that substantially interferes with or limits a person's role or ability to function in family, school, or community activities.

(3) "System of care framework" means a framework for collaboration among state agencies, minors who have a serious emotional disturbance or are at risk of developing a serious emotional disturbance, and the families of those minors that improves access to services and delivers effective community-based services that are family-driven, youth- or young adult-guided, and culturally and linguistically competent.

Revisor's Note

Section 531.251(a), Government Code, refers to definitions applicable "[i]n this section." The provisions of Section 531.251 are revised in this chapter as Subchapter B, and the revised law is drafted accordingly.

Revised Law

Sec. 547.0052. TEXAS SYSTEM OF CARE FRAMEWORK. (a) The commission shall implement a system of care framework to develop local mental health systems of care in communities for minors who:

(1) have or are at risk of developing a serious emotional disturbance;

(2) are receiving residential mental health services and supports or inpatient mental health hospitalization; or

(3) are at risk of being removed from the minor's home and placed in a more restrictive environment to receive mental health services and supports, including:

(A) an inpatient mental health hospital;

(B) a residential treatment facility; or

(C) a facility or program operated by the Department of Family and Protective Services or an agency that is part of the juvenile justice system.

(b) The commission shall:

(1) maintain a comprehensive plan for the delivery of mental health services and supports to a minor and a minor's family using a system of care framework, including best practices in the financing, administration, governance, and delivery of those services;

(2) enter into memoranda of understanding with the Department of State Health Services, the Department of Family and Protective Services, the Texas Education Agency, the Texas Juvenile Justice Department, and the Texas Correctional Office on Offenders with Medical or Mental Impairments that specify the roles and responsibilities of each agency in implementing the comprehensive plan;

(3) identify appropriate local, state, and federal funding sources to finance infrastructure and mental health services and supports necessary to support state and local system of care framework efforts; and

(4) develop an evaluation system to measure cross-system performance and outcomes of state and local system of care framework efforts.

(c) In implementing this section, the commission shall consult with stakeholders, including:

(1) minors who have or are at risk of developing a serious emotional disturbance or young adults who received mental health services and supports as a minor with or at risk of developing a serious emotional disturbance; and

(2) family members of those minors or young adults.

(Gov. Code, Secs. 531.251(b), (c).)

Source Law

(b) The commission shall implement a system of care framework to develop local mental health systems of care in communities for minors who are receiving residential mental health services and supports or inpatient mental health hospitalization, have or are at risk of developing a serious emotional disturbance, or are at risk of being removed from the minor's home and placed in a more restrictive environment to receive mental health services and supports, including an inpatient mental health hospital, a residential treatment facility, or a facility or program operated by the Department of Family and Protective Services or an agency that is part of the juvenile justice system.

(c) The commission shall:

(1) maintain a comprehensive plan for the delivery of mental health services and supports to a minor and a minor's family using a system of care framework, including best practices in the financing, administration, governance, and delivery of those services;

(2) enter memoranda of understanding with

the Department of State Health Services, the Department of Family and Protective Services, the Texas Education Agency, the Texas Juvenile Justice Department, and the Texas Correctional Office on Offenders with Medical or Mental Impairments that specify the roles and responsibilities of each agency in implementing the comprehensive plan described by Subdivision (1);

(3) identify appropriate local, state, and federal funding sources to finance infrastructure and mental health services and supports needed to support state and local system of care framework efforts;

(4) develop an evaluation system to measure cross-system performance and outcomes of state and local system of care framework efforts; and

(5) in implementing the provisions of this section, consult with stakeholders, including:

(A) minors who have or are at risk of developing a serious emotional disturbance or young adults who received mental health services and supports as a minor with or at risk of developing a serious emotional disturbance; and

(B) family members of those minors or young adults.

Revised Law

Sec. 547.0053. IMPLEMENTATION. The commission shall:

(1) monitor the implementation of a system of care framework under Section 547.0052; and

(2) adopt rules necessary to facilitate or adjust that implementation. (Gov. Code, Sec. 531.255.)

Source Law

Sec. 531.255. EVALUATION. The commission shall monitor the implementation of a system of care framework under Section 531.251 and adopt rules as necessary to facilitate or adjust that implementation.

Revised Law

Sec. 547.0054. TECHNICAL ASSISTANCE FOR LOCAL SYSTEMS OF CARE. The commission may provide technical assistance to a community that implements a local system of care. (Gov. Code, Sec. 531.257.)

Source Law

Sec. 531.257. TECHNICAL ASSISTANCE FOR PROJECTS. The commission may provide technical assistance to a community that implements a local system of care.

SUBCHAPTER C. SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCES

Revised Law

Sec. 547.0101. DEFINITIONS. In this subchapter:

(1) "Children with severe emotional disturbances" includes children:

(A) who are at risk of incarceration or placement in a residential mental health facility;

(B) who are students in a special education program under Subchapter A, Chapter 29, Education Code;

(C) with a substance use disorder or a developmental disability; and

(D) for whom a court may appoint the Department of Family and Protective Services as managing conservator.

(2) "Community resource coordination group" means a coordination group established under a memorandum of understanding adopted under Subchapter D, Chapter 522.

(3) "Systems of care services" means a comprehensive state system of mental health services and other necessary and related services that is organized as a coordinated network to meet the multiple and changing needs of children with severe emotional disturbances and their families. (Gov. Code, Sec. 531.421.)

Source Law

Sec. 531.421. DEFINITIONS. In this subchapter:

(1) "Children with severe emotional disturbances" includes:

(A) children who are at risk of incarceration or placement in a residential mental health facility;

(B) children for whom a court may appoint the Department of Family and Protective Services as managing conservator;

(C) children who are students in a special education program under Subchapter A, Chapter 29, Education Code; and

(D) children who have a substance abuse disorder or a developmental disability.

(2) "Community resource coordination group" means a coordination group established under a memorandum of understanding adopted under Section 531.055.

(3) "Systems of care services" means a comprehensive state system of mental health services and other necessary and related services that is organized as a coordinated network to meet the multiple and changing needs of children with severe emotional disturbances and their families.

Revisor's Note

Section 531.421(2), Government Code, refers to a

coordination group established under a memorandum of understanding adopted under Section 531.055, Government Code. The provisions of Section 531.055 are revised in this subtitle as Subchapter D, Chapter 522, and the revised law is drafted accordingly.

Revised Law

Sec. 547.0102. EVALUATIONS BY COMMUNITY RESOURCE COORDINATION GROUPS. (a) Each community resource coordination group shall evaluate the provision of systems of care services in the community that the group serves. The evaluation must:

(1) describe and prioritize services needed by children with severe emotional disturbances in the community;

(2) review and assess the available systems of care services in the community to meet those needs;

(3) assess the integration of the provision of those services; and

(4) identify barriers to the effective provision of those services.

(b) Each community resource coordination group shall create a report that includes the evaluation described by Subsection (a) and related recommendations, including:

(1) suggested policy and statutory changes for agencies providing systems of care services; and

(2) recommendations for overcoming barriers to the provision of systems of care services and improving the integration of those services.

(c) Each community resource coordination group shall submit the report described by Subsection (b) to the commission. The commission shall provide to each group a deadline for submitting the report that is coordinated with any regional reviews by the commission of the delivery of related services. (Gov. Code, Sec. 531.422.)

Source Law

Sec. 531.422. EVALUATIONS BY COMMUNITY RESOURCE

COORDINATION GROUPS. (a) Each community resource coordination group shall evaluate the provision of systems of care services in the community that the group serves. Each evaluation must:

(1) describe and prioritize services needed by children with severe emotional disturbances in the community;

(2) review and assess the systems of care services that are available in the community to meet those needs;

(3) assess the integration of the provision of those services; and

(4) identify any barriers to the effective provision of those services.

(b) Each community resource coordination group shall create a report that includes the evaluation in Subsection (a) and makes related recommendations, including:

(1) suggested policy and statutory changes at agencies that provide systems of care services; and

(2) recommendations for overcoming barriers to the provision of systems of care services and improving the integration of those services.

(c) Each community resource coordination group shall submit the report described by Subsection (b) to the commission. The commission shall provide to each group a deadline for submitting the reports that is coordinated with any regional reviews by the commission of the delivery of related services.

Revised Law

Sec. 547.0103. SUMMARY REPORT BY COMMISSION. (a) The commission shall create a summary report based on the evaluations in the reports submitted to the commission by community resource coordination groups under Section 547.0102. The commission's report must include:

(1) recommendations for policy and statutory changes at each agency involved in providing systems of care services; and

(2) the outcome expected from implementing each recommendation.

(b) The commission may include in the report created under this section recommendations for:

(1) the statewide expansion of sites participating in the Texas System of Care; and

(2) the integration of services provided at those sites with services provided by community resource coordination groups.

(c) The commission shall coordinate, where appropriate, the recommendations in the report created under this section with:

(1) recommendations in the assessment developed under Chapter 23 (S.B. 491), Acts of the 78th Legislature, Regular Session, 2003; and

(2) the continuum of care developed under Section 533.040(d), Health and Safety Code.

(d) The commission shall provide a copy of the report created under this section to each agency for which the report makes a recommendation and to other agencies as appropriate. (Gov. Code, Sec. 531.423.)

Source Law

> Sec. 531.423. SUMMARY REPORT BY COMMISSION. (a) The commission shall create a summary report based on the evaluations in the reports submitted to the commission by community resource coordination groups under Section 531.422. The commission's report must include recommendations for policy and statutory changes at each agency that is involved in the provision of systems of care services and the outcome expected from implementing each recommendation.
>
> (b) The commission shall coordinate, where appropriate, the recommendations in the report created under this section with recommendations in the assessment developed under Chapter 23 (S.B. 491), Acts of the 78th Legislature, Regular Session, 2003, and with the continuum of care developed under Section 533.040(d), Health and Safety Code.
>
> (c) The commission may include in the report created under this section recommendations for the statewide expansion of sites participating in the Texas System of Care and the integration of services provided at those sites with services provided by community resource coordination groups.
>
> (d) The commission shall provide a copy of the report created under this section to each agency for which the report makes a recommendation and to other agencies as appropriate.

Revised Law

Sec. 547.0104. AGENCY IMPLEMENTATION OF RECOMMENDATIONS. As appropriate, the person responsible for adopting rules for an agency described by Section 547.0103(a) shall implement the recommendations in the report created under Section 547.0103 by:

(1) adopting rules;

(2) implementing policy changes; and

(3) entering into memoranda of understanding with other agencies. (Gov. Code, Sec. 531.424.)

Source Law

Sec. 531.424. AGENCY IMPLEMENTATION OF RECOMMENDATIONS. As appropriate, the person or entity responsible for adopting rules for an agency described by Section 531.423(a) shall adopt rules, and the agency shall implement policy changes and enter into memoranda of understanding with other agencies, to implement the recommendations in the report created under Section 531.423.

Revisor's Note

Section 531.424, Government Code, refers to a "person or entity" responsible for adopting agency rules. The revised law omits "or entity" because, under Section 311.005, Government Code (Code Construction Act), the term "person" includes an entity.

SUBCHAPTER D. STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL

Revised Law

Sec. 547.0151. DEFINITION. In this subchapter, "council" means the statewide behavioral health coordinating council. (Gov. Code, Sec. 531.471.)

Source Law

Sec. 531.471. DEFINITION. In this subchapter, "council" means the statewide behavioral health coordinating council.

Revised Law

Sec. 547.0152. PURPOSE. The council is established to ensure a strategic statewide approach to behavioral health services. (Gov. Code, Sec. 531.472.)

Source Law

Sec. 531.472. PURPOSE. The council is established to ensure a strategic statewide approach to behavioral health services.

Revised Law

Sec. 547.0153. COMPOSITION OF COUNCIL. (a) The council is composed of at least one representative designated by each of the following entities:

(1) the governor's office;

(2) the Texas Veterans Commission;

(3) the commission;

(4) the Department of State Health Services;

(5) the Department of Family and Protective Services;

(6) the Texas Civil Commitment Office;

(7) The University of Texas Health Science Center at Houston;

(8) The University of Texas Health Science Center at Tyler;

(9) the Texas Tech University Health Sciences Center;

(10) the Texas Department of Criminal Justice;

(11) the Texas Correctional Office on Offenders with Medical or Mental Impairments;

(12) the Commission on Jail Standards;

(13) the Texas Indigent Defense Commission;

(14) the court of criminal appeals;

(15) the Texas Juvenile Justice Department;

(16) the Texas Military Department;

(17) the Texas Education Agency;

(18) the Texas Workforce Commission;

(19) the Health Professions Council, representing:

(A) the State Board of Dental Examiners;

(B) the Texas State Board of Pharmacy;

(C) the State Board of Veterinary Medical Examiners;

(D) the Texas Optometry Board;

(E) the Texas Board of Nursing; and

(F) the Texas Medical Board; and

(20) the Texas Department of Housing and Community Affairs.

(b) The executive commissioner shall determine the number of representatives that each entity may designate to serve on the council.

(c) The council may authorize another state agency or institution that provides specific behavioral health services with

the use of appropriated money to designate a representative to the council.

(d) A council member serves at the pleasure of the designating entity. (Gov. Code, Sec. 531.473.)

Source Law

Sec. 531.473. COMPOSITION OF COUNCIL. (a) The council is composed of at least one representative designated by each of the following entities:

(1) the governor's office;

(2) the Texas Veterans Commission;

(3) the commission;

(4) the Department of State Health Services;

(5) the Department of Family and Protective Services;

(6) the Texas Civil Commitment Office;

(7) The University of Texas Health Science Center at Houston;

(8) The University of Texas Health Science Center at Tyler;

(9) the Texas Tech University Health Sciences Center;

(10) the Texas Department of Criminal Justice;

(11) the Texas Correctional Office on Offenders with Medical or Mental Impairments;

(12) the Commission on Jail Standards;

(13) the Texas Indigent Defense Commission;

(14) the court of criminal appeals;

(15) the Texas Juvenile Justice Department;

(16) the Texas Military Department;

(17) the Texas Education Agency;

(18) the Texas Workforce Commission;

(19) the Health Professions Council, representing:

(A) the State Board of Dental Examiners;

(B) the Texas State Board of Pharmacy;

(C) the State Board of Veterinary Medical Examiners;

(D) the Texas Optometry Board;

(E) the Texas Board of Nursing; and

(F) the Texas Medical Board; and

(20) the Texas Department of Housing and Community Affairs.

(b) The executive commissioner shall determine the number of representatives that each entity may designate to serve on the council.

(c) The council may authorize another state agency or institution that provides specific behavioral health services with the use of appropriated money to designate a representative to the council.

(d) A council member serves at the pleasure of the designating entity.

Revised Law

Sec. 547.0154. PRESIDING OFFICER. The mental health

statewide coordinator shall serve as the presiding officer of the council. (Gov. Code, Sec. 531.474.)

Source Law

Sec. 531.474. PRESIDING OFFICER. The mental health statewide coordinator shall serve as the presiding officer of the council.

Revised Law

Sec. 547.0155. MEETINGS. The council shall meet at least once quarterly or more frequently at the call of the presiding officer. (Gov. Code, Sec. 531.475.)

Source Law

Sec. 531.475. MEETINGS. The council shall meet at least once quarterly or more frequently at the call of the presiding officer.

Revised Law

Sec. 547.0156. POWERS AND DUTIES. (a) The council:

(1) shall develop and monitor the implementation of a five-year statewide behavioral health strategic plan;

(2) shall develop a biennial coordinated statewide behavioral health expenditure proposal;

(3) shall annually publish an updated inventory of behavioral health programs and services that this state funds that includes a description of how those programs and services further the purpose of the statewide behavioral health strategic plan;

(4) may create subcommittees to carry out the council's duties under this subchapter; and

(5) may facilitate opportunities to increase collaboration for the effective expenditure of available federal and state funds for behavioral and mental health services in this state.

(b) The council shall include statewide suicide prevention efforts in the five-year statewide behavioral health strategic plan the council develops under Subsection (a). (Gov. Code, Sec. 531.476.)

Source Law

Sec. 531.476. POWERS AND DUTIES. (a) The

council:

(1) shall develop and monitor the implementation of a five-year statewide behavioral health strategic plan;

(2) shall develop a biennial coordinated statewide behavioral health expenditure proposal;

(3) shall annually publish an updated inventory of behavioral health programs and services that are funded by the state that includes a description of how those programs and services further the purpose of the statewide behavioral health strategic plan;

(4) may create subcommittees to carry out the council's duties under this subchapter; and

(5) may facilitate opportunities to increase collaboration for the effective expenditure of available federal and state funds for behavioral and mental health services in this state.

(b) The council shall include statewide suicide prevention efforts in its five-year statewide behavioral health strategic plan under Subsection (a).

Revised Law

Sec. 547.0157. SUICIDE PREVENTION SUBCOMMITTEE; SUICIDE DATA REPORTS. (a) The council shall create a suicide prevention subcommittee to focus on statewide suicide prevention efforts using information collected by the council from available sources of suicide data reports. The suicide prevention subcommittee shall establish guidelines for the frequent use of those reports in carrying out the council's purpose under this subchapter.

(b) The suicide prevention subcommittee shall establish a method for identifying how suicide data reports are used to make policy.

(c) Public or private entities that collect information regarding suicide and suicide prevention may provide suicide data reports to commission staff the executive commissioner designates to receive those reports. (Gov. Code, Sec. 531.477.)

Source Law

Sec. 531.477. SUICIDE PREVENTION SUBCOMMITTEE; SUICIDE DATA REPORTS. (a) The council shall create a suicide prevention subcommittee to focus on statewide suicide prevention efforts using information collected by the council from available sources of suicide data reports. The suicide prevention subcommittee shall establish guidelines for the frequent use of those reports in carrying out the council's purpose under this subchapter.

(b) The subcommittee created under this section shall establish a method for identifying how suicide data reports are used to make policy.

(c) Public or private entities that collect information regarding suicide and suicide prevention

may provide suicide data reports to commission staff designated by the executive commissioner to receive those reports.

SUBCHAPTER E. BEHAVIORAL HEALTH GRANT PROGRAMS GENERALLY

Revised Law

Sec. 547.0201. STREAMLINING PROCESS FOR AWARDING BEHAVIORAL HEALTH GRANTS. (a) The commission shall implement a process to better coordinate behavioral health grants the commission administers. The process must:

(1) streamline the administrative processes at the commission; and

(2) decrease the administrative burden on applicants applying for multiple grants.

(b) The process may include developing a standard application for multiple behavioral health grants. (Gov. Code, Sec. 531.0991(m).)

Source Law

(m) The commission shall implement a process to better coordinate all behavioral health grants administered by the commission in a manner that streamlines the administrative processes at the commission and decreases the administrative burden on applicants applying for multiple grants. This may include the development of a standard application for multiple behavioral health grants.

SUBCHAPTER F. MATCHING GRANT PROGRAM FOR CERTAIN COMMUNITY MENTAL HEALTH PROGRAMS ASSISTING INDIVIDUALS EXPERIENCING MENTAL ILLNESS

Revised Law

Sec. 547.0251. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Revisor's Note

The definition of "matching grant program" is added to the revised law for drafting convenience and to eliminate the frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 547.0252. MATCHING GRANT PROGRAM. To the extent money is appropriated to the commission for that purpose, the commission

shall establish a matching grant program to support community mental health programs providing services and treatment to individuals experiencing mental illness. (Gov. Code, Sec. 531.0991(a).)

Source Law

> Sec. 531.0991. GRANT PROGRAM FOR MENTAL HEALTH SERVICES. (a) To the extent money is appropriated to the commission for that purpose, the commission shall establish a matching grant program for the purpose of supporting community mental health programs providing services and treatment to individuals experiencing mental illness.

Revised Law

Sec. 547.0253. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS. (a) The commission shall:

(1) condition each grant awarded under this subchapter on the grant recipient obtaining and securing funds to match the grant from non-state sources in amounts of money or other consideration as required by Subsection (c); and

(2) ensure that each grant recipient obtains or secures contributions to match a grant awarded to the recipient in an amount of money or other consideration as required by Subsection (c).

(b) The matching contributions obtained or secured by the grant recipient, as the executive commissioner determines, may include cash or in-kind contributions from any person but may not include money from state or federal funds.

(c) A grant recipient must leverage funds in an amount equal to:

(1) 25 percent of the grant amount if the community mental health program is located in a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the community mental health program is located in a county with a population of 100,000 or more but less than 250,000;

(3) 100 percent of the grant amount if the community mental health program is located in a county with a population of at

least 250,000; and

(4) the percentage of the grant amount otherwise required by this subsection for the largest county in which a community mental health program is located if the community mental health program is located in more than one county. (Gov. Code, Secs. 531.0991(b), (g), (h).)

Source Law

(b) The commission shall ensure that each grant recipient obtains or secures contributions to match awarded grants in amounts of money or other consideration as required by Subsection (h). The money or other consideration obtained or secured by the recipient, as determined by the executive commissioner, may include cash or in-kind contributions from any person but may not include money from state or federal funds.

(g) The commission shall condition each grant awarded to a recipient under the program on the recipient obtaining or securing matching funds from non-state sources in amounts of money or other consideration as required by Subsection (h).

(h) A community that receives a grant under this section is required to leverage funds in an amount:

(1) equal to 25 percent of the grant amount if the community mental health program is located in a county with a population of less than 100,000;

(2) equal to 50 percent of the grant amount if the community mental health program is located in a county with a population of 100,000 or more but less than 250,000;

(3) equal to 100 percent of the grant amount if the community mental health program is located in a county with a population of at least 250,000; and

(4) equal to the percentage of the grant amount otherwise required by this subsection for the largest county in which a community mental health program is located if the community mental health program is located in more than one county.

Revisor's Note

Section 531.0991(h), Government Code, refers to "a community that receives a grant under this section." The revised law substitutes "grant recipient" for the quoted language for consistency of terminology and because it is clear from Sections 531.0991(b) and (g) that the provision applies to grant recipients.

Revised Law

Sec. 547.0254. SELECTION OF RECIPIENTS; APPLICATIONS AND

PROPOSALS. The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and governmental entities. The executive commissioner shall develop criteria for evaluating those applications or proposals and the selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address whether the services proposed in the application or proposal would duplicate services already available in the applicant's service area;

(3) address the possibility of and method for making multiple awards; and

(4) include other factors that the executive commissioner considers relevant. (Gov. Code, Sec. 531.0991(e).)

Source Law

(e) The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and governmental entities. The executive commissioner shall develop criteria for the evaluation of those applications or proposals and the selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address whether the services proposed in the application or proposal would duplicate services already available in the applicant's service area;

(3) address the possibility of and method for making multiple awards; and

(4) include other factors that the executive commissioner considers relevant.

Revised Law

Sec. 547.0255. LOCAL MENTAL HEALTH AUTHORITY INVOLVEMENT. (a) A nonprofit or governmental entity that applies for a grant under this subchapter must:

(1) notify each local mental health authority with a local service area covered wholly or partly by the entity's proposed community mental health program; and

(2) provide in the entity's application a letter of support from each of those local mental health authorities.

(b) The commission shall consider a local mental health authority's written input before awarding a grant under this subchapter and may take any recommendations made by the authority. (Gov. Code, Sec. 531.0991(f).)

Source Law

> (f) A nonprofit or governmental entity that applies for a grant under this section must notify each local mental health authority with a local service area that is covered wholly or partly by the entity's proposed community mental health program and must provide in the entity's application a letter of support from each local mental health authority with a local service area that is covered wholly or partly by the entity's proposed community mental health program. The commission shall consider a local mental health authority's written input before awarding a grant under this section and may take any recommendations made by the authority.

Revisor's Note

> Section 531.0991(f), Government Code, refers to awarding a grant "under this section." The provisions of Section 531.0991 are revised in this chapter as Subchapter F, and the revised law is drafted accordingly.

Revised Law

Sec. 547.0256. USE OF GRANTS AND MATCHING AMOUNTS. A grant awarded under the matching grant program and matching amounts must be used for the sole purpose of supporting community mental health programs that:

(1) provide mental health services and treatment to individuals with a mental illness; and

(2) coordinate mental health services for individuals with a mental illness with other transition support services. (Gov. Code, Sec. 531.0991(d).)

Source Law

(d) A grant awarded under the matching grant program and matching amounts must be used for the sole purpose of supporting community programs that provide mental health care services and treatment to individuals with a mental illness and that coordinate mental health care services for individuals with a mental illness with other transition support services.

Revisor's Note

(1) Section 531.0991(d), Government Code, refers to "community programs." The revised law substitutes "community mental health programs" for "community programs" for consistency of terminology and because it is clear from the context that "community programs" refers to "community mental health programs."

(2) Section 531.0991(d), Government Code, refers to "mental health care services." The revised law substitutes "mental health services" for "mental health care services" for consistency of terminology and because it is clear from the context that "mental health care services" refers to "mental health services."

Revised Law

Sec. 547.0257. DISTRIBUTING AND ALLOCATING APPROPRIATED MONEY. (a) The commission shall disburse money appropriated to or obtained by the commission for the matching grant program directly to a grant recipient, as the executive commissioner authorizes.

(b) Except as provided by Subsection (c), from money appropriated to the commission for each fiscal year to implement this subchapter, the commission shall reserve 50 percent of that total to be awarded only as grants to a community mental health program located in a county with a population not greater than 250,000.

(c) Without regard to the limitation provided by Subsection (b) and to the extent money appropriated to the commission to implement this subchapter for a fiscal year remains available to

the commission after the commission selects grant recipients for the fiscal year, the commission shall make grants available through a competitive request for proposal process using the remaining money for the fiscal year.

(d) The commission may use a reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this subchapter to pay the administrative costs of implementing this subchapter. (Gov. Code, Secs. 531.0991(c), (i), (j), (n).)

Source Law

(c) Money appropriated to or obtained by the commission for the matching grant program must be disbursed directly to grant recipients by the commission, as authorized by the executive commissioner.

(i) Except as provided by Subsection (j), from money appropriated to the commission for each fiscal year to implement this section, the commission shall reserve 50 percent of that total to be awarded only as grants to a community mental health program located in a county with a population not greater than 250,000.

(j) To the extent money appropriated to the commission to implement this section for a fiscal year remains available to the commission after the commission selects grant recipients for the fiscal year, the commission shall make grants available using the money remaining for the fiscal year through a competitive request for proposal process, without regard to the limitation provided by Subsection (i).

(n) A reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this section may be used by the commission to pay administrative costs of implementing this section.

Revised Law

Sec. 547.0258. RULES. The executive commissioner shall adopt rules necessary to implement the matching grant program under this subchapter. (Gov. Code, Sec. 531.0991(l).)

Source Law

(l) The executive commissioner shall adopt any rules necessary to implement the matching grant program under this section.

Revised Law

Sec. 547.0259. BIENNIAL REPORT. Not later than December 1 of each even-numbered year, the executive commissioner shall submit

to the governor, the lieutenant governor, and each member of the legislature a report evaluating the success of the matching grant program. (Gov. Code, Sec. 531.0991(k).)

Source Law

(k) Not later than December 1 of each even-numbered year, the executive commissioner shall submit to the governor, the lieutenant governor, and each member of the legislature a report evaluating the success of the matching grant program created by this section.

SUBCHAPTER G. MATCHING GRANT PROGRAM FOR COMMUNITY MENTAL HEALTH PROGRAMS ASSISTING VETERANS AND THEIR FAMILIES

Revised Law

Sec. 547.0301. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Revisor's Note

The definition of "matching grant program" is added to the revised law for drafting convenience and to eliminate the frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 547.0302. MATCHING GRANT PROGRAM. To the extent funds are appropriated to the commission for that purpose, the commission shall establish a matching grant program to support community mental health programs that provide services and treatment to veterans and their families. (Gov. Code, Sec. 531.0992(a).)

Source Law

Sec. 531.0992. GRANT PROGRAM FOR MENTAL HEALTH SERVICES FOR VETERANS AND THEIR FAMILIES. (a) To the extent funds are appropriated to the commission for that purpose, the commission shall establish a grant program for the purpose of supporting community mental health programs providing services and treatment to veterans and their families.

Revised Law

Sec. 547.0303. MATCHING CONTRIBUTIONS REQUIRED. (a) The commission shall ensure that each grant recipient obtains or secures contributions to match a grant awarded to the recipient in

amounts of money or other consideration as required by Section 547.0304 or 547.0305.

(b) The money or other consideration obtained or secured by the commission may, as the executive commissioner determines, include cash or in-kind contributions from private contributors or local governments but may not include state or federal funds. (Gov. Code, Sec. 531.0992(c).)

Source Law

> (c) The commission shall ensure that each grant recipient obtains or secures contributions to match awarded grants in amounts of money or other consideration as required by Subsection (d-1) or (d-2). The money or other consideration obtained or secured by the commission may, as determined by the executive commissioner, include cash or in-kind contributions from private contributors or local governments but may not include state or federal funds.

Revised Law

Sec. 547.0304. MATCHING GRANT CONDITIONS: SINGLE COUNTIES. For services and treatment provided in a single county, the commission shall condition each grant provided under this subchapter on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of 100,000 or more but less than 250,000; or

(3) 100 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of 250,000 or more. (Gov. Code, Sec. 531.0992(d-1).)

Source Law

> (d-1) For services and treatment provided in a single county, the commission shall condition each

grant provided under this section on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of 100,000 or more but less than 250,000; or

(3) 100 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of 250,000 or more.

Revisor's Note

Section 531.0992(d-1), Government Code, refers to a grant provided "under this section." The provisions of Section 531.0992 are revised in this chapter as Subchapter G, and the revised law is drafted accordingly.

Revised Law

Sec. 547.0305. MATCHING GRANT CONDITIONS: MULTIPLE COUNTIES. For a community mental health program that provides services and treatment in more than one county, the commission shall condition each grant provided under this subchapter on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of less than 100,000;

(2) 50 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of 100,000 or more but less than 250,000; or

(3) 100 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of 250,000 or more. (Gov. Code, Sec. 531.0992(d-2).)

Source Law

(d-2) For a community mental health program that provides services and treatment in more than one county, the commission shall condition each grant provided under this section on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of less than 100,000;

(2) 50 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of 100,000 or more but less than 250,000; or

(3) 100 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of 250,000 or more.

Revised Law

Sec. 547.0306. SELECTION OF RECIPIENTS; APPLICATIONS AND PROPOSALS. (a) The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and governmental entities.

(b) The executive commissioner shall develop criteria for evaluating the applications or proposals and the selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address the possibility of and method for making multiple awards; and

(3) include other factors that the executive commissioner considers relevant. (Gov. Code, Sec. 531.0992(f).)

Source Law

(f) The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and governmental entities. The executive commissioner shall develop criteria for the evaluation of those applications or proposals and the

selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address the possibility of and method for making multiple awards; and

(3) include other factors that the executive commissioner considers relevant.

Revised Law

Sec. 547.0307. USE OF GRANTS AND MATCHING AMOUNTS. A grant awarded under the matching grant program must be used for the sole purpose of supporting community mental health programs that:

(1) provide mental health services and treatment to veterans and their families; and

(2) coordinate mental health services for veterans and their families with other transition support services. (Gov. Code, Sec. 531.0992(e).)

Source Law

(e) All grants awarded under the grant program must be used for the sole purpose of supporting community programs that provide mental health care services and treatment to veterans and their families and that coordinate mental health care services for veterans and their families with other transition support services.

Revisor's Note

Section 531.0992(e), Government Code, refers to "community programs." The revised law substitutes "community mental health programs" for "community programs" for the reasons stated in Revisor's Note (1) to Section 547.0256.

Revised Law

Sec. 547.0308. DISTRIBUTING AND ALLOCATING APPROPRIATED MONEY. (a) As the executive commissioner authorizes, the commission shall disburse money appropriated to or obtained by the commission for the matching grant program directly to grant recipients.

(b) The commission may use a reasonable amount not to exceed five percent of the money appropriated by the legislature for the

purposes of this subchapter to pay the administrative costs of implementing this subchapter. (Gov. Code, Secs. 531.0992(d), (g).)

Source Law

(d) Money appropriated to, or obtained by, the commission for the grant program must be disbursed directly to grant recipients by the commission, as authorized by the executive commissioner.

(g) A reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this section may be used by the commission to pay administrative costs of implementing this section.

Revised Law

Sec. 547.0309. RULES. The executive commissioner shall adopt rules necessary to implement the matching grant program. (Gov. Code, Sec. 531.0992(h).)

Source Law

(h) The executive commissioner shall adopt any rules necessary to implement the grant program under this section.

SUBCHAPTER H. MATCHING GRANT PROGRAM FOR CERTAIN COMMUNITY COLLABORATIVES TO REDUCE INVOLVEMENT OF INDIVIDUALS WITH MENTAL ILLNESS IN CRIMINAL JUSTICE SYSTEM

Revised Law

Sec. 547.0351. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Revisor's Note

The definition of "matching grant program" is added to the revised law for consistency of terminology and drafting convenience and to eliminate the frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 547.0352. MATCHING GRANT PROGRAM. The commission shall establish a matching grant program to provide grants to county-based community collaboratives to reduce:

(1) recidivism by, the frequency of arrests of, and

incarceration of individuals with mental illness; and

(2) the total wait time for forensic commitment of individuals with mental illness to a state hospital. (Gov. Code, Sec. 531.0993(a).)

Source Law

> Sec. 531.0993. GRANT PROGRAM TO REDUCE RECIDIVISM, ARREST, AND INCARCERATION AMONG INDIVIDUALS WITH MENTAL ILLNESS AND TO REDUCE WAIT TIME FOR FORENSIC COMMITMENT. (a) The commission shall establish a program to provide grants to county-based community collaboratives for the purposes of reducing:
>
> (1) recidivism by, the frequency of arrests of, and incarceration of persons with mental illness; and
>
> (2) the total waiting time for forensic commitment of persons with mental illness to a state hospital.

Revised Law

Sec. 547.0353. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS. (a) The commission shall condition each grant provided to a community collaborative under this subchapter on the collaborative providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the collaborative includes a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the collaborative includes a county with a population of 100,000 or more but less than 250,000;

(3) 100 percent of the grant amount if the collaborative includes a county with a population of 250,000 or more; and

(4) the percentage of the grant amount otherwise required by this subsection for the largest county included in the collaborative, if the collaborative includes more than one county.

(b) A community collaborative may seek and receive gifts, grants, or donations from any person to raise the required funds from non-state sources. (Gov. Code, Secs. 531.0993(c), (c-1).)

Source Law

(c) The commission shall condition each grant provided to a community collaborative under this section on the collaborative providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the collaborative includes a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the collaborative includes a county with a population of 100,000 or more but less than 250,000;

(3) 100 percent of the grant amount if the collaborative includes a county with a population of 250,000 or more; and

(4) the percentage of the grant amount otherwise required by this subsection for the largest county included in the collaborative, if the collaborative includes more than one county.

(c-1) To raise the required non-state sourced funds, a collaborative may seek and receive gifts, grants, or donations from any person.

Revisor's Note

Section 531.0993(c), Government Code, refers to a grant provided "under this section." The provisions of Section 531.0993 are revised in this chapter as Subchapter H, and the revised law is drafted accordingly.

Revised Law

Sec. 547.0354. COMMUNITY COLLABORATIVE ELIGIBILITY; CERTAIN GRANTS PROHIBITED. (a) A community collaborative may petition the commission to receive a grant under the matching grant program only if the collaborative includes:

(1) a county;

(2) a local mental health authority that operates in the county; and

(3) each hospital district, if any, located in the county.

(b) A collaborative may include other local entities designated by the collaborative's members.

(c) The commission may not award a grant under this subchapter for a fiscal year to a community collaborative that includes a county with a population greater than four million if the legislature appropriates money for a mental health jail diversion

program in the county for that fiscal year. (Gov. Code, Secs. 531.0993(b), (i).)

Source Law

> (b) A community collaborative may petition the commission for a grant under the program only if the collaborative includes a county, a local mental health authority that operates in the county, and each hospital district, if any, located in the county. A community collaborative may include other local entities designated by the collaborative's members.
>
> (i) The commission may not award a grant under this section for a fiscal year to a community collaborative that includes a county with a population greater than four million if the legislature appropriates money for a mental health jail diversion program in the county for that fiscal year.

Revised Law

Sec. 547.0355. PETITION REQUIRED; CONTENTS. In each state fiscal year for which a community collaborative seeks a grant, the collaborative must submit a petition to the commission not later than the 30th day of that fiscal year. The collaborative must include with a petition:

(1) a statement indicating the amount of funds from non-state sources that the collaborative is able to provide; and

(2) a plan that:

(A) is endorsed by each of the collaborative's member entities;

(B) identifies a target population;

(C) describes how the grant money and the funds from non-state sources will be used;

(D) includes outcome measures to evaluate the success of the plan; and

(E) describes how the success of the plan, in accordance with the outcome measures, would further the state's interest in the grant program's purposes. (Gov. Code, Sec. 531.0993(d).)

Source Law

> (d) For each state fiscal year for which a community collaborative seeks a grant, the collaborative must submit a petition to the commission not later than the 30th day of that fiscal year. The

community collaborative must include with a petition:

(1) a statement indicating the amount of funds from non-state sources the collaborative is able to provide; and

(2) a plan that:

(A) is endorsed by each of the collaborative's member entities;

(B) identifies a target population;

(C) describes how the grant money and funds from non-state sources will be used;

(D) includes outcome measures to evaluate the success of the plan; and

(E) describes how the success of the plan in accordance with the outcome measures would further the state's interest in the grant program's purposes.

Revised Law

Sec. 547.0356. REVIEW OF PETITION BY COMMISSION. The commission must review plans submitted with a petition under Section 547.0355 before the commission provides a grant under this subchapter. The commission must fulfill this requirement not later than the 60th day of each fiscal year. (Gov. Code, Sec. 531.0993(e).)

Source Law

(e) The commission must review plans submitted with a petition under Subsection (d) before the commission provides a grant under this section. The commission must fulfill the commission's requirements under this subsection not later than the 60th day of each fiscal year.

Revised Law

Sec. 547.0357. USE OF GRANT MONEY AND MATCHING FUNDS. Acceptable uses of the grant money and matching funds include:

(1) continuing a mental health jail diversion program;

(2) establishing or expanding a mental health jail diversion program;

(3) establishing alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) providing assertive community treatment or forensic assertive community treatment with an outreach component;

(5) providing intensive mental health services and substance use treatment not readily available in the county;

(6) providing continuity of care services for an individual being released from a state hospital;

(7) establishing interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) providing local community hospital, crisis, respite, or residential beds. (Gov. Code, Sec. 531.0993(f).)

Source Law

(f) Acceptable uses for the grant money and matching funds include:

(1) the continuation of a mental health jail diversion program;

(2) the establishment or expansion of a mental health jail diversion program;

(3) the establishment of alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) the provision of assertive community treatment or forensic assertive community treatment with an outreach component;

(5) the provision of intensive mental health services and substance abuse treatment not readily available in the county;

(6) the provision of continuity of care services for an individual being released from a state hospital;

(7) the establishment of interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) the provision of local community hospital, crisis, respite, or residential beds.

Revised Law

Sec. 547.0358. REPORT BY COMMUNITY COLLABORATIVE. Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this subchapter, each grant recipient shall prepare and submit a report to the commission describing the effect of the grant money and matching funds in achieving the standard defined by the outcome measures in the plan submitted with a petition under Section 547.0355. (Gov. Code, Sec. 531.0993(g).)

Source Law

(g) Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this section, each community collaborative that receives a grant shall prepare and

submit a report describing the effect of the grant money and matching funds in achieving the standard defined by the outcome measures in the plan submitted under Subsection (d).

Revised Law

Sec. 547.0359. INSPECTIONS. The commission may inspect the operation and provision of mental health services provided by a community collaborative to ensure state money appropriated for the matching grant program is used effectively. (Gov. Code, Sec. 531.0993(h).)

Source Law

(h) The commission may make inspections of the operation and provision of mental health services provided by a community collaborative to ensure state money appropriated for the grant program is used effectively.

Revised Law

Sec. 547.0360. ALLOCATING APPROPRIATED MONEY. (a) Except as provided by Subsection (b), the commission shall reserve at least 20 percent of money appropriated to the commission for each fiscal year to implement the matching grant program to be awarded only as grants to a community collaborative that includes a county with a population of less than 250,000.

(b) Without regard to the limitation provided by Subsection (a) and to the extent money appropriated to the commission for a fiscal year to implement this subchapter remains available to the commission after the commission has selected grant recipients for the fiscal year, the commission shall make grants available through a competitive request for proposal process using the remaining money for the fiscal year.

(c) The commission may use a reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this subchapter to pay the administrative costs of implementing this subchapter. (Gov. Code, Secs. 531.0993(c-2), (f-1), (j).)

Source Law

(c-2) Beginning on or after September 1, 2018, from money appropriated to the commission for each fiscal year to implement this section, the commission

shall reserve at least 20 percent of that total to be awarded only as grants to a community collaborative that includes a county with a population of less than 250,000.

(f-1) Beginning on or after September 1, 2018, to the extent money appropriated to the commission for a fiscal year to implement this section remains available to the commission after the commission selects grant recipients for the fiscal year, the commission shall make grants available using the money remaining for the fiscal year through a competitive request for proposal process, without regard to the limitation provided by Subsection (c-2).

(j) A reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this section may be used by the commission to pay administrative costs of implementing this section.

Revisor's Note

Sections 531.0993(c-2) and (f-1), Government Code, require the commission to take certain action "[b]eginning on or after September 1, 2018." The revised law omits the quoted language as unnecessary because that date has passed.

SUBCHAPTER I. MATCHING GRANT PROGRAM FOR COMMUNITY COLLABORATIVE IN MOST POPULOUS COUNTY TO REDUCE INVOLVEMENT OF INDIVIDUALS WITH MENTAL ILLNESS IN CRIMINAL JUSTICE SYSTEM

Revised Law

Sec. 547.0401. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Revisor's Note

The definition of "matching grant program" is added to the revised law for consistency of terminology and drafting convenience and to eliminate the frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 547.0402. MATCHING GRANT PROGRAM. The commission shall establish a matching grant program to provide a grant to a county-based community collaborative in the most populous county in this state to reduce:

(1) recidivism by, the frequency of arrests of, and incarceration of individuals with mental illness; and

(2) the total wait time for forensic commitment of individuals with mental illness to a state hospital. (Gov. Code, Sec. 531.09935(a).)

Source Law

> Sec. 531.09935. GRANT PROGRAM TO REDUCE RECIDIVISM, ARREST, AND INCARCERATION AMONG INDIVIDUALS WITH MENTAL ILLNESS AND TO REDUCE WAIT TIME FOR FORENSIC COMMITMENT IN MOST POPULOUS COUNTY. (a) The commission shall establish a program to provide a grant to a county-based community collaborative in the most populous county in this state for the purposes of reducing:
>
> (1) recidivism by, the frequency of arrests of, and incarceration of persons with mental illness; and
>
> (2) the total waiting time for forensic commitment of persons with mental illness to a state hospital.

Revised Law

Sec. 547.0403. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS. (a) The commission shall condition a grant provided to the community collaborative under this subchapter on the collaborative providing funds from non-state sources in a total amount at least equal to the grant amount.

(b) A community collaborative may seek and receive gifts, grants, or donations from any person to raise the required funds from non-state sources. (Gov. Code, Secs. 531.09935(d), (e).)

Source Law

> (d) The commission shall condition a grant provided to the community collaborative under this section on the collaborative providing funds from non-state sources in a total amount at least equal to the grant amount.
>
> (e) To raise the required non-state sourced funds, the collaborative may seek and receive gifts, grants, or donations from any person.

Revisor's Note

Section 531.09935(d), Government Code, refers to a grant provided "under this section." The provisions of Section 531.09935 are revised in this chapter as Subchapter I, and the revised law is drafted accordingly.

Revised Law

Sec. 547.0404. COMMUNITY COLLABORATIVE ELIGIBILITY. (a) A community collaborative may receive a grant under the matching grant program only if the collaborative includes:

(1) the county;

(2) a local mental health authority operating in the county; and

(3) each hospital district located in the county.

(b) A collaborative may include other local entities designated by the collaborative's members. (Gov. Code, Sec. 531.09935(b).)

Source Law

> (b) The community collaborative may receive a grant under the program only if the collaborative includes the county, a local mental health authority that operates in the county, and each hospital district located in the county. A community collaborative may include other local entities designated by the collaborative's members.

Revised Law

Sec. 547.0405. DISTRIBUTION OF GRANT. Not later than the 30th day of each fiscal year, the commission shall make available to the community collaborative established in the county described by Section 547.0402 a grant in an amount equal to the lesser of:

(1) the amount appropriated to the commission for that fiscal year for a mental health jail diversion pilot program in that county; or

(2) the collaborative's available matching funds. (Gov. Code, Sec. 531.09935(c).)

Source Law

> (c) Not later than the 30th day of each fiscal year, the commission shall make available to the community collaborative established in the county described by Subsection (a) a grant in an amount equal to the lesser of:
>
> (1) the amount appropriated to the commission for that fiscal year for a mental health jail diversion pilot program in that county; or
>
> (2) the collaborative's available matching funds.

Revised Law

Sec. 547.0406. USE OF GRANT MONEY AND MATCHING FUNDS. Acceptable uses of the grant money and matching funds include:

(1) continuing a mental health jail diversion program;

(2) establishing or expanding a mental health jail diversion program;

(3) establishing alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) providing assertive community treatment or forensic assertive community treatment with an outreach component;

(5) providing intensive mental health services and substance use treatment not readily available in the county;

(6) providing continuity of care services for an individual being released from a state hospital;

(7) establishing interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) providing local community hospital, crisis, respite, or residential beds. (Gov. Code, Sec. 531.09935(f).)

Source Law

(f) Acceptable uses for the grant money and matching funds include:

(1) the continuation of a mental health jail diversion program;

(2) the establishment or expansion of a mental health jail diversion program;

(3) the establishment of alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) the provision of assertive community treatment or forensic assertive community treatment with an outreach component;

(5) the provision of intensive mental health services and substance abuse treatment not readily available in the county;

(6) the provision of continuity of care services for an individual being released from a state hospital;

(7) the establishment of interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health

emergencies; and

(8) the provision of local community hospital, crisis, respite, or residential beds.

Revised Law

Sec. 547.0407. REPORT BY COMMUNITY COLLABORATIVE. Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this subchapter, the grant recipient shall prepare and submit a report to the commission describing the effect of the grant money and matching funds in fulfilling the purpose described by Section 547.0402. (Gov. Code, Sec. 531.09935(g).)

Source Law

(g) Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this section, the community collaborative shall prepare and submit a report describing the effect of the grant money and matching funds in fulfilling the purpose described by Subsection (a).

Revised Law

Sec. 547.0408. INSPECTIONS. The commission may inspect the operation and provision of mental health services provided by the community collaborative to ensure state money appropriated for the matching grant program is used effectively. (Gov. Code, Sec. 531.09935(h).)

Source Law

(h) The commission may make inspections of the operation and provision of mental health services provided by the community collaborative to ensure state money appropriated for the grant program is used effectively.

CHAPTER 547A. COMMUNITY COLLABORATIVES

Sec. 547A.0001. GRANTS FOR ESTABLISHING AND EXPANDING COMMUNITY COLLABORATIVES . . . . . 991

Sec. 547A.0002. ACCEPTABLE USES OF GRANT MONEY . . . . . 994

Sec. 547A.0003. ELEMENTS OF COMMUNITY COLLABORATIVES . . . . 995

Sec. 547A.0004. OUTCOME MEASURES FOR COMMUNITY COLLABORATIVES . . . . . 996

Sec. 547A.0005. PLAN REQUIRED FOR CERTAIN COMMUNITY COLLABORATIVES . . . . . 998

Sec. 547A.0006. ANNUAL REVIEW OF OUTCOME MEASURES . . . . . 999
Sec. 547A.0007. REDUCTION AND CESSATION OF FUNDING . . . . . 999
Sec. 547A.0008. RULES . . . . . 1000
Sec. 547A.0009. ADMINISTRATIVE COSTS . . . . . 1000

CHAPTER 547A. COMMUNITY COLLABORATIVES

Revised Law

Sec. 547A.0001. GRANTS FOR ESTABLISHING AND EXPANDING COMMUNITY COLLABORATIVES. (a) To the extent funds are appropriated to the commission for that purpose, the commission shall make grants to entities, including local governmental entities, nonprofit community organizations, and faith-based community organizations, to establish or expand community collaboratives that bring the public and private sectors together to provide services to individuals experiencing homelessness, substance use issues, or mental illness. In awarding grants, the commission shall give special consideration to entities:

(1) establishing new collaboratives; or

(2) establishing or expanding collaboratives that serve two or more counties, each with a population of less than 100,000.

(b) Except as provided by Subsection (c), the commission shall require each entity awarded a grant under this section to:

(1) leverage additional funding or in-kind contributions from private contributors or local governments, excluding state or federal funds, in an amount that is at least equal to the amount of the grant awarded under this section;

(2) provide evidence of significant coordination and collaboration between the entity, local mental health authorities, municipalities, local law enforcement agencies, and other community stakeholders in establishing or expanding a community collaborative funded by a grant awarded under this section; and

(3) provide evidence of a local law enforcement policy to divert appropriate individuals from jails or other detention facilities to an entity affiliated with a community collaborative

for the purpose of providing services to those individuals.

(c) The commission may award a grant under this section to an entity for the purpose of establishing a community mental health program in a county with a population of less than 250,000, if the entity leverages additional funding or in-kind contributions from private contributors or local governments, excluding state or federal funds, in an amount equal to one-quarter of the grant amount to be awarded under this section, and the entity otherwise meets the requirements of Subsections (b)(2) and (3). (Gov. Code, Sec. 539.002.)

Source Law

Sec. 539.002. GRANTS FOR ESTABLISHMENT AND EXPANSION OF COMMUNITY COLLABORATIVES. (a) To the extent funds are appropriated to the department for that purpose, the department shall make grants to entities, including local governmental entities, nonprofit community organizations, and faith-based community organizations, to establish or expand community collaboratives that bring the public and private sectors together to provide services to persons experiencing homelessness, substance abuse issues, or mental illness. In awarding grants, the department shall give special consideration to entities:

(1) establishing new collaboratives; or

(2) establishing or expanding collaboratives that serve two or more counties, each with a population of less than 100,000.

(b) Except as provided by Subsection (c), the department shall require each entity awarded a grant under this section to:

(1) leverage additional funding or in-kind contributions from private contributors or local governments, excluding state or federal funds, in an amount that is at least equal to the amount of the grant awarded under this section;

(2) provide evidence of significant coordination and collaboration between the entity, local mental health authorities, municipalities, local law enforcement agencies, and other community stakeholders in establishing or expanding a community collaborative funded by a grant awarded under this section; and

(3) provide evidence of a local law enforcement policy to divert appropriate persons from jails or other detention facilities to an entity affiliated with a community collaborative for the purpose of providing services to those persons.

(c) The department may award a grant under this chapter to an entity for the purpose of establishing a community mental health program in a county with a population of less than 250,000, if the entity leverages additional funding or in-kind contributions from private contributors or local governments, excluding state or federal funds, in an amount equal to one-quarter of the amount of the grant to be awarded

under this section, and the entity otherwise meets the requirements of Subsections (b)(2) and (3).

Revisor's Note

(1) Section 539.002(a), Government Code, authorizes the "department," meaning the Department of State Health Services, to make grants to entities to establish or expand community collaboratives. The Department of State Health Services' client services functions, including functions related to community collaboratives, were transferred to the Health and Human Services Commission in accordance with Section 531.0201(a)(2)(C), Government Code, which is executed law that expires September 1, 2023. Therefore, throughout this chapter the revised law substitutes "commission" for "department."

(2) Sections 539.002(a) and (b), Government Code, refer to "persons" experiencing homelessness, substance abuse issues, or mental illness and diverting appropriate "persons" from jails and other detention facilities, respectively. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), which applies to this code.

(3) Section 539.002(a), Government Code, refers to providing services for persons with "substance abuse" issues. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), published by the American Psychiatric Association to assist in classifying mental disorders, combines the categories of substance abuse and substance dependence into a single disorder referred to as "substance use disorder." Therefore, throughout this chapter the

revised law substitutes "substance use" for "substance abuse" to reflect modern terminology.

(4) Section 539.002(c), Government Code, refers to a grant provided to an entity "under this chapter." For consistency of terminology and because the specific authority to provide a grant is contained in the revised section, the revised law substitutes "section" for "chapter."

Revised Law

Sec. 547A.0002. ACCEPTABLE USES OF GRANT MONEY. An entity shall use money received from a grant made by the commission and private funding sources to establish or expand a community collaborative. Acceptable uses for the money include:

(1) developing the infrastructure of the collaborative and the start-up costs of the collaborative;

(2) establishing, operating, or maintaining other community service providers in the community the collaborative serves, including intake centers, detoxification units, sheltering centers for food, workforce training centers, microbusinesses, and educational centers;

(3) providing clothing, hygiene products, and medical services to and arranging transitional and permanent residential housing for individuals the collaborative serves;

(4) providing mental health services and substance use treatment not readily available in the community the collaborative serves;

(5) providing information, tools, and resource referrals to assist individuals the collaborative serves in addressing the needs of their children; and

(6) establishing and operating coordinated intake processes, including triage procedures, to protect public safety in the community the collaborative serves. (Gov. Code, Sec. 539.003.)

Source Law

Sec. 539.003. ACCEPTABLE USES OF GRANT

MONEY. An entity shall use money received from a grant made by the department and private funding sources for the establishment or expansion of a community collaborative. Acceptable uses for the money include:

(1) the development of the infrastructure of the collaborative and the start-up costs of the collaborative;

(2) the establishment, operation, or maintenance of other community service providers in the community served by the collaborative, including intake centers, detoxification units, sheltering centers for food, workforce training centers, microbusinesses, and educational centers;

(3) the provision of clothing, hygiene products, and medical services to and the arrangement of transitional and permanent residential housing for persons served by the collaborative;

(4) the provision of mental health services and substance abuse treatment not readily available in the community served by the collaborative;

(5) the provision of information, tools, and resource referrals to assist persons served by the collaborative in addressing the needs of their children; and

(6) the establishment and operation of coordinated intake processes, including triage procedures, to protect the public safety in the community served by the collaborative.

Revised Law

Sec. 547A.0003. ELEMENTS OF COMMUNITY COLLABORATIVES. (a) If appropriate, an entity may incorporate into the community collaborative the entity operates the use of the homeless management information system, transportation plans, and case managers. An entity may also consider incorporating into a collaborative mentoring and volunteering opportunities, strategies to assist homeless youth and homeless families with children, strategies to reintegrate individuals who were recently incarcerated into the community, services for veterans, and strategies for individuals the collaborative serves to participate in the planning, governance, and oversight of the collaborative.

(b) The focus of a community collaborative shall be the eventual successful transition of individuals from receiving services from the collaborative to becoming integrated into the community the collaborative serves through community relationships and family supports. (Gov. Code, Sec. 539.004.)

Source Law

Sec. 539.004. ELEMENTS OF COMMUNITY

COLLABORATIVES. (a) If appropriate, an entity may incorporate into the community collaborative operated by the entity the use of the Homeless Management Information System, transportation plans, and case managers. An entity may also consider incorporating into a collaborative mentoring and volunteering opportunities, strategies to assist homeless youth and homeless families with children, strategies to reintegrate persons who were recently incarcerated into the community, services for veterans, and strategies for persons served by the collaborative to participate in the planning, governance, and oversight of the collaborative.

(b) The focus of a community collaborative shall be the eventual successful transition of persons from receiving services from the collaborative to becoming integrated into the community served by the collaborative through community relationships and family supports.

Revised Law

Sec. 547A.0004. OUTCOME MEASURES FOR COMMUNITY COLLABORATIVES. Each entity that receives a grant from the commission to establish or expand a community collaborative shall select at least four of the following outcome measures that the entity will focus on meeting through implementing and operating the collaborative:

(1) individuals the collaborative serves finding employment that results in those individuals having incomes that are at or above 100 percent of the federal poverty level;

(2) individuals the collaborative serves finding permanent housing;

(3) individuals the collaborative serves completing alcohol or substance use programs;

(4) the collaborative helping to start social businesses in the community or engaging in job creation, job training, or other workforce development activities;

(5) a decrease in the use of jail beds by individuals the collaborative serves;

(6) a decrease in the need for emergency care by individuals the collaborative serves;

(7) a decrease in the number of children whose families lack adequate housing referred to the Department of Family and Protective Services or a local entity responsible for child

welfare; and

(8) any other appropriate outcome measure the commission approves that measures whether a collaborative is meeting a specific need of the community the collaborative serves. (Gov. Code, Sec. 539.005.)

Source Law

Sec. 539.005. OUTCOME MEASURES FOR COMMUNITY COLLABORATIVES. Each entity that receives a grant from the department to establish or expand a community collaborative shall select at least four of the following outcome measures that the entity will focus on meeting through the implementation and operation of the collaborative:

(1) persons served by the collaborative will find employment that results in those persons having incomes that are at or above 100 percent of the federal poverty level;

(2) persons served by the collaborative will find permanent housing;

(3) persons served by the collaborative will complete alcohol or substance abuse programs;

(4) the collaborative will help start social businesses in the community or engage in job creation, job training, or other workforce development activities;

(5) there will be a decrease in the use of jail beds by persons served by the collaborative;

(6) there will be a decrease in the need for emergency care by persons served by the collaborative;

(7) there will be a decrease in the number of children whose families lack adequate housing referred to the Department of Family and Protective Services or a local entity responsible for child welfare; and

(8) any other appropriate outcome measure that measures whether a collaborative is meeting a specific need of the community served by the collaborative and that is approved by the department.

Revisor's Note

Section 539.005, Government Code, refers to an alcohol "abuse" program. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), published by the American Psychiatric Association to assist in classifying mental disorders, combines the categories of alcohol abuse and alcohol dependence into a single disorder referred to as "alcohol use disorder." Therefore, the revised law substitutes "use" for "abuse" to reflect modern terminology.

Revised Law

Sec. 547A.0005. PLAN REQUIRED FOR CERTAIN COMMUNITY COLLABORATIVES. (a) The governing body of a county shall develop and make public a plan detailing the method by which:

(1) local mental health authorities, municipalities, local law enforcement agencies, and other community stakeholders in the county may coordinate to establish or expand a community collaborative to accomplish the goals of Section 547A.0001;

(2) entities in the county may leverage funding from private sources to accomplish the goals of Section 547A.0001 through the formation or expansion of a community collaborative; and

(3) the formation or expansion of a community collaborative may establish or support resources or services to help local law enforcement agencies to divert individuals who have been arrested to appropriate mental health care or substance use treatment.

(b) The governing body of a county in which an entity that received a grant under former Section 539.002 before September 1, 2017, is located is not required to develop a plan under Subsection (a).

(c) Two or more counties, each with a population of less than 100,000, may form a joint plan under Subsection (a). (Gov. Code, Sec. 539.0051.)

Source Law

Sec. 539.0051. PLAN REQUIRED FOR CERTAIN COMMUNITY COLLABORATIVES. (a) The governing body of a county shall develop and make public a plan detailing:

(1) how local mental health authorities, municipalities, local law enforcement agencies, and other community stakeholders in the county could coordinate to establish or expand a community collaborative to accomplish the goals of Section 539.002;

(2) how entities in the county may leverage funding from private sources to accomplish the goals of Section 539.002 through the formation or expansion of a community collaborative; and

(3) how the formation or expansion of a community collaborative could establish or support resources or services to help local law enforcement

agencies to divert persons who have been arrested to appropriate mental health care or substance abuse treatment.

(b) The governing body of a county in which an entity that received a grant under Section 539.002 before September 1, 2017, is located is not required to develop a plan under Subsection (a).

(c) Two or more counties, each with a population of less than 100,000, may form a joint plan under Subsection (a).

Revised Law

Sec. 547A.0006. ANNUAL REVIEW OF OUTCOME MEASURES. The commission shall contract with an independent third party to verify annually whether a community collaborative is meeting the outcome measures the entity that operates the collaborative selects under Section 547A.0004. (Gov. Code, Sec. 539.006.)

Source Law

Sec. 539.006. ANNUAL REVIEW OF OUTCOME MEASURES. The department shall contract with an independent third party to verify annually whether a community collaborative is meeting the outcome measures under Section 539.005 selected by the entity that operates the collaborative.

Revised Law

Sec. 547A.0007. REDUCTION AND CESSATION OF FUNDING. The commission shall establish processes by which the commission may reduce or cease providing funding to an entity if the community collaborative the entity operates does not meet the outcome measures the entity for the collaborative selects under Section 547A.0004. The commission shall redistribute on a competitive basis any funds withheld from an entity under this section to other entities operating high-performing collaboratives. (Gov. Code, Sec. 539.007.)

Source Law

Sec. 539.007. REDUCTION AND CESSATION OF FUNDING. The department shall establish processes by which the department may reduce or cease providing funding to an entity if the community collaborative operated by the entity does not meet the outcome measures selected by the entity for the collaborative under Section 539.005. The department shall redistribute any funds withheld from an entity under this section to other entities operating high-performing collaboratives on a competitive basis.

Revised Law

Sec. 547A.0008. RULES. The executive commissioner shall adopt any rules necessary to implement the community collaborative grant program established under this chapter, including rules establishing:

(1) the requirements for an entity to be eligible to receive a grant;

(2) the required elements of a community collaborative an entity operates; and

(3) permissible and prohibited uses of money an entity receives from a grant the commission makes. (Gov. Code, Sec. 539.008.)

Source Law

> Sec. 539.008. RULES. The executive commissioner shall adopt any rules necessary to implement the community collaborative grant program established under this chapter, including rules to establish the requirements for an entity to be eligible to receive a grant, the required elements of a community collaborative operated by an entity, and permissible and prohibited uses of money received by an entity from a grant made by the department under this chapter.

Revised Law

Sec. 547A.0009. ADMINISTRATIVE COSTS. The commission may use a reasonable amount not to exceed five percent of the money the legislature appropriates for the purposes of this chapter to pay administrative costs of implementing this chapter. (Gov. Code, Sec. 539.009.)

Source Law

> Sec. 539.009. ADMINISTRATIVE COSTS. A reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this subchapter may be used by the commission to pay administrative costs of implementing this subchapter.

Revisor's Note

Section 539.009, Government Code, refers to money appropriated by the legislature for the purposes of "this subchapter" and for implementing "this subchapter." The quoted language is clearly a

drafting error because Section 539.009 is included in Chapter 539, Government Code, and Chapter 539 does not contain subchapters. The revised law retains the chapter structure. Accordingly, the revised law substitutes "chapter" for "subchapter."

Revisor's Note
(End of Chapter)

Section 539.001, Government Code, defines "department" as meaning the Department of State Health Services. The revised law omits the definition for the reason stated in Revisor's Note (1) to Section 547A.0001. The omitted law reads:

> Sec. 539.001. DEFINITION. In this chapter, "department" means the Department of State Health Services.

CHAPTER 548. HEALTH CARE SERVICES PROVIDED THROUGH TELE-CONNECTIVE MEANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 548.0001. PROVISION OF SERVICES THROUGH TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY UNDER MEDICAID AND OTHER PUBLIC BENEFITS PROGRAMS . . . . . 1004
Sec. 548.0002. RULES AND PROCEDURES REGARDING REIMBURSING CERTAIN TELEMEDICINE MEDICAL SERVICES . . . . . 1007

SUBCHAPTER B. TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, TELEHEALTH, AND HOME TELEMONITORING SERVICES PROVIDED UNDER MEDICAID IN GENERAL

Sec. 548.0051. MEDICAID REIMBURSEMENT SYSTEM FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES . . . . . 1008
Sec. 548.0052. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE BY MEDICAID MANAGED CARE ORGANIZATION . . . . . 1008

Sec. 548.0053. REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE . . . . . 1009
Sec. 548.0054. PROVIDER AND FACILITY PARTICIPATION . . . . . 1010
Sec. 548.0055. PROMOTION AND SUPPORT OF MEDICAL HOME AND CARE COORDINATION . . . . . 1011
Sec. 548.0056. BIENNIAL REPORT . . . . . 1013
Sec. 548.0057. RULES . . . . . 1013
SUBCHAPTER C. PROVISION OF AND REIMBURSEMENT FOR TELEMEDICINE MEDICAL AND TELEHEALTH SERVICES IN GENERAL
Sec. 548.0101. DEFINITIONS . . . . . 1014
Sec. 548.0102. MEDICAID REIMBURSEMENT REQUIREMENTS: TELEMEDICINE MEDICAL SERVICES . . . . . 1015
Sec. 548.0103. PHYSICIAN'S CHOICE OF PLATFORM . . . . . 1016
Sec. 548.0104. CERTAIN TELEMEDICINE MEDICAL SERVICE REIMBURSEMENT DENIALS PROHIBITED . . . . . 1016
Sec. 548.0105. PROTOCOLS AND GUIDELINES . . . . . 1017
Sec. 548.0106. PROVIDER COORDINATION . . . . . 1017
Sec. 548.0107. COMPLIANCE . . . . . 1018
Sec. 548.0108. TEXAS MEDICAL BOARD RULES . . . . . 1018
Sec. 548.0109. EFFECT ON OTHER REQUIREMENTS . . . . . 1018
SUBCHAPTER D. PROVISION OF AND REIMBURSEMENT FOR TELEDENTISTRY DENTAL SERVICES IN GENERAL
Sec. 548.0151. MEDICAID REIMBURSEMENT REQUIREMENTS . . . . . 1019
Sec. 548.0152. DENTIST'S CHOICE OF PLATFORM . . . . . 1020
Sec. 548.0153. CERTAIN TELEDENTISTRY DENTAL SERVICES REIMBURSEMENT DENIALS PROHIBITED . . . . . 1020
Sec. 548.0154. STATE BOARD OF DENTAL EXAMINERS RULES . . . . 1020

SUBCHAPTER E. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES PROVIDED TO CERTAIN CHILDREN
Sec. 548.0201. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES PROVIDED TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS . . . . . 1021
Sec. 548.0202. MEDICAID REIMBURSEMENT FOR TELEMEDICINE MEDICAL SERVICES PROVIDED IN SCHOOL-BASED SETTING . . . . . 1023
Sec. 548.0203. MEDICAID REIMBURSEMENT FOR TELEHEALTH SERVICES PROVIDED THROUGH SCHOOL DISTRICT OR CHARTER SCHOOL . . . . . 1025
SUBCHAPTER F. MEDICAID REIMBURSEMENT FOR HOME TELEMONITORING SERVICES
Sec. 548.0251. DEFINITIONS . . . . . 1026
Sec. 548.0252. MEDICAID REIMBURSEMENT PROGRAM FOR HOME TELEMONITORING SERVICES AUTHORIZED . . . . 1027
Sec. 548.0253. REIMBURSEMENT PROGRAM REQUIREMENTS . . . . . 1027
Sec. 548.0254. DISCONTINUATION OF REIMBURSEMENT PROGRAM UNDER CERTAIN CIRCUMSTANCES . . . . 1029
Sec. 548.0255. DETERMINATION OF COST SAVINGS FOR MEDICARE PROGRAM . . . . . 1030
Sec. 548.0256. REIMBURSEMENT FOR OTHER CONDITIONS AND RISK FACTORS . . . . . 1030
SUBCHAPTER G. MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATIONS
Sec. 548.0301. DEFINITION . . . . . 1031
Sec. 548.0302. MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATION AUTHORIZED . . . . . 1031
Sec. 548.0303. PILOT PROGRAM FOR MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATION . . . . . 1032

SUBCHAPTER H. PEDIATRIC TELE-CONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS
Sec. 548.0351. DEFINITIONS . . . . . 1033
Sec. 548.0352. ESTABLISHMENT OF PEDIATRIC TELE-CONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS . . . . . 1035
Sec. 548.0353. USE OF PROGRAM GRANT . . . . . 1035
Sec. 548.0354. SELECTION OF PROGRAM GRANT RECIPIENTS . . . . 1036
Sec. 548.0355. GIFTS, GRANTS, AND DONATIONS . . . . . 1037
Sec. 548.0356. WORK GROUP . . . . . 1038
Sec. 548.0357. BIENNIAL REPORT . . . . . 1038
Sec. 548.0358. RULES . . . . . 1039
Sec. 548.0359. APPROPRIATION REQUIRED . . . . . 1039
SUBCHAPTER I. TELEHEALTH TREATMENT PROGRAM FOR SUBSTANCE USE DISORDERS
Sec. 548.0401. TELEHEALTH TREATMENT PROGRAM FOR SUBSTANCE USE DISORDERS . . . . . 1039

## CHAPTER 548. HEALTH CARE SERVICES PROVIDED THROUGH TELE-CONNECTIVE MEANS

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 548.0001. PROVISION OF SERVICES THROUGH TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY UNDER MEDICAID AND OTHER PUBLIC BENEFITS PROGRAMS. (a) In this section:

(1) "Behavioral health services" has the meaning assigned by Section 540.0703.

(2) "Case management services" includes service coordination, service management, and care coordination.

(b) To the extent permitted by federal law and to the extent it is cost-effective and clinically effective, as the commission determines, the commission shall ensure that Medicaid recipients, child health plan program enrollees, and other individuals receiving benefits under a public benefits program the commission or a health and human services agency administers, regardless of

whether receiving benefits through a managed care delivery model or another delivery model, have the option to receive services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, including the following services:

(1) preventive health and wellness services;

(2) case management services, including targeted case management services;

(3) subject to Subsection (c), behavioral health services;

(4) occupational, physical, and speech therapy services;

(5) nutritional counseling services; and

(6) assessment services, including nursing assessments under the following Section 1915(c) waiver programs:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the deaf-blind with multiple disabilities (DBMD) waiver program;

(C) the home and community-based services (HCS) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(c) To the extent permitted by state and federal law and to the extent it is cost-effective and clinically effective, as the commission determines, the executive commissioner by rule shall develop and implement a system that ensures behavioral health services may be provided using an audio-only platform consistent with Section 111.008, Occupations Code, to a Medicaid recipient, a child health plan program enrollee, or another individual receiving those services under another public benefits program the commission or a health and human services agency administers.

(d) If the executive commissioner determines that providing services other than behavioral health services is appropriate using an audio-only platform under a public benefits program the

commission or a health and human services agency administers, in accordance with applicable federal and state law, the executive commissioner may by rule authorize the provision of those services under the applicable program using the audio-only platform. In determining whether the use of an audio-only platform in a program is appropriate under this subsection, the executive commissioner shall consider whether using the platform would be cost-effective and clinically effective. (Gov. Code, Sec. 531.02161.)

Source Law

Sec. 531.02161. PROVISION OF SERVICES THROUGH TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY UNDER MEDICAID AND OTHER PUBLIC BENEFITS PROGRAMS. (a) In this section:

(1) "Behavioral health services" has the meaning assigned by Section 533.00255.

(2) "Case management services" includes service coordination, service management, and care coordination.

(b) To the extent permitted by federal law and to the extent it is cost-effective and clinically effective, as determined by the commission, the commission shall ensure that Medicaid recipients, child health plan program enrollees, and other individuals receiving benefits under a public benefits program administered by the commission or a health and human services agency, regardless of whether receiving benefits through a managed care delivery model or another delivery model, have the option to receive services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, including the following services:

(1) preventive health and wellness services;

(2) case management services, including targeted case management services;

(3) subject to Subsection (c), behavioral health services;

(4) occupational, physical, and speech therapy services;

(5) nutritional counseling services; and

(6) assessment services, including nursing assessments under the following Section 1915(c) waiver programs:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the deaf-blind with multiple disabilities (DBMD) waiver program;

(C) the home and community-based services (HCS) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(c) To the extent permitted by state and federal law and to the extent it is cost-effective and clinically effective, as determined by the commission, the executive commissioner by rule shall develop and implement a system that ensures behavioral health services may be provided using an audio-only platform

consistent with Section 111.008, Occupations Code, to a Medicaid recipient, a child health plan program enrollee, or another individual receiving those services under another public benefits program administered by the commission or a health and human services agency.

(d) If the executive commissioner determines that providing services other than behavioral health services is appropriate using an audio-only platform under a public benefits program administered by the commission or a health and human services agency, in accordance with applicable federal and state law, the executive commissioner may by rule authorize the provision of those services under the applicable program using the audio-only platform. In determining whether the use of an audio-only platform in a program is appropriate under this subsection, the executive commissioner shall consider whether using the platform would be cost-effective and clinically effective.

Revised Law

Sec. 548.0002. RULES AND PROCEDURES REGARDING REIMBURSING CERTAIN TELEMEDICINE MEDICAL SERVICES. (a) In addition to the authority granted by other law regarding telemedicine medical services, the executive commissioner may review rules and procedures applicable to reimbursement of a telemedicine medical service provided through any government-funded health program subject to the commission's oversight. The executive commissioner may modify the rules and procedures as necessary to ensure that reimbursement for a telemedicine medical service is provided:

(1) in a cost-effective manner; and

(2) only in circumstances in which providing the service is clinically effective.

(b) This section does not affect the commission's authority or duties under other law regarding reimbursing a telemedicine medical service under Medicaid. (Gov. Code, Sec. 531.02174.)

Source Law

Sec. 531.02174. ADDITIONAL AUTHORITY REGARDING TELEMEDICINE MEDICAL SERVICES. (a) In addition to the authority granted by other law regarding telemedicine medical services, the executive commissioner may review rules and procedures applicable to reimbursement of telemedicine medical services provided through any government-funded health program subject to the commission's oversight.

(b) The executive commissioner may modify rules and procedures described by Subsection (a) as necessary to ensure that reimbursement for telemedicine medical services is provided in a cost-effective manner and only in circumstances in which the provision of those services is clinically

effective.

(c) This section does not affect the commission's authority or duties under other law regarding reimbursement of telemedicine medical services under Medicaid.

SUBCHAPTER B. TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, TELEHEALTH, AND HOME TELEMONITORING SERVICES PROVIDED UNDER MEDICAID IN GENERAL

Revised Law

Sec. 548.0051. MEDICAID REIMBURSEMENT SYSTEM FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES. The executive commissioner by rule shall develop and implement a system to reimburse Medicaid providers for telemedicine medical services, teledentistry dental services, or telehealth services performed. (Gov. Code, Sec. 531.0216(a).)

Source Law

Sec. 531.0216. PARTICIPATION AND REIMBURSEMENT OF TELEMEDICINE MEDICAL SERVICE PROVIDERS, TELEDENTISTRY DENTAL SERVICE PROVIDERS, AND TELEHEALTH SERVICE PROVIDERS UNDER MEDICAID. (a) The executive commissioner by rule shall develop and implement a system to reimburse providers of services under Medicaid for services performed using telemedicine medical services, teledentistry dental services, or telehealth services.

Revised Law

Sec. 548.0052. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE BY MEDICAID MANAGED CARE ORGANIZATION. (a) The commission shall ensure that a Medicaid managed care organization does not:

(1) deny reimbursement for a covered health care service or procedure delivered by a health care provider with whom the organization contracts to a Medicaid recipient as a telemedicine medical service, teledentistry dental service, or telehealth service solely because the covered service or procedure is not provided through an in-person consultation; or

(2) limit, deny, or reduce reimbursement for a covered health care service or procedure delivered by a health care provider with whom the organization contracts to a Medicaid recipient as a telemedicine medical service, teledentistry dental

service, or telehealth service based on the provider's choice of platform for providing the health care service or procedure.

(b) In complying with state and federal requirements to provide access to medically necessary services under the Medicaid managed care program, a Medicaid managed care organization determining whether reimbursement for a telemedicine medical service, teledentistry dental service, or telehealth service is appropriate shall continue to consider other factors, including whether:

(1) reimbursement is cost-effective; and

(2) providing the service is clinically effective.

(Gov. Code, Secs. 531.0216(g) (part), (j).)

Source Law

> (g) The commission shall ensure that a Medicaid managed care organization:
>
> (1) does not deny reimbursement for a covered health care service or procedure delivered by a health care provider with whom the managed care organization contracts to a Medicaid recipient as a telemedicine medical service, a teledentistry dental service, or a telehealth service solely because the covered service or procedure is not provided through an in-person consultation;
>
> (2) does not limit, deny, or reduce reimbursement for a covered health care service or procedure delivered by a health care provider with whom the managed care organization contracts to a Medicaid recipient as a telemedicine medical service, a teledentistry dental service, or a telehealth service based on the health care provider's choice of platform for providing the health care service or procedure; and
>
> . . .
>
> (j) In complying with state and federal requirements to provide access to medically necessary services under the Medicaid managed care program, a Medicaid managed care organization determining whether reimbursement for a telemedicine medical service, teledentistry dental service, or telehealth service is appropriate shall continue to consider other factors, including whether reimbursement is cost-effective and whether the provision of the service is clinically effective.

Revised Law

Sec. 548.0053. REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE. (a) Subject to Subsection (b), the executive commissioner by rule shall ensure that a rural health clinic as

defined by 42 U.S.C. Section 1396d(l)(1) and a federally qualified health center as defined by 42 U.S.C. Section 1396d(l)(2)(B) may be reimbursed for the originating site facility fee or the distant site practitioner fee or both, as appropriate, for a covered telemedicine medical service, teledentistry dental service, or telehealth service delivered by a health care provider to a Medicaid recipient.

(b) The commission is required to implement this section only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement this section using other money available to the commission for that purpose. (Gov. Code, Sec. 531.0216(i).)

Source Law

> (i) The executive commissioner by rule shall ensure that a rural health clinic as defined by 42 U.S.C. Section 1396d(l)(1) and a federally-qualified health center as defined by 42 U.S.C. Section 1396d(l)(2)(B) may be reimbursed for the originating site facility fee or the distant site practitioner fee or both, as appropriate, for a covered telemedicine medical service, teledentistry dental service, or telehealth service delivered by a health care provider to a Medicaid recipient. The commission is required to implement this subsection only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement this subsection using other money available to the commission for that purpose.

Revised Law

Sec. 548.0054. PROVIDER AND FACILITY PARTICIPATION. (a) The commission shall encourage health care providers and health care facilities to provide telemedicine medical services, teledentistry dental services, and telehealth services in the health care delivery system. The commission may not require that a service be provided to a patient through telemedicine medical services, teledentistry dental services, or telehealth services.

(b) The commission shall explore opportunities to increase STAR Health program providers' use of telemedicine medical services in medically underserved areas of this state. (Gov. Code, Secs.

531.0216(c), (c-1).)

Source Law

> (c) The commission shall encourage health care providers and health care facilities to provide telemedicine medical services, teledentistry dental services, and telehealth services in the health care delivery system. The commission may not require that a service be provided to a patient through telemedicine medical services, teledentistry dental services, or telehealth services.
>
> (c-1) The commission shall explore opportunities to increase STAR Health program providers' use of telemedicine medical services in medically underserved areas of this state.

Revised Law

Sec. 548.0055. PROMOTION AND SUPPORT OF MEDICAL HOME AND CARE COORDINATION. (a) The commission shall ensure that a Medicaid managed care organization ensures that using telemedicine medical services, teledentistry dental services, or telehealth services promotes and supports patient-centered medical homes by allowing a Medicaid recipient to receive a telemedicine medical service, teledentistry dental service, or telehealth service from a provider other than the recipient's primary care physician or provider, except as provided by Section 548.0202(b), only if:

(1) the service is provided in accordance with the law and contract requirements applicable to providing the same health care service in an in-person setting, including requirements regarding care coordination; and

(2) subject to Subsection (b), the provider of the service gives notice to the Medicaid recipient's primary care physician or provider regarding the service, including a summary of the service, exam findings, a list of prescribed or administered medications, and patient instructions, for the purpose of sharing medical information.

(b) A provider of a telemedicine medical service, teledentistry dental service, or telehealth service is required to provide notice under Subsection (a)(2) only if:

(1) the recipient has a primary care physician or provider; and

(2) the recipient or, if appropriate, the recipient's parent or legal guardian, consents to the notice.

(c) The commission shall develop, document, and implement a monitoring process to ensure that a Medicaid managed care organization ensures that using telemedicine medical services, teledentistry dental services, or telehealth services promotes and supports patient-centered medical homes and care coordination in accordance with Subsection (a). The process must include monitoring of the rate at which a telemedicine medical service, teledentistry dental service, or telehealth service provider gives notice in accordance with Subsection (a)(2). (Gov. Code, Secs. 531.0216(g) (part), (h).)

Source Law

> (g) The commission shall ensure that a Medicaid managed care organization:
>
> . . .
>
> (3) ensures that the use of telemedicine medical services, teledentistry dental services, or telehealth services promotes and supports patient-centered medical homes by allowing a Medicaid recipient to receive a telemedicine medical service, teledentistry dental service, or telehealth service from a provider other than the recipient's primary care physician or provider, except as provided by Section 531.0217(c-4), only if:
>
> (A) the telemedicine medical service, teledentistry dental service, or telehealth service is provided in accordance with the law and contract requirements applicable to the provision of the same health care service in an in-person setting, including requirements regarding care coordination; and
>
> (B) the provider of the telemedicine medical service, teledentistry dental service, or telehealth service gives notice to the Medicaid recipient's primary care physician or provider regarding the service, including a summary of the service, exam findings, a list of prescribed or administered medications, and patient instructions, for the purpose of sharing medical information, provided that the recipient has a primary care physician or provider and the recipient or, if appropriate, the recipient's parent or legal guardian, consents to the notice.
>
> (h) The commission shall develop, document, and implement a monitoring process to ensure that a Medicaid managed care organization ensures that the use of telemedicine medical services, teledentistry dental services, or telehealth services promotes and supports patient-centered medical homes and care coordination in accordance with Subsection (g)(3). The process must include monitoring of the rate at which a telemedicine medical service, teledentistry dental service, or telehealth service provider gives

notice in accordance with Subsection (g)(3)(B).

Revised Law

Sec. 548.0056. BIENNIAL REPORT. Not later than December 1 of each even-numbered year, the commission shall report to the speaker of the house of representatives and the lieutenant governor on the effects of telemedicine medical services, teledentistry dental services, telehealth services, and home telemonitoring services on Medicaid in this state, including:

(1) the number of physicians, dentists, health professionals, and licensed health care facilities using the services;

(2) the geographic and demographic disposition of the physicians, dentists, and health professionals;

(3) the number of patients receiving the services;

(4) the types of services being provided;

(5) the utilization cost; and

(6) the cost savings to Medicaid from using the services. (Gov. Code, Sec. 531.0216(f).)

Source Law

> (f) Not later than December 1 of each even-numbered year, the commission shall report to the speaker of the house of representatives and the lieutenant governor on the effects of telemedicine medical services, teledentistry dental services, telehealth services, and home telemonitoring services on Medicaid in the state, including the number of physicians, dentists, health professionals, and licensed health care facilities using telemedicine medical services, teledentistry dental services, telehealth services, or home telemonitoring services, the geographic and demographic disposition of the physicians, dentists, and health professionals, the number of patients receiving telemedicine medical services, teledentistry dental services, telehealth services, and home telemonitoring services, the types of services being provided, the cost of utilization, and the cost savings of telemedicine medical services, teledentistry dental services, telehealth services, and home telemonitoring services to Medicaid.

Revised Law

Sec. 548.0057. RULES. Subject to Sections 111.004 and 153.004, Occupations Code, the executive commissioner may adopt rules as necessary to implement this subchapter. In the rules adopted under this subchapter, the executive commissioner shall

refer to:

(1) the site where the patient is physically located as the patient site; and

(2) the site where the physician, dentist, or health professional providing the telemedicine medical service, teledentistry dental service, or telehealth service is physically located as the distant site. (Gov. Code, Sec. 531.0216(d).)

Source Law

(d) Subject to Sections 111.004 and 153.004, Occupations Code, the executive commissioner may adopt rules as necessary to implement this section. In the rules adopted under this section, the executive commissioner shall:

(1) refer to the site where the patient is physically located as the patient site; and

(2) refer to the site where the physician, dentist, or health professional providing the telemedicine medical service, teledentistry dental service, or telehealth service is physically located as the distant site.

SUBCHAPTER C. PROVISION OF AND REIMBURSEMENT FOR TELEMEDICINE MEDICAL AND TELEHEALTH SERVICES IN GENERAL

Revised Law

Sec. 548.0101. DEFINITIONS. In this subchapter:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec. 531.0217(a).)

Source Law

Sec. 531.0217. REIMBURSEMENT FOR CERTAIN MEDICAL CONSULTATIONS. (a) In this section:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

Revisor's Note

(1) Section 531.0217(a), Government Code, refers to definitions applicable "[i]n this section." The provisions of Section 531.0217 are revised in this chapter as Subchapter C and Section 548.0202. Accordingly, in this subchapter the revised law substitutes "this subchapter" for "this section."

(2) Section 531.0217(a)(2), Government Code, defines a physician as a "person" licensed to practice medicine in this state. Throughout this chapter, the revised law substitutes "individuals" or "individual" for "people" or "person," respectively, for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), applicable to this code.

Revised Law

Sec. 548.0102. MEDICAID REIMBURSEMENT REQUIREMENTS: TELEMEDICINE MEDICAL SERVICES. (a) The executive commissioner by rule shall require each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a telemedicine medical service initiated or provided by a physician.

(b) The commission shall ensure that reimbursement is provided only for a telemedicine medical service a physician initiates or provides.

(c) The commission shall require reimbursement for a telemedicine medical service at the same rate Medicaid reimburses for the same in-person medical service. (Gov. Code, Secs. 531.0217(b), (c), (d) (part).)

Source Law

> (b) The executive commissioner by rule shall require each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a telemedicine medical service initiated or provided by a physician.
>
> (c) The commission shall ensure that reimbursement is provided only for a telemedicine medical service initiated or provided by a physician.
>
> (d) The commission shall require reimbursement for a telemedicine medical service at the same rate as Medicaid reimburses for the same in-person medical service. . . .

Revised Law

Sec. 548.0103. PHYSICIAN'S CHOICE OF PLATFORM. The commission may not limit a physician's choice of platform for providing a telemedicine medical service or telehealth service by requiring that the physician use a particular platform to receive Medicaid reimbursement for the service. (Gov. Code, Sec. 531.0217(d) (part).)

Source Law

> (d) [The commission shall require reimbursement for a telemedicine medical service at the same rate as Medicaid reimburses for the same in-person medical service.] . . . The commission may not limit a physician's choice of platform for providing a telemedicine medical service or telehealth service by requiring that the physician use a particular platform to receive reimbursement for the service.

Revised Law

Sec. 548.0104. CERTAIN TELEMEDICINE MEDICAL SERVICE REIMBURSEMENT DENIALS PROHIBITED. A request for Medicaid reimbursement for a telemedicine medical service may not be denied solely because an in-person medical service between a physician and a patient did not occur. (Gov. Code, Sec. 531.0217(d) (part).)

Source Law

(d) [The commission shall require reimbursement for a telemedicine medical service at the same rate as Medicaid reimburses for the same in-person medical service.] A request for reimbursement may not be denied solely because an in-person medical service between a physician and a patient did not occur. . . .

Revised Law

Sec. 548.0105. PROTOCOLS AND GUIDELINES. A health care facility that receives reimbursement under this subchapter for a telemedicine medical service provided by a physician who practices in that facility or a health professional who participates in a telemedicine medical service under this subchapter shall establish quality of care protocols and patient confidentiality guidelines to ensure that the telemedicine medical service meets legal requirements and acceptable patient care standards. (Gov. Code, Sec. 531.0217(e).)

Source Law

(e) A health care facility that receives reimbursement under this section for a telemedicine medical service provided by a physician who practices in that facility or a health professional who participates in a telemedicine medical service under this section shall establish quality of care protocols and patient confidentiality guidelines to ensure that the telemedicine medical service meets legal requirements and acceptable patient care standards.

Revised Law

Sec. 548.0106. PROVIDER COORDINATION. If a patient receiving a telemedicine medical service has a primary care physician or provider and the patient or, if appropriate, the patient's parent or legal guardian consents to the notification, the commission shall require that the primary care physician or provider be notified of the telemedicine medical service for the purpose of sharing medical information. (Gov. Code, Sec. 531.0217(g) (part).)

Source Law

(g) If a patient receiving a telemedicine medical service has a primary care physician or provider and consents or, if appropriate, the patient's parent or legal guardian consents to the notification, the commission shall require that the primary care physician or provider be notified of the

telemedicine medical service for the purpose of sharing medical information. . . .

Revised Law

Sec. 548.0107. COMPLIANCE. The commission in consultation with the Texas Medical Board shall monitor and regulate the use of telemedicine medical services to ensure compliance with this subchapter. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this subchapter. (Gov. Code, Sec. 531.0217(h).)

Source Law

(h) The commission in consultation with the Texas Medical Board shall monitor and regulate the use of telemedicine medical services to ensure compliance with this section. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this section.

Revised Law

Sec. 548.0108. TEXAS MEDICAL BOARD RULES. The Texas Medical Board, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services; and

(2) prevent abuse and fraud through the use of telemedicine medical services, including rules relating to filing claims and records required to be maintained in connection with telemedicine. (Gov. Code, Sec. 531.0217(i).)

Source Law

(i) The Texas Medical Board, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services; and

(2) prevent abuse and fraud through the use of telemedicine medical services, including rules relating to filing of claims and records required to be maintained in connection with telemedicine.

Revised Law

Sec. 548.0109. EFFECT ON OTHER REQUIREMENTS. This subchapter does not affect any requirement relating to:

(1) a rural health clinic; or

(2) physician delegation to an advanced practice nurse or physician assistant of the authority to carry out or sign prescription drug orders. (Gov. Code, Sec. 531.0217(k).)

Source Law

(k) This section does not affect any requirement relating to:

(1) a rural health clinic; or

(2) physician delegation of the authority to carry out or sign prescription drug orders to an advanced practice nurse or physician assistant.

SUBCHAPTER D. PROVISION OF AND REIMBURSEMENT FOR TELEDENTISTRY DENTAL SERVICES IN GENERAL

Revised Law

Sec. 548.0151. MEDICAID REIMBURSEMENT REQUIREMENTS. (a) The executive commissioner by rule shall require each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for teledentistry dental services provided by a dentist licensed to practice dentistry in this state.

(b) The commission shall require reimbursement for a teledentistry dental service at the same rate as the Medicaid program reimburses for the same in-person dental service. (Gov. Code, Secs. 531.02172(a), (b) (part).)

Source Law

Sec. 531.02172. REIMBURSEMENT FOR TELEDENTISTRY DENTAL SERVICES. (a) The commission by rule shall require each health and human services agency that administers a part of the Medicaid program to provide Medicaid reimbursement for teledentistry dental services provided by a dentist licensed to practice dentistry in this state.

(b) The commission shall require reimbursement for a teledentistry dental service at the same rate as the Medicaid program reimburses for the same in-person dental service. . . .

Revisor's Note

Section 531.02172(a), Government Code, states that the "commission" by rule shall require certain health and human services agencies to provide Medicaid reimbursement for teledentistry dental services. The revised law substitutes "executive commissioner" for the quoted language for clarity and consistency in the

terminology used within Subtitle I, Title 4, Government Code, which includes this chapter, and because under Section 531.033, Government Code, revised as Section 524.0151, the executive commissioner of the Health and Human Services Commission adopts rules for the commission.

Revised Law

Sec. 548.0152. DENTIST'S CHOICE OF PLATFORM. The commission may not limit a dentist's choice of platform for providing a teledentistry dental service by requiring that the dentist use a particular platform to receive reimbursement for the service. (Gov. Code, Sec. 531.02172(b) (part).)

Source Law

> (b) [The commission shall require reimbursement for a teledentistry dental service at the same rate as the Medicaid program reimburses for the same in-person dental service.] . . . The commission may not limit a dentist's choice of platform for providing a teledentistry dental service by requiring that the dentist use a particular platform to receive reimbursement for the service.

Revised Law

Sec. 548.0153. CERTAIN TELEDENTISTRY DENTAL SERVICES REIMBURSEMENT DENIALS PROHIBITED. A request for reimbursement may not be denied solely because an in-person dental service between a dentist and a patient did not occur. (Gov. Code, Sec. 531.02172(b) (part).)

Source Law

> (b) [The commission shall require reimbursement for a teledentistry dental service at the same rate as the Medicaid program reimburses for the same in-person dental service.] A request for reimbursement may not be denied solely because an in-person dental service between a dentist and a patient did not occur. . . .

Revised Law

Sec. 548.0154. STATE BOARD OF DENTAL EXAMINERS RULES. The State Board of Dental Examiners, in consultation with the commission and the commission's office of inspector general, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of

care, is provided to patients who receive teledentistry dental services; and

(2) prevent abuse and fraud through the use of teledentistry dental services, including rules relating to filing claims and the records required to be maintained in connection with teledentistry dental services. (Gov. Code, Sec. 531.02172(c).)

Source Law

> (c) The State Board of Dental Examiners, in consultation with the commission and the commission's office of inspector general, as appropriate, may adopt rules as necessary to:
>
> (1) ensure that appropriate care, including quality of care, is provided to patients who receive teledentistry dental services; and
>
> (2) prevent abuse and fraud through the use of teledentistry dental services, including rules relating to filing claims and the records required to be maintained in connection with teledentistry dental services.

SUBCHAPTER E. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES PROVIDED TO CERTAIN CHILDREN

Revised Law

Sec. 548.0201. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES PROVIDED TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS. (a) In this section, "child with special health care needs" has the meaning assigned by Section 35.0022, Health and Safety Code.

(b) The executive commissioner by rule shall establish policies that permit reimbursement under Medicaid and the child health plan program for services provided through telemedicine medical services, teledentistry dental services, and telehealth services to children with special health care needs.

(c) The policies required under this section must:

(1) be designed to:

(A) prevent unnecessary travel and encourage efficient use of telemedicine medical services, teledentistry dental services, and telehealth services for children with special health care needs in all suitable circumstances; and

(B) ensure in a cost-effective manner the availability to a child with special health care needs of services appropriately performed using telemedicine medical services, teledentistry dental services, and telehealth services that are comparable to the same types of services available to that child without using telemedicine medical services, teledentistry dental services, and telehealth services; and

(2) provide for reimbursement of multiple providers of different services who participate in a single session of telemedicine medical services, teledentistry dental services, telehealth services, or any combination of those services for a child with special health care needs, if the commission determines that reimbursing each provider for the session is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without using telemedicine medical services, teledentistry dental services, and telehealth services, including the costs of transportation and lodging and other direct costs. (Gov. Code, Sec. 531.02162.)

Source Law

Sec. 531.02162. MEDICAID SERVICES PROVIDED THROUGH TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS. (a) In this section, "child with special health care needs" has the meaning assigned by Section 35.0022, Health and Safety Code.

(b) The executive commissioner by rule shall establish policies that permit reimbursement under Medicaid and the child health plan program for services provided through telemedicine medical services, teledentistry dental services, and telehealth services to children with special health care needs.

(c) The policies required under this section must:

(1) be designed to:

(A) prevent unnecessary travel and encourage efficient use of telemedicine medical services, teledentistry dental services, and telehealth services for children with special health care needs in all suitable circumstances; and

(B) ensure in a cost-effective manner the availability to a child with special health care needs of services appropriately performed using telemedicine medical services, teledentistry dental services, and telehealth services that are comparable to the same types of services available to that child without the use of telemedicine medical services, teledentistry dental services, and telehealth

services; and

(2) provide for reimbursement of multiple providers of different services who participate in a single session of telemedicine medical services, teledentistry dental services, telehealth services, or any combination of those services, for a child with special health care needs, if the commission determines that reimbursing each provider for the session is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services, teledentistry dental services, and telehealth services, including the costs of transportation and lodging and other direct costs.

Revised Law

Sec. 548.0202. MEDICAID REIMBURSEMENT FOR TELEMEDICINE MEDICAL SERVICES PROVIDED IN SCHOOL-BASED SETTING. (a) In this section, "physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(b) The commission shall ensure that Medicaid reimbursement is provided to a physician for a telemedicine medical service provided by the physician, even if the physician is not the patient's primary care physician or provider, if:

(1) the physician is an authorized Medicaid health care provider;

(2) the patient is a child who receives the service in a primary or secondary school-based setting; and

(3) the parent or legal guardian of the patient provides consent before the service is provided.

(c) In the case of a telemedicine medical service provided to a child in a school-based setting as described by Subsection (b), the notification under Section 548.0106, if any, must include a summary of the service, including exam findings, prescribed or administered medications, and patient instructions.

(d) If a patient receiving a telemedicine medical service in a school-based setting as described by Subsection (b) does not have a primary care physician or provider, the commission shall require that the patient's parent or legal guardian receive:

(1) the notification required under Section 548.0106; and

(2) a list of primary care physicians or providers

from which the patient may select the patient's primary care physician or provider.

(e) The commission in consultation with the Texas Medical Board shall monitor and regulate the use of telemedicine medical services to ensure compliance with this section. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this section.

(f) The Texas Medical Board, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services; and

(2) prevent abuse and fraud through the use of telemedicine medical services, including rules relating to filing of claims and records required to be maintained in connection with telemedicine.

(g) This section does not affect any requirement relating to:

(1) a rural health clinic; or

(2) physician delegation to an advanced practice nurse or physician assistant of the authority to carry out or sign prescription drug orders. (Gov. Code, Secs. 531.0217(a)(2), (c-4), (g) (part), (g-1), (h), (i), (k).)

Source Law

(a) In this section:

(2) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(c-4) The commission shall ensure that Medicaid reimbursement is provided to a physician for a telemedicine medical service provided by the physician, even if the physician is not the patient's primary care physician or provider, if:

(1) the physician is an authorized health care provider under Medicaid;

(2) the patient is a child who receives the service in a primary or secondary school-based setting; and

(3) the parent or legal guardian of the patient provides consent before the service is provided.

(g) . . . In the case of a service provided to a child in a school-based setting as described by Subsection (c-4), the notification, if any, must include a summary of the service, including exam findings, prescribed or administered medications, and patient instructions.

(g-1) If a patient receiving a telemedicine medical service in a school-based setting as described by Subsection (c-4) does not have a primary care physician or provider, the commission shall require that the patient's parent or legal guardian receive:

(1) the notification required under Subsection (g); and

(2) a list of primary care physicians or providers from which the patient may select the patient's primary care physician or provider.

(h) The commission in consultation with the Texas Medical Board shall monitor and regulate the use of telemedicine medical services to ensure compliance with this section. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this section.

(i) The Texas Medical Board, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services; and

(2) prevent abuse and fraud through the use of telemedicine medical services, including rules relating to filing of claims and records required to be maintained in connection with telemedicine.

(k) This section does not affect any requirement relating to:

(1) a rural health clinic; or

(2) physician delegation of the authority to carry out or sign prescription drug orders to an advanced practice nurse or physician assistant.

Revised Law

Sec. 548.0203. MEDICAID REIMBURSEMENT FOR TELEHEALTH SERVICES PROVIDED THROUGH SCHOOL DISTRICT OR CHARTER SCHOOL. (a) In this section, "health professional" means an individual who is:

(1) licensed, registered, certified, or otherwise authorized by this state to practice as a social worker, occupational therapist, or speech-language pathologist;

(2) a licensed professional counselor;

(3) a licensed marriage and family therapist; or

(4) a licensed specialist in school psychology.

(b) The commission shall ensure that Medicaid reimbursement is provided to a school district or open-enrollment charter school for telehealth services provided through the school district or charter school by a health professional, even if the health

professional is not the patient's primary care provider, if:

(1) the school district or charter school is an authorized Medicaid health care provider; and

(2) the parent or legal guardian of the patient provides consent before the service is provided. (Gov. Code, Sec. 531.02171.)

Source Law

Sec. 531.02171. REIMBURSEMENT FOR CERTAIN TELEHEALTH SERVICES. (a) In this section, "health professional" means an individual who is:

(1) licensed, registered, certified, or otherwise authorized by this state to practice as a social worker, occupational therapist, or speech-language pathologist;

(2) a licensed professional counselor;

(3) a licensed marriage and family therapist; or

(4) a licensed specialist in school psychology.

(b) The commission shall ensure that Medicaid reimbursement is provided to a school district or open-enrollment charter school for telehealth services provided through the school district or charter school by a health professional, even if the health professional is not the patient's primary care provider, if:

(1) the school district or charter school is an authorized health care provider under Medicaid; and

(2) the parent or legal guardian of the patient provides consent before the service is provided.

SUBCHAPTER F. MEDICAID REIMBURSEMENT FOR HOME TELEMONITORING SERVICES

Revised Law

Sec. 548.0251. DEFINITIONS. In this subchapter:

(1) "Home and community support services agency" means a person licensed under Chapter 142, Health and Safety Code, to provide home health, hospice, or personal assistance services as those terms are defined by Section 142.001, Health and Safety Code.

(2) "Hospital" means a hospital licensed under Chapter 241, Health and Safety Code. (Gov. Code, Sec. 531.02164(a).)

Source Law

Sec. 531.02164. MEDICAID SERVICES PROVIDED THROUGH HOME TELEMONITORING SERVICES. (a) In this section:

(1) "Home and community support services agency" means a person licensed under Chapter 142,

Health and Safety Code, to provide home health, hospice, or personal assistance services as defined by Section 142.001, Health and Safety Code.

(2) "Hospital" means a hospital licensed under Chapter 241, Health and Safety Code.

Revisor's Note

Section 531.02164(a), Government Code, refers to definitions applicable "[i]n this section." The provisions of Section 531.02164 are revised in this chapter as Subchapter F, and the revised law is drafted accordingly.

Revised Law

Sec. 548.0252. MEDICAID REIMBURSEMENT PROGRAM FOR HOME TELEMONITORING SERVICES AUTHORIZED. If the commission determines that establishing a statewide program that permits Medicaid reimbursement for home telemonitoring services would be cost-effective and feasible, the executive commissioner by rule shall establish the program as provided by this subchapter. (Gov. Code, Sec. 531.02164(b).)

Source Law

(b) If the commission determines that establishing a statewide program that permits reimbursement under Medicaid for home telemonitoring services would be cost-effective and feasible, the executive commissioner by rule shall establish the program as provided under this section.

Revised Law

Sec. 548.0253. REIMBURSEMENT PROGRAM REQUIREMENTS. (a) A program established under this subchapter must:

(1) provide that home telemonitoring services are available only to an individual who:

(A) is diagnosed with one or more of the following conditions:

(i) pregnancy;

(ii) diabetes;

(iii) heart disease;

(iv) cancer;

(v) chronic obstructive pulmonary disease;

(vi) hypertension;

(vii) congestive heart failure;

(viii) mental illness or serious emotional disturbance;

(ix) asthma;

(x) myocardial infarction; or

(xi) stroke; and

(B) exhibits two or more of the following risk factors:

(i) two or more hospitalizations in the prior 12-month period;

(ii) frequent or recurrent emergency room admissions;

(iii) a documented history of poor adherence to ordered medication regimens;

(iv) a documented history of falls in the prior six-month period;

(v) limited or absent informal support systems;

(vi) living alone or being home alone for extended periods; and

(vii) a documented history of care access challenges;

(2) ensure that clinical information gathered by a home and community support services agency or hospital while providing home telemonitoring services is shared with the patient's physician; and

(3) ensure that the program does not duplicate disease management program services provided under Section 32.057, Human Resources Code.

(b) Notwithstanding Subsection (a)(1), a program established under this subchapter must also provide that home telemonitoring services are available to pediatric individuals who:

(1) are diagnosed with end-stage solid organ disease;

(2) have received an organ transplant; or

(3) require mechanical ventilation. (Gov. Code, Secs. 531.02164(c), (c-1).)

Source Law

(c) The program required under this section must:

(1) provide that home telemonitoring services are available only to persons who:

(A) are diagnosed with one or more of the following conditions:

(i) pregnancy;

(ii) diabetes;

(iii) heart disease;

(iv) cancer;

(v) chronic obstructive pulmonary disease;

(vi) hypertension;

(vii) congestive heart failure;

(viii) mental illness or serious emotional disturbance;

(ix) asthma;

(x) myocardial infarction; or

(xi) stroke; and

(B) exhibit two or more of the following risk factors:

(i) two or more hospitalizations in the prior 12-month period;

(ii) frequent or recurrent emergency room admissions;

(iii) a documented history of poor adherence to ordered medication regimens;

(iv) a documented history of falls in the prior six-month period;

(v) limited or absent informal support systems;

(vi) living alone or being home alone for extended periods of time; and

(vii) a documented history of care access challenges;

(2) ensure that clinical information gathered by a home and community support services agency or hospital while providing home telemonitoring services is shared with the patient's physician; and

(3) ensure that the program does not duplicate disease management program services provided under Section 32.057, Human Resources Code.

(c-1) Notwithstanding Subsection (c)(1), the program required under this section must also provide that home telemonitoring services are available to pediatric persons who:

(1) are diagnosed with end-stage solid organ disease;

(2) have received an organ transplant; or

(3) require mechanical ventilation.

Revised Law

Sec. 548.0254. DISCONTINUATION OF REIMBURSEMENT PROGRAM UNDER CERTAIN CIRCUMSTANCES. If, after implementation, the commission determines that the program established under this

subchapter is not cost-effective, the commission may discontinue the program and stop providing Medicaid reimbursement for home telemonitoring services, notwithstanding Subchapter B or any other law. (Gov. Code, Sec. 531.02164(d).)

Source Law

> (d) If, after implementation, the commission determines that the program established under this section is not cost-effective, the commission may discontinue the program and stop providing reimbursement under Medicaid for home telemonitoring services, notwithstanding Section 531.0216 or any other law.

Revised Law

Sec. 548.0255. DETERMINATION OF COST SAVINGS FOR MEDICARE PROGRAM. The commission shall determine whether providing home telemonitoring services to individuals who are eligible to receive benefits under both Medicaid and the Medicare program achieves cost savings for the Medicare program. (Gov. Code, Sec. 531.02164(e).)

Source Law

> (e) The commission shall determine whether the provision of home telemonitoring services to persons who are eligible to receive benefits under both Medicaid and the Medicare program achieves cost savings for the Medicare program.

Revised Law

Sec. 548.0256. REIMBURSEMENT FOR OTHER CONDITIONS AND RISK FACTORS. (a) To comply with state and federal requirements to provide access to medically necessary services under the Medicaid managed care program, a Medicaid managed care organization may reimburse providers for home telemonitoring services provided to individuals who have conditions and exhibit risk factors other than those expressly authorized by this subchapter.

(b) In determining whether the Medicaid managed care organization should provide reimbursement for services under this section, the organization shall consider whether reimbursement for the service is cost-effective and providing the service is clinically effective. (Gov. Code, Sec. 531.02164(f).)

Source Law

> (f) To comply with state and federal

requirements to provide access to medically necessary services under the Medicaid managed care program, a Medicaid managed care organization may reimburse providers for home telemonitoring services provided to persons who have conditions and exhibit risk factors other than those expressly authorized by this section. In determining whether the managed care organization should provide reimbursement for services under this subsection, the organization shall consider whether reimbursement for the service is cost-effective and providing the service is clinically effective.

SUBCHAPTER G. MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATIONS

Revised Law

Sec. 548.0301. DEFINITION. In this subchapter, "physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec. 531.02175(a).)

Source Law

Sec. 531.02175. REIMBURSEMENT FOR ONLINE MEDICAL CONSULTATIONS. (a) In this section, "physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

Revisor's Note

Section 531.02175(a), Government Code, refers to a definition applicable "[i]n this section." The provisions of Section 531.02175 are revised in this chapter as Subchapter G, and the revised law is drafted accordingly.

Revised Law

Sec. 548.0302. MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATION AUTHORIZED. (a) The executive commissioner by rule may require the commission and each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a medical consultation that a physician or other health care professional provides using the Internet as a cost-effective alternative to an in-person consultation.

(b) The executive commissioner may require the commission or a health and human services agency to provide the reimbursement described by this section only if the Centers for Medicare and

Medicaid Services develops an appropriate Current Procedural Terminology code for medical services provided using the Internet. (Gov. Code, Sec. 531.02175(b).)

Source Law

> (b) Subject to the requirements of this subsection, the executive commissioner by rule may require the commission and each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a medical consultation that is provided by a physician or other health care professional using the Internet as a cost-effective alternative to an in-person consultation. The executive commissioner may require the commission or a health and human services agency to provide the reimbursement described by this subsection only if the Centers for Medicare and Medicaid Services develop an appropriate Current Procedural Terminology code for medical services provided using the Internet.

Revisor's Note

Section 531.02175(b), Government Code, refers to action by the executive commissioner of the Health and Human Services Commission "[s]ubject to the requirements of this subsection." The revised law omits the quoted language as unnecessary because the requirements of the subsection, which is revised as this section, apply by their own terms.

Revised Law

Sec. 548.0303. PILOT PROGRAM FOR MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATION. (a) The executive commissioner may develop and implement a pilot program in one or more sites the executive commissioner chooses under which Medicaid reimbursements are paid for medical consultations provided by physicians or other health care professionals using the Internet. The pilot program must be designed to test whether an Internet medical consultation is a cost-effective alternative to an in-person consultation under Medicaid.

(b) The executive commissioner may modify the pilot program as necessary throughout the program's implementation to maximize the potential cost-effectiveness of Internet medical consultations.

(c) If the executive commissioner determines from the pilot program that Internet medical consultations are cost-effective, the executive commissioner may expand the pilot program to additional sites or implement Medicaid reimbursements for Internet medical consultations statewide.

(d) The executive commissioner is not required to implement the pilot program authorized under Subsection (a) as a prerequisite to providing Medicaid reimbursement authorized by Section 548.0302 on a statewide basis. (Gov. Code, Secs. 531.02175(c), (d).)

Source Law

> (c) The executive commissioner may develop and implement a pilot program in one or more sites chosen by the executive commissioner under which Medicaid reimbursements are paid for medical consultations provided by physicians or other health care professionals using the Internet. The pilot program must be designed to test whether an Internet medical consultation is a cost-effective alternative to an in-person consultation under Medicaid. The executive commissioner may modify the pilot program as necessary throughout its implementation to maximize the potential cost-effectiveness of Internet medical consultations. If the executive commissioner determines from the pilot program that Internet medical consultations are cost-effective, the executive commissioner may expand the pilot program to additional sites or may implement Medicaid reimbursements for Internet medical consultations statewide.
>
> (d) The executive commissioner is not required to implement the pilot program authorized under Subsection (c) as a prerequisite to providing Medicaid reimbursement authorized by Subsection (b) on a statewide basis.

SUBCHAPTER H. PEDIATRIC TELE-CONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS

Revised Law

Sec. 548.0351. DEFINITIONS. In this subchapter:

(1) "Nonurban health care facility" means a hospital licensed under Chapter 241, Health and Safety Code, or other licensed health care facility in this state that is located in a rural area as defined by Section 845.002, Insurance Code.

(2) "Pediatric specialist" means a physician who is certified in general pediatrics by the American Board of Pediatrics or American Osteopathic Board of Pediatrics.

(3) "Pediatric subspecialist" means a physician who is certified in a pediatric subspecialty by a member board of the American Board of Medical Specialties or American Osteopathic Board of Pediatrics.

(4) "Pediatric tele-specialty provider" means a pediatric health care facility in this state that offers continuous access to telemedicine medical services provided by pediatric subspecialists.

(5) "Physician" means an individual licensed to practice medicine in this state.

(6) "Program" means the pediatric tele-connectivity resource program for rural Texas established under this subchapter.

(7) Notwithstanding Section 521.0001, "telemedicine medical service" means a health care service delivered to a patient:

(A) by a physician acting within the scope of the physician's license or a health professional acting under the delegation and supervision of a physician and within the scope of the health professional's license;

(B) from a physical location that is different from the patient's location; and

(C) using telecommunications or information technology. (Gov. Code, Sec. 541.001.)

Source Law

Sec. 541.001. DEFINITIONS. In this chapter:

(1) "Nonurban health care facility" means a hospital licensed under Chapter 241, Health and Safety Code, or other licensed health care facility in this state that is located in a rural area as defined by Section 845.002, Insurance Code.

(2) "Pediatric specialist" means a physician who is certified in general pediatrics by the American Board of Pediatrics or American Osteopathic Board of Pediatrics.

(3) "Pediatric subspecialist" means a physician who is certified in a pediatric subspecialty by a member board of the American Board of Medical Specialties or American Osteopathic Board of Pediatrics.

(4) "Pediatric tele-specialty provider" means a pediatric health care facility in this state that offers continuous access to telemedicine medical services provided by pediatric subspecialists.

(5) "Physician" means a person licensed to practice medicine in this state.

(6) "Program" means the pediatric tele-connectivity resource program for rural Texas established under this chapter.

(7) "Telemedicine medical services" means health care services delivered to a patient:

(A) by a physician acting within the scope of the physician's license or a health professional acting under the delegation and supervision of a physician and within the scope of the health professional's license;

(B) from a physical location that is different from the patient's location; and

(C) using telecommunications or information technology.

Revisor's Note

Section 541.001, Government Code, refers to definitions applicable "[i]n this chapter," meaning Chapter 541, Government Code. The provisions of Chapter 541 are revised in this chapter as Subchapter H, and the revised law is drafted accordingly.

Revised Law

Sec. 548.0352. ESTABLISHMENT OF PEDIATRIC TELE-CONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS. The commission with any necessary assistance of pediatric tele-specialty providers shall establish a pediatric tele-connectivity resource program for rural Texas to award grants to nonurban health care facilities to connect the facilities with pediatric specialists and pediatric subspecialists who provide telemedicine medical services. (Gov. Code, Sec. 541.002.)

Source Law

Sec. 541.002. PEDIATRIC TELE-CONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS. The commission with any necessary assistance of pediatric tele-specialty providers shall establish a pediatric tele-connectivity resource program for rural Texas to award grants to nonurban health care facilities to connect the facilities with pediatric specialists and pediatric subspecialists who provide telemedicine medical services.

Revised Law

Sec. 548.0353. USE OF PROGRAM GRANT. A nonurban health care facility awarded a grant under this subchapter may use grant money to:

(1) purchase equipment necessary for implementing a

telemedicine medical service;

(2) modernize the facility's information technology infrastructure and secure information technology support to ensure an uninterrupted two-way video signal that is compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(3) pay a service fee to a pediatric tele-specialty provider under an annual contract with the provider; or

(4) pay for other activities, services, supplies, facilities, resources, and equipment the commission determines necessary for the facility to use a telemedicine medical service. (Gov. Code, Sec. 541.003.)

Source Law

> Sec. 541.003. USE OF GRANT. A nonurban health care facility awarded a grant under this chapter may use grant money to:
>
> (1) purchase equipment necessary for implementing a telemedicine medical service;
>
> (2) modernize the facility's information technology infrastructure and secure information technology support to ensure an uninterrupted two-way video signal that is compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);
>
> (3) pay a service fee to a pediatric tele-specialty provider under an annual contract with the provider; or
>
> (4) pay for other activities, services, supplies, facilities, resources, and equipment the commission determines necessary for the facility to use a telemedicine medical service.

Revised Law

Sec. 548.0354. SELECTION OF PROGRAM GRANT RECIPIENTS. (a) The commission with any necessary assistance of pediatric tele-specialty providers may select an eligible nonurban health care facility to receive a grant under this subchapter.

(b) To be eligible for a grant, a nonurban health care facility must have:

(1) a quality assurance program that measures the compliance of the facility's health care providers with the facility's medical protocols;

(2) on staff at least one full-time equivalent

physician who has training and experience in pediatrics and one individual who is responsible for ongoing nursery and neonatal support and care;

(3) a designated neonatal intensive care unit or an emergency department;

(4) a commitment to obtaining neonatal or pediatric education from a tertiary facility to expand the facility's depth and breadth of telemedicine medical service capabilities; and

(5) the capability of maintaining records and producing reports that measure the effectiveness of the grant the facility would receive. (Gov. Code, Sec. 541.004.)

Source Law

Sec. 541.004. SELECTION OF GRANT RECIPIENTS. (a) The commission with any necessary assistance of pediatric tele-specialty providers may select an eligible nonurban health care facility to receive a grant under this chapter.

(b) To be eligible for a grant under this chapter, a nonurban health care facility must have:

(1) a quality assurance program that measures the compliance of the facility's health care providers with the facility's medical protocols;

(2) on staff at least one full-time equivalent physician who has training and experience in pediatrics and one person who is responsible for ongoing nursery and neonatal support and care;

(3) a designated neonatal intensive care unit or an emergency department;

(4) a commitment to obtaining neonatal or pediatric education from a tertiary facility to expand the facility's depth and breadth of telemedicine medical service capabilities; and

(5) the capability of maintaining records and producing reports that measure the effectiveness of a grant received by the facility under this chapter.

Revised Law

Sec. 548.0355. GIFTS, GRANTS, AND DONATIONS. (a) The commission may solicit and accept gifts, grants, and donations from any public or private source for the purposes of this subchapter.

(b) A political subdivision that participates in the program may pay part of the costs of the program. (Gov. Code, Sec. 541.005.)

Source Law

Sec. 541.005. GIFTS, GRANTS, AND DONATIONS. (a) The commission may solicit and accept gifts, grants, and donations from any public or private

source for the purposes of this chapter.

(b) A political subdivision that participates in the program may pay part of the costs of the program.

Revised Law

Sec. 548.0356. WORK GROUP. (a) The commission may establish a program work group to:

(1) assist the commission with developing, implementing, or evaluating the program; and

(2) prepare a report on the results and outcomes of the grants awarded under this subchapter.

(b) A program work group member is not entitled to compensation for serving on the program work group and may not be reimbursed for travel or other expenses incurred while conducting the business of the program work group.

(c) A program work group is not subject to Chapter 2110. (Gov. Code, Sec. 541.006.)

Source Law

Sec. 541.006. WORK GROUP. (a) The commission may establish a program work group to:

(1) assist the commission with developing, implementing, or evaluating the program; and

(2) prepare a report on the results and outcomes of the grants awarded under this chapter.

(b) A member of a program work group established under this section is not entitled to compensation for serving on the program work group and may not be reimbursed for travel or other expenses incurred while conducting the business of the program work group.

(c) A program work group established under this section is not subject to Chapter 2110.

Revised Law

Sec. 548.0357. BIENNIAL REPORT. Not later than December 1 of each even-numbered year, the commission shall submit a report to the governor and members of the legislature regarding the activities of the program and grant recipients under the program, including the results and outcomes of grants awarded under this subchapter. (Gov. Code, Sec. 541.007.)

Source Law

Sec. 541.007. REPORT TO GOVERNOR AND LEGISLATURE. Not later than December 1 of each even-numbered year, the commission shall submit a report to the governor and members of the legislature regarding the activities of the program and grant

recipients, including the results and outcomes of grants awarded under this chapter.

Revised Law

Sec. 548.0358. RULES. The executive commissioner may adopt rules necessary to implement this subchapter. (Gov. Code, Sec. 541.008.)

Source Law

Sec. 541.008. RULES. The executive commissioner may adopt rules necessary to implement this chapter.

Revised Law

Sec. 548.0359. APPROPRIATION REQUIRED. The commission may not spend state funds to accomplish the purposes of this subchapter and is not required to award a grant under this subchapter unless money is appropriated for the purposes of this subchapter. (Gov. Code, Sec. 541.009.)

Source Law

Sec. 541.009. SPECIFIC APPROPRIATION REQUIRED. The commission may not spend state funds to accomplish the purposes of this chapter and is not required to award a grant under this chapter unless money is appropriated for the purposes of this chapter.

SUBCHAPTER I. TELEHEALTH TREATMENT PROGRAM FOR SUBSTANCE USE DISORDERS

Revised Law

Sec. 548.0401. TELEHEALTH TREATMENT PROGRAM FOR SUBSTANCE USE DISORDERS. The executive commissioner by rule shall establish a program to increase opportunities and expand access to telehealth treatment for substance use disorders in this state. (Gov. Code, Sec. 531.02253.)

Source Law

Sec. 531.02253. TELEHEALTH TREATMENT FOR SUBSTANCE USE DISORDERS. The executive commissioner by rule shall establish a program to increase opportunities and expand access to telehealth treatment for substance use disorders in this state.

CHAPTER 549. PROVISION OF DRUGS AND DRUG INFORMATION
SUBCHAPTER A. GENERAL PROVISIONS APPLICABLE TO PROVISION OF DRUGS UNDER VENDOR DRUG PROGRAM AND CERTAIN OTHER PROGRAMS
Sec. 549.0001. BULK PURCHASING WITH ANOTHER STATE OF PRESCRIPTION DRUGS AND OTHER MEDICATIONS . . . . . 1043
Sec. 549.0002. VALUE-BASED ARRANGEMENT IN MEDICAID VENDOR DRUG PROGRAM . . . . . 1045
Sec. 549.0003. PERIOD OF VALIDITY OF PRESCRIPTIONS UNDER MEDICAID . . . . . 1046
Sec. 549.0004. CERTAIN MEDICATIONS FOR SEX OFFENDERS PROHIBITED . . . . . 1047
Sec. 549.0005. PRIOR APPROVAL OF AND PHARMACY PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS AND ENROLLEES . . . . . 1048
SUBCHAPTER B. REVIEW AND ANALYSIS OF CERTAIN PRESCRIPTION DRUG PURCHASES AND PATTERNS
Sec. 549.0051. PERIODIC REVIEW OF VENDOR DRUG PROGRAM PURCHASES . . . . . 1049
Sec. 549.0052. MEDICAID PRESCRIPTION DRUG USE AND EXPENDITURE PATTERNS . . . . . 1050
SUBCHAPTER C. SUPPLEMENTAL REBATES OR PROGRAM BENEFITS FOR PRESCRIPTION DRUGS
Sec. 549.0101. DEFINITIONS . . . . . 1050
Sec. 549.0102. REQUIREMENT TO NEGOTIATE FOR SUPPLEMENTAL REBATES FOR CERTAIN PROGRAMS . . . . . 1052
Sec. 549.0103. VOLUNTARY NEGOTIATION FOR MANUFACTURER AND LABELER SUPPLEMENTAL REBATES . . . . . 1053
Sec. 549.0104. CONSIDERATIONS IN SUPPLEMENTAL REBATE NEGOTIATIONS . . . . . 1053
Sec. 549.0105. REQUIRED DISCLOSURES IN NEGOTIATIONS FOR SUPPLEMENTAL REBATES . . . . . 1054

Sec. 549.0106. PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES; MONETARY CONTRIBUTION OR DONATION . . . . . 1055
Sec. 549.0107. LIMITATIONS ON AGREEMENT TO ACCEPT PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES . . . . . 1057
Sec. 549.0108. TREATMENT OF PROGRAM BENEFITS FOR CERTAIN PURPOSES . . . . . 1058
SUBCHAPTER D. CONFIDENTIALITY OF INFORMATION RELATING TO PRESCRIPTION DRUG REBATE NEGOTIATIONS AND AGREEMENTS
Sec. 549.0151. CERTAIN PRESCRIPTION DRUG INFORMATION CONFIDENTIAL . . . . . 1058
Sec. 549.0152. GENERAL PRESCRIPTION DRUG INFORMATION NOT CONFIDENTIAL; EXCEPTION . . . . . 1060
Sec. 549.0153. EXISTENCE OR NONEXISTENCE OF SUPPLEMENTAL REBATE AGREEMENT NOT CONFIDENTIAL . . . . . 1060
SUBCHAPTER E. PREFERRED DRUG LISTS
Sec. 549.0201. DEFINITION . . . . . 1061
Sec. 549.0202. PREFERRED DRUG LISTS REQUIRED FOR MEDICAID VENDOR DRUG AND CHILD HEALTH PLAN PROGRAMS . . . . . 1061
Sec. 549.0203. PREFERRED DRUG LISTS AUTHORIZED FOR CERTAIN PROGRAMS . . . . . 1061
Sec. 549.0204. LIMITATION ON DRUGS INCLUDED ON PREFERRED DRUG LISTS; EXCEPTIONS . . . . . 1062
Sec. 549.0205. CONSIDERATIONS FOR INCLUDING DRUG ON PREFERRED DRUG LISTS . . . . . 1062
Sec. 549.0206. SUBMISSION OF EVIDENCE TO SUPPORT INCLUDING DRUG ON PREFERRED DRUG LISTS . . . . . 1064
Sec. 549.0207. PUBLICATION OF INFORMATION RELATING TO AND DISTRIBUTION OF PREFERRED DRUG LISTS . . . . . 1064

SUBCHAPTER F. PRIOR AUTHORIZATION FOR CERTAIN DRUGS
Sec. 549.0251. DRUGS SUBJECT TO PRIOR AUTHORIZATION REQUIREMENTS . . . . . 1066
Sec. 549.0252. PRIOR AUTHORIZATION AND CERTAIN PROTOCOL REQUIREMENTS PROHIBITED FOR CERTAIN ANTIRETROVIRAL DRUGS . . . . . 1067
Sec. 549.0253. PRIOR AUTHORIZATION PROHIBITED FOR CERTAIN NONPREFERRED ANTIPSYCHOTIC DRUGS . . . . . 1068
Sec. 549.0254. ADMINISTRATION OF PRIOR AUTHORIZATION REQUIREMENTS . . . . . 1070
Sec. 549.0255. PREREQUISITE TO IMPLEMENTING PRIOR AUTHORIZATION REQUIREMENT FOR CERTAIN DRUGS . . . . . 1070
Sec. 549.0256. NOTICE OF PRIOR AUTHORIZATION REQUIREMENT IMPLEMENTATION AND PROCEDURES . . . . . 1071
Sec. 549.0257. PRIOR AUTHORIZATION PROCEDURES . . . . . 1071
Sec. 549.0258. PRIOR AUTHORIZATION AUTOMATION AND POINT-OF-SALE REQUIREMENTS . . . . . 1073
Sec. 549.0259. APPLICABILITY OF PRIOR AUTHORIZATION REQUIREMENTS TO PRIOR PRESCRIPTIONS . . . . 1074
Sec. 549.0260. APPEAL OF PRIOR AUTHORIZATION DENIAL UNDER MEDICAID VENDOR DRUG PROGRAM . . . . . 1075
SUBCHAPTER G. DRUG UTILIZATION REVIEW BOARD
Sec. 549.0301. DEFINITION . . . . . 1075
Sec. 549.0302. BOARD COMPOSITION; APPLICATION PROCESS . . . 1075
Sec. 549.0303. CONFLICTS OF INTEREST . . . . . 1077
Sec. 549.0304. BOARD MEMBER TERMS . . . . . 1077
Sec. 549.0305. PRESIDING OFFICER . . . . . 1077
Sec. 549.0306. INAPPLICABILITY OF OTHER LAW TO BOARD . . . . 1078
Sec. 549.0307. ADMINISTRATIVE SUPPORT FOR BOARD . . . . . 1078
Sec. 549.0308. RULES FOR BOARD OPERATION . . . . . 1078
Sec. 549.0309. GENERAL POWERS AND DUTIES OF BOARD . . . . . 1079

Sec. 549.0310. BOARD MEETINGS; REVIEW OF CERTAIN PRODUCTS . . . . . 1080
Sec. 549.0311. BOARD SUMMARY OF CERTAIN INFORMATION REQUIRED . . . . . 1082
Sec. 549.0312. PUBLIC DISCLOSURE OF CERTAIN BOARD RECOMMENDATIONS REQUIRED . . . . . 1083
SUBCHAPTER H. MEDICAID DRUG UTILIZATION REVIEW PROGRAM
Sec. 549.0351. DEFINITIONS . . . . . 1084
Sec. 549.0352. DRUG USE REVIEWS . . . . . 1085
Sec. 549.0353. ANNUAL REPORT . . . . . 1086
SUBCHAPTER I. PHARMACEUTICAL PATIENT ASSISTANCE PROGRAM INFORMATION
Sec. 549.0401. DEFINITION . . . . . 1087
Sec. 549.0402. PROVISION OF PROGRAM INFORMATION BY PHARMACEUTICAL COMPANY . . . . . 1087
Sec. 549.0403. PUBLIC ACCESS TO PROGRAM INFORMATION . . . . . 1088
SUBCHAPTER J. STATE PRESCRIPTION DRUG PROGRAM
Sec. 549.0451. DEVELOPMENT AND IMPLEMENTATION OF STATE PRESCRIPTION DRUG PROGRAM . . . . . 1088
Sec. 549.0452. PROGRAM ELIGIBILITY . . . . . 1089
Sec. 549.0453. RULES . . . . . 1090
Sec. 549.0454. GENERIC EQUIVALENT AUTHORIZED . . . . . 1091
Sec. 549.0455. PROGRAM FUNDING AND FUNDING PRIORITIES . . . 1091

## CHAPTER 549. PROVISION OF DRUGS AND DRUG INFORMATION

### SUBCHAPTER A. GENERAL PROVISIONS APPLICABLE TO PROVISION OF DRUGS UNDER VENDOR DRUG PROGRAM AND CERTAIN OTHER PROGRAMS

Revised Law

Sec. 549.0001. BULK PURCHASING WITH ANOTHER STATE OF PRESCRIPTION DRUGS AND OTHER MEDICATIONS. (a) Subject to Subsection (b), the commission and each health and human services agency the executive commissioner authorizes may enter into an agreement with one or more other states for the joint bulk purchasing of prescription drugs and other medications to be used in Medicaid, the child health plan program, or another program

under the commission's authority.

(b) A joint bulk purchasing agreement may not be entered into until:

(1) the commission determines that entering into the agreement would be feasible and cost-effective; and

(2) if appropriated money would be spent under the proposed agreement, the governor and the Legislative Budget Board grant prior approval to spend appropriated money under the proposed agreement.

(c) In determining the feasibility and cost-effectiveness of entering into a joint bulk purchasing agreement, the commission shall identify:

(1) the most cost-effective existing joint bulk purchasing agreement; and

(2) any potential groups of states with which this state could enter into a new cost-effective joint bulk purchasing agreement.

(d) If a joint bulk purchasing agreement is entered into, the commission shall adopt procedures applicable to an agreement and joint purchase described by this section. The procedures must ensure that this state receives:

(1) all prescription drugs and other medications purchased with money provided by this state; and

(2) an equitable share of any price benefits resulting from the joint bulk purchase. (Gov. Code, Sec. 531.090.)

Source Law

> Sec. 531.090. JOINT PURCHASING OF PRESCRIPTION DRUGS AND OTHER MEDICATIONS. (a) Subject to Subsection (b), the commission and each health and human services agency authorized by the executive commissioner may enter into an agreement with one or more other states for the joint bulk purchasing of prescription drugs and other medications to be used in Medicaid, the state child health plan, or another program under the authority of the commission.
>
> (b) An agreement under this section may not be entered into until:
>
> (1) the commission determines that entering into the agreement would be feasible and cost-effective; and
>
> (2) if appropriated money would be spent

under the proposed agreement, the governor and the Legislative Budget Board grant prior approval to expend appropriated money under the proposed agreement.

(c) If an agreement is entered into, the commission shall adopt procedures applicable to an agreement and joint purchase required by this section. The procedures must ensure that this state receives:

(1) all prescription drugs and other medications purchased with money provided by this state; and

(2) an equitable share of any price benefits resulting from the joint bulk purchase.

(d) In determining the feasibility and cost-effectiveness of entering into an agreement under this section, the commission shall identify:

(1) the most cost-effective existing joint bulk purchasing agreement; and

(2) any potential groups of states with which this state could enter into a new cost-effective joint bulk purchasing agreement.

Revisor's Note

(1) Section 531.090(a), Government Code, refers to the "state child health plan." The revised law substitutes "child health plan program" for "state child health plan" for clarity and consistency in the terminology used within the chapter and because "child health plan program" is the defined term under Section 531.001, Government Code, which is revised in this subtitle as Section 521.0001 and applies to the revised law in this chapter.

(2) Section 531.090(c), Government Code, refers to an agreement between certain agencies of this state and other states for the joint bulk purchasing of certain medications as being "required" by Section 531.090. The revised law substitutes "described" for "required" because that section does not require that an agreement be entered into. Instead, that section is permissive and allows for an agreement to be entered into if certain conditions are met.

Revised Law

Sec. 549.0002. VALUE-BASED ARRANGEMENT IN MEDICAID VENDOR DRUG PROGRAM. (a) In this section, "manufacturer" has the meaning assigned by Section 549.0101.

(b) Subject to Subchapter D, the commission may enter into a value-based arrangement for the Medicaid vendor drug program by written agreement with a manufacturer based on outcome data or other metrics to which this state and the manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus, or any other thing of value. (Gov. Code, Sec. 531.0701.)

Source Law

> Sec. 531.0701. VALUE-BASED ARRANGEMENTS. (a) In this section, "manufacturer" has the meaning assigned by Section 531.070.
>
> (b) Subject to Section 531.071, the commission may enter into a value-based arrangement for the Medicaid vendor drug program by written agreement with a manufacturer based on outcome data or other metrics to which this state and the manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus, or any other thing of value.

Revised Law

Sec. 549.0003. PERIOD OF VALIDITY OF PRESCRIPTIONS UNDER MEDICAID. (a) This section does not apply to a prescription for a controlled substance, as defined by Chapter 481, Health and Safety Code.

(b) In the rules and standards governing the vendor drug program, the executive commissioner, to the extent allowed by federal law and laws regulating the writing of prescriptions and dispensing of prescription medications, shall ensure that a prescription written by an authorized health care provider under Medicaid is valid for the lesser of:

(1) the period for which the prescription is written; or

(2) one year. (Gov. Code, Sec. 531.0694.)

Source Law

> Sec. 531.0694. PERIOD OF VALIDITY FOR PRESCRIPTION. In the rules and standards governing

the vendor drug program, the executive commissioner, to the extent allowed by federal law and laws regulating the writing and dispensing of prescription medications, shall ensure that a prescription written by an authorized health care provider under Medicaid is valid for the lesser of the period for which the prescription is written or one year. This section does not apply to a prescription for a controlled substance, as defined by Chapter 481, Health and Safety Code.

Revised Law

Sec. 549.0004. CERTAIN MEDICATIONS FOR SEX OFFENDERS PROHIBITED. (a) To the maximum extent allowed under federal law, the commission may not provide a sexual performance enhancing medication under the vendor drug program or any other health and human services program to an individual required to register as a sex offender under Chapter 62, Code of Criminal Procedure.

(b) The executive commissioner may adopt rules as necessary to implement this section. (Gov. Code, Sec. 531.089.)

Source Law

Sec. 531.089. CERTAIN MEDICATION FOR SEX OFFENDERS PROHIBITED. (a) To the maximum extent allowable under federal law, the commission may not provide sexual performance enhancing medication under the Medicaid vendor drug program or any other health and human services program to a person required to register as a sex offender under Chapter 62, Code of Criminal Procedure.

(b) The executive commissioner may adopt rules as necessary to implement this section.

Revisor's Note

(1) Section 531.089(a), Government Code, prohibits the Health and Human Services Commission from providing certain medications to sex offenders "under the Medicaid vendor drug program or any other health and human services program." The revised law omits the term "Medicaid" as unnecessarily restrictive because the prohibition also applies to any health and human services program, which includes all other health and human services programs for which the vendor drug program provides medications.

(2) Section 531.089(a), Government Code, refers to a "person required to register as a sex offender

under Chapter 62, Code of Criminal Procedure." Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), which applies to this code.

Revised Law

Sec. 549.0005. PRIOR APPROVAL OF AND PHARMACY PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS AND ENROLLEES. (a) This section applies to:

(1) the vendor drug program for Medicaid and the child health plan program;

(2) the kidney health care program;

(3) the children with special health care needs program; and

(4) any other state program the commission administers that provides prescription drug benefits.

(b) A managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that administers claims for prescription drug benefits under a program to which this section applies shall, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients or enrollees collectively under a program:

(1) submit a copy of the communication to the commission for approval; and

(2) if applicable, allow the pharmacy providers of the recipients or enrollees who are to receive the communication access to the communication. (Gov. Code, Sec. 531.0697.)

Source Law

Sec. 531.0697. PRIOR APPROVAL AND PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS. (a) This section applies to:

(1) the vendor drug program for Medicaid and the child health plan program;

(2) the kidney health care program;

(3) the children with special health care needs program; and

(4) any other state program administered by the commission that provides prescription drug benefits.

(b) A managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that administers claims for prescription drug benefits under a program to which this section applies shall, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients collectively under a program:

(1) submit a copy of the communication to the commission for approval; and

(2) if applicable, allow the pharmacy providers of recipients who are to receive the communication access to the communication.

Revisor's Note

Section 531.0697(b), Government Code, refers to "recipients" under certain programs, including Medicaid and the child health plan program. A person who receives benefits under Medicaid is generally referred to as a "recipient" and a person who receives benefits under the child health plan program is generally referred to as an "enrollee." The revised law substitutes "recipients or enrollees" for the references to "recipients" for accuracy and consistency throughout Subtitle I, Title 4, Government Code, which includes this chapter.

SUBCHAPTER B. REVIEW AND ANALYSIS OF CERTAIN PRESCRIPTION DRUG PURCHASES AND PATTERNS

Revised Law

Sec. 549.0051. PERIODIC REVIEW OF VENDOR DRUG PROGRAM PURCHASES. (a) The commission shall periodically review all purchases made under the vendor drug program to determine the cost-effectiveness of including a component for prescription drug benefits in any capitation rate paid by this state under a Medicaid managed care program or the child health plan program.

(b) In making the determination required by Subsection (a), the commission shall consider the value of any prescription drug

rebates this state receives. (Gov. Code, Sec. 531.069.)

Source Law

Sec. 531.069. PERIODIC REVIEW OF VENDOR DRUG PROGRAM. (a) The commission shall periodically review all purchases made under the vendor drug program to determine the cost-effectiveness of including a component for prescription drug benefits in any capitation rate paid by the state under a Medicaid managed care program or the child health plan program.

(b) In making the determination required by Subsection (a), the commission shall consider the value of any prescription drug rebates received by the state.

Revised Law

Sec. 549.0052. MEDICAID PRESCRIPTION DRUG USE AND EXPENDITURE PATTERNS. The commission shall:

(1) monitor and analyze Medicaid prescription drug use and expenditure patterns;

(2) identify the therapeutic prescription drug classes and individual prescription drugs that are most often prescribed to patients or that represent the greatest expenditures; and

(3) post the data the commission identifies under this section on the commission's Internet website and update the information on a quarterly basis. (Gov. Code, Sec. 531.0693.)

Source Law

Sec. 531.0693. PRESCRIPTION DRUG USE AND EXPENDITURE PATTERNS. (a) The commission shall monitor and analyze prescription drug use and expenditure patterns in Medicaid. The commission shall identify the therapeutic prescription drug classes and individual prescription drugs that are most often prescribed to patients or that represent the greatest expenditures.

(b) The commission shall post the data determined by the commission under Subsection (a) on the commission's website and update the information on a quarterly basis.

SUBCHAPTER C. SUPPLEMENTAL REBATES OR PROGRAM BENEFITS FOR PRESCRIPTION DRUGS

Revised Law

Sec. 549.0101. DEFINITIONS. In this subchapter:

(1) "Labeler" means a person that:

(A) has a labeler code from the United States

Food and Drug Administration under 21 C.F.R. Section 207.33; and

(B) receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

(2) "Manufacturer" means a manufacturer of prescription drugs as defined by 42 U.S.C. Section 1396r-8(k)(5), including a subsidiary or affiliate of a manufacturer.

(3) "Supplemental rebate" means a cash rebate a manufacturer pays to this state:

(A) on the basis of appropriate quarterly health and human services program utilization data relating to the manufacturer's products; and

(B) in accordance with a state supplemental rebate agreement negotiated with the manufacturer and, if necessary, approved by the federal government under 42 U.S.C. Section 1396r-8.

(4) "Wholesaler" means a person licensed under Subchapter I, Chapter 431, Health and Safety Code. (Gov. Code, Secs. 531.070(a), (b).)

Source Law

Sec. 531.070. SUPPLEMENTAL REBATES. (a) In this section:

(1) "Labeler" means a person that:

(A) has a labeler code from the United States Food and Drug Administration under 21 C.F.R. Section 207.20; and

(B) receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

(2) "Manufacturer" means a manufacturer of prescription drugs as defined by 42 U.S.C. Section 1396r-8(k)(5) and its subsequent amendments, including a subsidiary or affiliate of a manufacturer.

(3) "Wholesaler" means a person licensed under Subchapter I, Chapter 431, Health and Safety Code.

(b) For purposes of this section, the term "supplemental rebates" means cash rebates paid by a manufacturer to the state on the basis of appropriate quarterly health and human services program utilization data relating to the manufacturer's products, pursuant to a state supplemental rebate agreement negotiated with the manufacturer and, if necessary, approved by the federal government under Section 1927 of the federal Social Security Act (42 U.S.C. Section 1396r-8).

Revisor's Note

(1) Section 531.070(a)(1)(A), Government Code, refers to a labeler code under 21 C.F.R. Section 207.20. The regulation 21 C.F.R. Section 207.20 was revised in August 2016 (see 81 Fed. Reg. 60170 (August 31, 2016)), and the relevant provisions for obtaining a labeler code are now codified in 21 C.F.R. Section 207.33. The revised law is drafted accordingly.

(2) Section 531.070(a)(2), Government Code, refers to 42 U.S.C. Section 1396r-8(k)(5) "and its subsequent amendments." Throughout this chapter, the revised law omits the quoted language because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to a statute applies to all reenactments, revisions, or amendments of that statute, unless expressly provided otherwise.

Revised Law

Sec. 549.0102. REQUIREMENT TO NEGOTIATE FOR SUPPLEMENTAL REBATES FOR CERTAIN PROGRAMS. (a) Subject to Subsection (b), the commission shall negotiate with manufacturers and labelers, including generic manufacturers and labelers, to obtain supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8;

(2) the child health plan program; and

(3) any other state program the commission or a health and human services agency administers, including a community mental health center or state mental health hospital.

(b) The commission may by contract authorize a private entity to negotiate with manufacturers and labelers on the commission's behalf. (Gov. Code, Secs. 531.070(h), (i).)

Source Law

(h) Subject to Subsection (i), the commission

shall negotiate with manufacturers and labelers, including generic manufacturers and labelers, to obtain supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including community mental health centers and state mental health hospitals.

(i) The commission may by contract authorize a private entity to negotiate with manufacturers and labelers on behalf of the commission.

Revised Law

Sec. 549.0103. VOLUNTARY NEGOTIATION FOR MANUFACTURER AND LABELER SUPPLEMENTAL REBATES. A manufacturer or labeler that sells prescription drugs in this state may voluntarily negotiate with the commission and enter into an agreement to provide supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8;

(2) the child health plan program; and

(3) any other state program the commission or a health and human services agency administers, including a community mental health center or state mental health hospital. (Gov. Code, Sec. 531.070(j).)

Source Law

(j) A manufacturer or labeler that sells prescription drugs in this state may voluntarily negotiate with the commission and enter into an agreement to provide supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including community mental health centers and state mental health hospitals.

Revised Law

Sec. 549.0104. CONSIDERATIONS IN SUPPLEMENTAL REBATE NEGOTIATIONS. (a) In negotiating terms for a supplemental rebate amount, the commission shall consider:

(1) rebates calculated under the Medicaid rebate

program in accordance with 42 U.S.C. Section 1396r-8;

(2) any other available information on prescription drug prices or rebates; and

(3) other program benefits as specified in Section 549.0106(b).

(b) In negotiating terms for a supplemental rebate, the commission shall use the average manufacturer price as defined in 42 U.S.C. Section 1396r-8(k)(1) as the cost basis for the product. (Gov. Code, Secs. 531.070(k), (m).)

Source Law

> (k) In negotiating terms for a supplemental rebate amount, the commission shall consider:
>
> (1) rebates calculated under the Medicaid rebate program in accordance with 42 U.S.C. Section 1396r-8 and its subsequent amendments;
>
> (2) any other available information on prescription drug prices or rebates; and
>
> (3) other program benefits as specified in Subsection (c).
>
> (m) In negotiating terms for a supplemental rebate, the commission shall use the average manufacturer price (AMP), as defined in 42 U.S.C. Section 1396r-8(k)(1), as the cost basis for the product.

Revised Law

Sec. 549.0105. REQUIRED DISCLOSURES IN NEGOTIATIONS FOR SUPPLEMENTAL REBATES. Before or during supplemental rebate agreement negotiations for a prescription drug being considered for the preferred drug list, the commission shall disclose to pharmaceutical manufacturers any clinical edits or clinical protocols that may be imposed on drugs within a particular drug category that are placed on the preferred drug list during the contract period. Clinical edits may not be imposed for a preferred drug during the contract period unless the disclosure is made. (Gov. Code, Sec. 531.070(n).)

Source Law

> (n) Prior to or during supplemental rebate agreement negotiations for drugs being considered for the preferred drug list, the commission shall disclose to pharmaceutical manufacturers any clinical edits or clinical protocols that may be imposed on drugs within a particular drug category that are placed on the preferred list during the contract period. Clinical edits will not be imposed for a preferred drug during

the contract period unless the above disclosure is made.

Revised Law

Sec. 549.0106. PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES; MONETARY CONTRIBUTION OR DONATION. (a) For purposes of this section, a program benefit may mean a disease management program authorized under this title, a drug product donation program, a drug utilization control program, prescriber and beneficiary counseling and education, a fraud or abuse initiative, and another service or administrative investment with guaranteed savings to a program a health and human services agency operates.

(b) The commission may enter into a written agreement with a manufacturer to accept a program benefit instead of a supplemental rebate only if:

(1) the program benefit yields savings that are at least equal to the amount the manufacturer would have provided under a state supplemental rebate agreement during the current biennium as determined by the written agreement;

(2) the manufacturer:

(A) posts a performance bond guaranteeing savings to this state; and

(B) agrees that if the savings are not achieved in accordance with the written agreement, the manufacturer will forfeit the bond to this state, less any savings that were achieved; and

(3) the program benefit is in addition to other program benefits the manufacturer currently offers to recipients of Medicaid or related programs.

(c) For purposes of this subchapter, the commission may consider a monetary contribution or donation to the arrangements described in Subsection (b) for the purpose of offsetting expenditures to other state health care programs, but that funding may not be used to offset expenditures for covered outpatient drugs as defined by 42 U.S.C. Section 1396r-8(k)(2) under the vendor drug program. An arrangement under this subsection may not yield less

than the amount this state would have benefited under a supplemental rebate. The commission may consider an arrangement under this subchapter as satisfying the requirements of Section 549.0204(a). (Gov. Code, Secs. 531.070(c), (d), (g).)

Source Law

> (c) The commission may enter into a written agreement with a manufacturer to accept certain program benefits in lieu of supplemental rebates, as defined by this section, only if:
>
> (1) the program benefit yields savings that are at least equal to the amount the manufacturer would have provided under a state supplemental rebate agreement during the current biennium as determined by the written agreement;
>
> (2) the manufacturer posts a performance bond guaranteeing savings to the state, and agrees that if the savings are not achieved in accordance with the written agreement, the manufacturer will forfeit the bond to the state less any savings that were achieved; and
>
> (3) the program benefit is in addition to other program benefits currently offered by the manufacturer to recipients of Medicaid or related programs.
>
> (d) For purposes of this section, a program benefit may mean disease management programs authorized under this title, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to a program operated by a health and human services agency.
>
> (g) For purposes of this section, the commission may consider a monetary contribution or donation to the arrangements described in Subsection (c) for the purpose of offsetting expenditures to other state health care programs, but which funding may not be used to offset expenditures for covered outpatient drugs as defined by 42 U.S.C. Section 1396r-8(k)(2) under the vendor drug program. An arrangement under this subsection may not yield less than the amount the state would have benefited under a supplemental rebate. The commission may consider an arrangement under this section as satisfying the requirements related to Section 531.072(b).

Revisor's Note

Section 531.070(c), Government Code, refers to supplemental rebates "as defined by this section," meaning Section 531.070, Government Code, which is revised as this subchapter. The revised law omits the quoted language as unnecessary. Section 531.070(b), Government Code, revised in this subchapter as Section

549.0101(3), defines "supplemental rebate." That definition applies by its own terms to the law revised in this section.

Revised Law

Sec. 549.0107. LIMITATIONS ON AGREEMENT TO ACCEPT PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES. (a) A commission agreement to accept a program benefit described by Section 549.0106:

(1) may not prohibit the commission from entering into a similar agreement with another entity that relates to a different drug class;

(2) must be limited to a period the commission expressly determines; and

(3) subject to Subsection (b), may cover only a product that has received United States Food and Drug Administration approval as of the date the commission enters into the agreement.

(b) A new product the United States Food and Drug Administration approves after the commission enters into the agreement may be incorporated into the agreement only under an amendment to the agreement. (Gov. Code, Sec. 531.070(f).)

Source Law

(f) Agreements by the commission to accept program benefits as defined by this section:

(1) may not prohibit the commission from entering into similar agreements related to different drug classes with other entities;

(2) shall be limited to a time period expressly determined by the commission; and

(3) may only cover products that have received approval by the Federal Drug Administration at the time of the agreement, and new products approved after the agreement may be incorporated only under an amendment to the agreement.

Revisor's Note

(1) Section 531.070(f), Government Code, refers to program benefits "as defined by this section," meaning Section 531.070, Government Code. The revised law substitutes "described" for "defined" because

Section 531.070(d), Government Code, revised in this subchapter as Section 549.0106(a), describes but does not define "program benefits."

(2) Section 531.070(f)(3), Government Code, refers to the "Federal Drug Administration." The revised law substitutes "United States Food and Drug Administration" for "Federal Drug Administration" to reflect the correct name of the federal agency.

Revised Law

Sec. 549.0108. TREATMENT OF PROGRAM BENEFITS FOR CERTAIN PURPOSES. Other than as required to satisfy the provisions of this subchapter, a program benefit described by Section 549.0106 is considered an alternative to, and not the equivalent of, a supplemental rebate. A program benefit must be treated in this state's submissions to the federal government, including, as appropriate, waiver requests and quarterly Medicaid claims, so as to maximize the availability of federal matching payments. (Gov. Code, Sec. 531.070(e).)

Source Law

(e) Other than as required to satisfy the provisions of this section, the program benefits shall be deemed an alternative to, and not the equivalent of, supplemental rebates and shall be treated in the state's submissions to the federal government (including, as appropriate, waiver requests and quarterly Medicaid claims) so as to maximize the availability of federal matching payments.

SUBCHAPTER D. CONFIDENTIALITY OF INFORMATION RELATING TO PRESCRIPTION DRUG REBATE NEGOTIATIONS AND AGREEMENTS

Revised Law

Sec. 549.0151. CERTAIN PRESCRIPTION DRUG INFORMATION CONFIDENTIAL. (a) Notwithstanding any other state law other than Sections 549.0152 and 549.0153, information the commission obtains or maintains regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure

under Chapter 552.

(b) Information that is confidential under Subsection (a) includes information described by that subsection that the commission obtains or maintains in connection with:

(1) the vendor drug program;

(2) the child health plan program;

(3) the kidney health care program;

(4) the children with special health care needs program; or

(5) another state program the commission or a health and human services agency administers. (Gov. Code, Secs. 531.071(a), (b).)

Source Law

> Sec. 531.071. CONFIDENTIALITY OF INFORMATION REGARDING DRUG REBATES, PRICING, AND NEGOTIATIONS. (a) Notwithstanding any other state law, information obtained or maintained by the commission regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure under Chapter 552.
>
> (b) Information that is confidential under Subsection (a) includes information described by Subsection (a) that is obtained or maintained by the commission in connection with the Medicaid vendor drug program, the child health plan program, the kidney health care program, the children with special health care needs program, or another state program administered by the commission or a health and human services agency.

Revisor's Note

(1) Section 531.071(a), Government Code, provides that "[n]otwithstanding any other state law," information the Health and Human Services Commission obtains or maintains with respect to prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement is confidential and not subject to disclosure under Chapter 552, Government Code. Sections 531.071(c) and (d), revised in this subchapter as Sections 549.0152 and 549.0153, respectively, provide exceptions to the

confidentiality requirement. Because the exceptions are revised as separate sections of the subchapter, the revised law adds "other than Sections 549.0152 and 549.0153" immediately after "[n]otwithstanding any other state law" to avoid ambiguity and ensure application of the exceptions.

(2) Section 531.071(b), Government Code, refers to the "Medicaid vendor drug program . . . or another state program administered by the commission or a health and human services agency." The revised law omits the reference to "Medicaid" for the reason stated in Revisor's Note (1) to Section 549.0004 of this chapter.

Revised Law

Sec. 549.0152. GENERAL PRESCRIPTION DRUG INFORMATION NOT CONFIDENTIAL; EXCEPTION. General information about the aggregate costs of different classes of prescription drugs is not confidential under Section 549.0151(a), except that a drug name or information that could reveal a drug name is confidential. (Gov. Code, Sec. 531.071(c).)

Source Law

(c) General information about the aggregate costs of different classes of drugs is not confidential under Subsection (a), except that a drug name or information that could reveal a drug name is confidential.

Revised Law

Sec. 549.0153. EXISTENCE OR NONEXISTENCE OF SUPPLEMENTAL REBATE AGREEMENT NOT CONFIDENTIAL. Information about whether the commission and a manufacturer or labeler reached or did not reach a supplemental rebate agreement under Subchapter C for a particular prescription drug is not confidential under Section 549.0151(a). (Gov. Code, Sec. 531.071(d).)

Source Law

(d) Information about whether the commission and a manufacturer or labeler reached or did not reach a supplemental rebate agreement under Section 531.070

for a particular drug is not confidential under Subsection (a).

SUBCHAPTER E. PREFERRED DRUG LISTS

Revised Law

Sec. 549.0201. DEFINITION. In this subchapter, "board" means the Drug Utilization Review Board. (New.)

Revisor's Note

The definition of "board" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 549.0202. PREFERRED DRUG LISTS REQUIRED FOR MEDICAID VENDOR DRUG AND CHILD HEALTH PLAN PROGRAMS. In a manner that complies with state and federal law, the commission shall adopt preferred drug lists for:

(1) the Medicaid vendor drug program; and

(2) prescription drugs purchased through the child health plan program. (Gov. Code, Sec. 531.072(a) (part).)

Source Law

Sec. 531.072. PREFERRED DRUG LISTS. (a) In a manner that complies with applicable state and federal law, the commission shall adopt preferred drug lists for the Medicaid vendor drug program and for prescription drugs purchased through the child health plan program. . . .

Revised Law

Sec. 549.0203. PREFERRED DRUG LISTS AUTHORIZED FOR CERTAIN PROGRAMS. The commission may adopt preferred drug lists for:

(1) community mental health centers;

(2) state mental health hospitals; and

(3) any state program the commission or a state health and human services agency administers other than a program for which Section 549.0202 requires the adoption of preferred drug lists. (Gov. Code, Sec. 531.072(a) (part).)

Source Law

(a) . . . The commission may adopt preferred drug lists for community mental health centers, state

mental health hospitals, and any other state program administered by the commission or a state health and human services agency.

Revised Law

Sec. 549.0204. LIMITATION ON DRUGS INCLUDED ON PREFERRED DRUG LISTS; EXCEPTIONS. (a) The preferred drug lists adopted under this subchapter may contain only drugs provided by a manufacturer or labeler that reaches an agreement with the commission on supplemental rebates under Subchapter C.

(b) Notwithstanding Subsection (a), the preferred drug lists may contain:

(1) a drug provided by a manufacturer or labeler that has not reached a supplemental rebate agreement with the commission if the commission determines that including the drug on the preferred drug lists will not have a negative cost impact to this state; or

(2) a drug provided by a manufacturer or labeler that has reached an agreement with the commission to provide program benefits instead of supplemental rebates as described by Subchapter C. (Gov. Code, Secs. 531.072(b), (b-1).)

Source Law

(b) The preferred drug lists may contain only drugs provided by a manufacturer or labeler that reaches an agreement with the commission on supplemental rebates under Section 531.070.

(b-1) Notwithstanding Subsection (b), the preferred drug lists may contain:

(1) a drug provided by a manufacturer or labeler that has not reached a supplemental rebate agreement with the commission if the commission determines that inclusion of the drug on the preferred drug lists will have no negative cost impact to the state; or

(2) a drug provided by a manufacturer or labeler that has reached an agreement with the commission to provide program benefits in lieu of supplemental rebates, as described by Section 531.070.

Revised Law

Sec. 549.0205. CONSIDERATIONS FOR INCLUDING DRUG ON PREFERRED DRUG LISTS. (a) In making a decision regarding the placement of a drug on each of the preferred drug lists adopted under this subchapter, the commission shall consider:

(1) the board's recommendations under Section

549.0309;

(2) the drug's clinical efficacy;

(3) the price of competing drugs after deducting any federal and state rebate amounts; and

(4) program benefit offerings solely or in conjunction with rebates and other pricing information.

(b) The commission shall consider including on a preferred drug list:

(1) multiple methods of delivery within each drug class, including liquid, capsule, and tablet, including an orally disintegrating tablet; and

(2) all strengths and dosage forms of a drug. (Gov. Code, Secs. 531.072(b-2), (c), (c-1).)

Source Law

(b-2) Consideration must be given to including all strengths and dosage forms of a drug on the preferred drug lists.

(c) In making a decision regarding the placement of a drug on each of the preferred drug lists, the commission shall consider:

(1) the recommendations of the Drug Utilization Review Board under Section 531.0736;

(2) the clinical efficacy of the drug;

(3) the price of competing drugs after deducting any federal and state rebate amounts; and

(4) program benefit offerings solely or in conjunction with rebates and other pricing information.

(c-1) In addition to the considerations listed under Subsection (c), the commission shall consider the inclusion of multiple methods of delivery within each drug class, including liquid, tablet, capsule, and orally disintegrating tablets.

Revisor's Note

(1) Section 531.072(c)(1), Government Code, refers to Drug Utilization Review Board recommendations under Section 531.0736, Government Code. The provisions of Section 531.0736 relating to board recommendations are revised in this chapter as Section 549.0309, and the revised law is drafted accordingly.

(2) Section 531.072(c-1), Government Code,

requires the Health and Human Services Commission to consider certain factors with respect to preferred drug lists "[i]n addition to the considerations listed under Subsection (c)" of Section 531.072, Government Code. The revised law omits the quoted language as unnecessary because the requirement to consider the factors listed in Subsection (c), which is revised as Subsection (a) of this section, applies by its own terms.

Revised Law

Sec. 549.0206. SUBMISSION OF EVIDENCE TO SUPPORT INCLUDING DRUG ON PREFERRED DRUG LISTS. (a) In this section, "labeler" and "manufacturer" have the meanings assigned by Section 549.0101.

(b) The commission shall ensure that a manufacturer or labeler may submit written evidence that supports including a drug on the preferred drug lists before a supplemental rebate agreement is reached with the commission. (Gov. Code, Sec. 531.072(e) (part).)

Source Law

> (e) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 531.070. The commission shall ensure that:
>
> (1) a manufacturer or labeler may submit written evidence supporting the inclusion of a drug on the preferred drug lists before a supplemental agreement is reached with the commission; and
>
> . . .

Revisor's Note

Section 531.072(e), Government Code, refers to definitions provided under Section 531.070, Government Code. The relevant definitions are revised in this chapter as Section 549.0101, and the revised law is drafted accordingly.

Revised Law

Sec. 549.0207. PUBLICATION OF INFORMATION RELATING TO AND DISTRIBUTION OF PREFERRED DRUG LISTS. (a) The commission shall publish on the commission's Internet website any decisions on

preferred drug list placement, including:

(1) a list of drugs reviewed and the commission's decision for or against placement on a preferred drug list of each reviewed drug;

(2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Subchapter C; and

(3) the rationale for any departure from a board recommendation under Section 549.0309.

(b) The commission shall:

(1) provide for the distribution of current copies of the preferred drug lists adopted under this subchapter by posting the lists on the Internet; and

(2) mail copies of the lists to a health care provider on the provider's request. (Gov. Code, Secs. 531.072(d), 531.0741.)

Source Law

[Sec. 531.072]

(d) The commission shall provide for the distribution of current copies of the preferred drug lists by posting the list on the Internet. In addition, the commission shall mail copies of the lists to any health care provider on request of that provider.

Sec. 531.0741. PUBLICATION OF INFORMATION REGARDING COMMISSION DECISIONS ON PREFERRED DRUG LIST PLACEMENT. The commission shall publish on the commission's Internet website any decisions on preferred drug list placement, including:

(1) a list of drugs reviewed and the commission's decision for or against placement on a preferred drug list of each drug reviewed;

(2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Section 531.070; and

(3) the rationale for any departure from a recommendation of the Drug Utilization Review Board under Section 531.0736.

Revisor's Note

Section 531.0741(3), Government Code, refers to Drug Utilization Review Board recommendations under Section 531.0736, Government Code. The revised law substitutes a reference to Section 549.0309 of this

chapter for the reference to Section 531.0736, Government Code, for the reason stated in Revisor's Note (1) to Section 549.0205 of this chapter.

SUBCHAPTER F. PRIOR AUTHORIZATION FOR CERTAIN DRUGS

Revised Law

Sec. 549.0251. DRUGS SUBJECT TO PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program and the child health plan program, shall require prior authorization for the reimbursement of a drug that is not included in the appropriate preferred drug list adopted under Subchapter E unless:

(1) the drug is exempt from prior authorization requirements by federal law; or

(2) the executive commissioner is prohibited under Sections 549.0252 and 549.0253(a) from requiring prior authorization for the drug.

(b) The executive commissioner may require prior authorization for the reimbursement of a drug provided through any state program, other than a program described by Subsection (a), that the commission or a state health and human services agency administers, including a community mental health center and a state mental health hospital if the commission adopts a preferred drug list under Subchapter E that applies to that facility and the drug is not included in the appropriate list.

(c) The executive commissioner shall require that the prior authorization be obtained by the prescribing physician or prescribing practitioner. (Gov. Code, Sec. 531.073(a).)

Source Law

> Sec. 531.073. PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTION DRUGS. (a) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program and the child health plan program, shall require prior authorization for the reimbursement of a drug that is not included in the appropriate preferred drug list adopted under Section 531.072, except for any drug exempted from prior authorization requirements by federal law and except as provided by Subsections (a-3) and (j). The executive commissioner may require prior

authorization for the reimbursement of a drug provided through any other state program administered by the commission or a state health and human services agency, including a community mental health center and a state mental health hospital if the commission adopts preferred drug lists under Section 531.072 that apply to those facilities and the drug is not included in the appropriate list. The executive commissioner shall require that the prior authorization be obtained by the prescribing physician or prescribing practitioner.

Revisor's Note

Section 531.073(a), Government Code, refers to preferred drug lists adopted under Section 531.072, Government Code. The provisions of Section 531.072 relating to the adoption of preferred drug lists are revised in this chapter as Subchapter E, and the revised law is drafted accordingly.

Revised Law

Sec. 549.0252. PRIOR AUTHORIZATION AND CERTAIN PROTOCOL REQUIREMENTS PROHIBITED FOR CERTAIN ANTIRETROVIRAL DRUGS. (a) In this section, "antiretroviral drug" means a drug that treats human immunodeficiency virus infection or prevents acquired immune deficiency syndrome. The term includes:

(1) protease inhibitors;

(2) non-nucleoside reverse transcriptase inhibitors;

(3) nucleoside reverse transcriptase inhibitors;

(4) integrase inhibitors;

(5) fusion inhibitors;

(6) attachment inhibitors;

(7) CD4 post-attachment inhibitors;

(8) CCR5 receptor antagonists; and

(9) other antiretroviral drugs used to treat human immunodeficiency virus infection or prevent acquired immune deficiency syndrome.

(b) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program, may not require a clinical, nonpreferred, or other prior authorization for an antiretroviral drug, or a step therapy or other protocol, that

could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse. (Gov. Code, Sec. 531.073(j).)

Source Law

> (j) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program, may not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse. In this subsection, "antiretroviral drug" means a drug that treats human immunodeficiency virus infection or prevents acquired immune deficiency syndrome. The term includes:
>
> (1) protease inhibitors;
>
> (2) non-nucleoside reverse transcriptase inhibitors;
>
> (3) nucleoside reverse transcriptase inhibitors;
>
> (4) integrase inhibitors;
>
> (5) fusion inhibitors;
>
> (6) attachment inhibitors;
>
> (7) CD4 post-attachment inhibitors;
>
> (8) CCR5 receptor antagonists; and
>
> (9) other antiretroviral drugs used to treat human immunodeficiency virus infection or prevent acquired immune deficiency syndrome.

Revised Law

Sec. 549.0253. PRIOR AUTHORIZATION PROHIBITED FOR CERTAIN NONPREFERRED ANTIPSYCHOTIC DRUGS. (a) The executive commissioner, in the rules and standards governing the vendor drug program, may not require prior authorization for a nonpreferred antipsychotic drug that is included on the vendor drug formulary and prescribed to an adult patient if:

(1) during the preceding year, the patient was prescribed and unsuccessfully treated with a 14-day treatment trial of an antipsychotic drug that is included on the appropriate preferred drug list adopted under Subchapter E and for which a single claim was paid;

(2) the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription is for the purpose of drug dosage titration; or

(3) subject to federal law on maximum dosage limits and commission rules on drug quantity limits, the patient has previously been prescribed and obtained prior authorization for the

nonpreferred antipsychotic drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.

(b) Subsection (a) does not affect:

(1) a pharmacist's authority to dispense the generic equivalent or interchangeable biological product of a prescription drug in accordance with Subchapter A, Chapter 562, Occupations Code;

(2) any drug utilization review requirements prescribed by state or federal law; or

(3) clinical prior authorization edits to preferred and nonpreferred antipsychotic drug prescriptions. (Gov. Code, Secs. 531.073(a-3), (a-4).)

Source Law

> (a-3) The executive commissioner, in the rules and standards governing the vendor drug program, may not require prior authorization for a nonpreferred antipsychotic drug that is included on the vendor drug formulary and prescribed to an adult patient if:
>
> (1) during the preceding year, the patient was prescribed and unsuccessfully treated with a 14-day treatment trial of an antipsychotic drug that is included on the appropriate preferred drug list adopted under Section 531.072 and for which a single claim was paid;
>
> (2) the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription is for the purpose of drug dosage titration; or
>
> (3) subject to federal law on maximum dosage limits and commission rules on drug quantity limits, the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.
>
> (a-4) Subsection (a-3) does not affect:
>
> (1) the authority of a pharmacist to dispense the generic equivalent or interchangeable biological product of a prescription drug in accordance with Subchapter A, Chapter 562, Occupations Code;
>
> (2) any drug utilization review requirements prescribed by state or federal law; or
>
> (3) clinical prior authorization edits to preferred and nonpreferred antipsychotic drug prescriptions.

Revisor's Note

Section 531.073(a-3)(1), Government Code, refers

to a preferred drug list adopted under Section 531.072, Government Code. The revised law substitutes a reference to Subchapter E of this chapter for the reference to Section 531.072 for the reason stated in the revisor's note to Section 549.0251 of this chapter.

Revised Law

Sec. 549.0254. ADMINISTRATION OF PRIOR AUTHORIZATION REQUIREMENTS. (a) The commission may by contract authorize a private entity to administer the prior authorization requirements imposed by Sections 549.0251 and 549.0255 through 549.0259 on the commission's behalf.

(b) The commission shall ensure that the prior authorization requirements are implemented in a manner that minimizes the cost to this state and any administrative burden placed on providers. (Gov. Code, Secs. 531.073(e), (f).)

Source Law

(e) The commission may by contract authorize a private entity to administer the prior authorization requirements imposed by this section on behalf of the commission.

(f) The commission shall ensure that the prior authorization requirements are implemented in a manner that minimizes the cost to the state and any administrative burden placed on providers.

Revised Law

Sec. 549.0255. PREREQUISITE TO IMPLEMENTING PRIOR AUTHORIZATION REQUIREMENT FOR CERTAIN DRUGS. Until the commission completes a study evaluating the impact of a prior authorization requirement on recipients of certain drugs, the executive commissioner shall delay requiring prior authorization for drugs that are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies. (Gov. Code, Sec. 531.073(a-1).)

Source Law

(a-1) Until the commission has completed a study evaluating the impact of a requirement of prior

authorization on recipients of certain drugs, the executive commissioner shall delay requiring prior authorization for drugs that are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies.

Revised Law

Sec. 549.0256. NOTICE OF PRIOR AUTHORIZATION REQUIREMENT IMPLEMENTATION AND PROCEDURES. Not later than the 30th day before the date a prior authorization requirement is implemented, the commission shall post on the Internet for consumers and providers:

(1) notice of the implementation date; and

(2) a detailed description of the procedures to be used in obtaining prior authorization. (Gov. Code, Sec. 531.073(a-2).)

Source Law

(a-2) Not later than the 30th day before the date on which prior authorization requirements are implemented, the commission shall post on the Internet for consumers and providers:

(1) a notification of the implementation date; and

(2) a detailed description of the procedures to be used in obtaining prior authorization.

Revised Law

Sec. 549.0257. PRIOR AUTHORIZATION PROCEDURES. (a) The commission shall establish procedures for the prior authorization requirement under the Medicaid vendor drug program to ensure that the requirements of 42 U.S.C. Section 1396r-8(d)(5) are met. The procedures must ensure that:

(1) a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Drug Utilization Review Board under Subchapter G;

(2) a response to a request for prior authorization is provided by telephone or other telecommunications device within 24 hours after receipt of the request; and

(3) a 72-hour supply of the drug prescribed is provided in an emergency or if the commission does not provide a response within the period required by Subdivision (2).

(b) The commission shall implement procedures to ensure that a recipient or enrollee under Medicaid, the child health plan program, or another state program the commission administers, or an individual who becomes eligible under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, receives continuity of care in relation to certain prescriptions the commission identifies.

(c) The commission shall ensure that requests for prior authorization may be submitted by telephone, facsimile, or electronic communications through the Internet.

(d) The commission shall provide an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request. (Gov. Code, Secs. 531.073(b), (d), (g), (h).)

Source Law

> (b) The commission shall establish procedures for the prior authorization requirement under the Medicaid vendor drug program to ensure that the requirements of 42 U.S.C. Section 1396r-8(d)(5) and its subsequent amendments are met. Specifically, the procedures must ensure that:
>
> (1) a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Drug Utilization Review Board under Section 531.0736;
>
> (2) there will be a response to a request for prior authorization by telephone or other telecommunications device within 24 hours after receipt of a request for prior authorization; and
>
> (3) a 72-hour supply of the drug prescribed will be provided in an emergency or if the commission does not provide a response within the time required by Subdivision (2).
>
> (d) The commission shall implement procedures to ensure that a recipient under the child health plan program, Medicaid, or another state program administered by the commission or a person who becomes eligible under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency receives continuity of care in relation to certain prescriptions identified by the commission.
>
> (g) The commission shall ensure that requests for prior authorization may be submitted by telephone, facsimile, or electronic communications through the Internet.

(h) The commission shall provide an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request.

Revisor's Note

Section 531.073(d), Government Code, refers to a "recipient" under Medicaid or the child health plan program. The revised law substitutes "recipient or enrollee" for the quoted language for the reason stated in the revisor's note to Section 549.0005 of this chapter.

Revised Law

Sec. 549.0258. PRIOR AUTHORIZATION AUTOMATION AND POINT-OF-SALE REQUIREMENTS. The executive commissioner, in the rules and standards governing the vendor drug program and as part of the requirements under a contract between the commission and a Medicaid managed care organization, shall:

(1) require, to the maximum extent possible based on a pharmacy benefit manager's claim system, automation of clinical prior authorization for each drug in the antipsychotic drug class; and

(2) ensure that, at the time a nonpreferred or clinical prior authorization edit is denied, a pharmacist is immediately provided a point-of-sale return message that:

(A) clearly specifies the contact and other information necessary for the pharmacist to submit a prior authorization request for the prescription; and

(B) instructs the pharmacist to dispense, only if clinically appropriate under federal or state law, a 72-hour supply of the prescription. (Gov. Code, Sec. 531.073(a-5).)

Source Law

(a-5) The executive commissioner, in the rules and standards governing the vendor drug program and as part of the requirements under a contract between the commission and a Medicaid managed care organization, shall:

(1) require, to the maximum extent

possible based on a pharmacy benefit manager's claim system, automation of clinical prior authorization for each drug in the antipsychotic drug class; and

(2) ensure that, at the time a nonpreferred or clinical prior authorization edit is denied, a pharmacist is immediately provided a point-of-sale return message that:

(A) clearly specifies the contact and other information necessary for the pharmacist to submit a prior authorization request for the prescription; and

(B) instructs the pharmacist to dispense, only if clinically appropriate under federal or state law, a 72-hour supply of the prescription.

Revised Law

Sec. 549.0259. APPLICABILITY OF PRIOR AUTHORIZATION REQUIREMENTS TO PRIOR PRESCRIPTIONS. The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient or enrollee under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, or for an individual who becomes eligible under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, is not subject to any prior authorization requirement under this subchapter until the earlier of:

(1) the date the recipient or enrollee exhausts all the prescription, including any authorized refills; or

(2) the expiration of a period the commission prescribes. (Gov. Code, Sec. 531.073(c).)

Source Law

(c) The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency or for a person who becomes eligible under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency is not subject to any requirement for prior authorization under this section unless the recipient has exhausted all the prescription, including any authorized refills, or a period prescribed by the commission has expired, whichever occurs first.

Revisor's Note

Section 531.073(c), Government Code, refers to a

"recipient" under Medicaid or the child health plan program. The revised law substitutes "recipient or enrollee" for the quoted language for the reason stated in the revisor's note to Section 549.0005 of this chapter.

Revised Law

Sec. 549.0260. APPEAL OF PRIOR AUTHORIZATION DENIAL UNDER MEDICAID VENDOR DRUG PROGRAM. A recipient of drug benefits under the Medicaid vendor drug program may appeal through the Medicaid fair hearing process a denial of prior authorization under this subchapter for a covered drug or covered dosage. (Gov. Code, Sec. 531.072(f).)

Source Law

(f) A recipient of drug benefits under the Medicaid vendor drug program may appeal a denial of prior authorization under Section 531.073 of a covered drug or covered dosage through the Medicaid fair hearing process.

SUBCHAPTER G. DRUG UTILIZATION REVIEW BOARD

Revised Law

Sec. 549.0301. DEFINITION. In this subchapter, "board" means the Drug Utilization Review Board. (Gov. Code, Sec. 531.0736(a).)

Source Law

Sec. 531.0736. DRUG UTILIZATION REVIEW BOARD. (a) In this section, "board" means the Drug Utilization Review Board.

Revised Law

Sec. 549.0302. BOARD COMPOSITION; APPLICATION PROCESS. (a) The composition of the board must comply with federal law, including 42 C.F.R. Section 456.716. The executive commissioner shall determine the board's composition, which must include:

(1) two representatives of managed care organizations, one of whom must be a physician and one of whom must be a pharmacist, as nonvoting members;

(2) at least 17 physicians and pharmacists who:

(A) provide services across the entire

population of Medicaid recipients and represent different specialties, including at least one of each of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist; and

(v) an adult psychiatrist; and

(B) have experience in either developing or practicing under a preferred drug list; and

(3) a consumer advocate who represents Medicaid recipients.

(b) The executive commissioner by rule shall develop and implement a process by which an individual may apply to become a board member and shall post the application and information regarding the application process on the commission's Internet website. (Gov. Code, Secs. 531.0736(c), (c-1).)

Source Law

(c) The executive commissioner shall determine the composition of the board, which must:

(1) comply with applicable federal law, including 42 C.F.R. Section 456.716;

(2) include two representatives of managed care organizations as nonvoting members, one of whom must be a physician and one of whom must be a pharmacist;

(3) include at least 17 physicians and pharmacists who:

(A) provide services across the entire population of Medicaid recipients and represent different specialties, including at least one of each of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist; and

(v) an adult psychiatrist; and

(B) have experience in either developing or practicing under a preferred drug list; and

(4) include a consumer advocate who represents Medicaid recipients.

(c-1) The executive commissioner by rule shall develop and implement a process by which a person may apply to become a member of the board and shall post

the application and information regarding the application process on the commission's Internet website.

Revised Law

Sec. 549.0303. CONFLICTS OF INTEREST. (a) A voting board member may not have a contractual relationship with, ownership interest in, or other conflict of interest with:

(1) a pharmaceutical manufacturer or labeler; or

(2) an entity the commission engages to assist in developing preferred drug lists or administering the Medicaid Drug Utilization Review Program.

(b) The executive commissioner may implement this section by:

(1) adopting rules that identify prohibited relationships and conflicts; or

(2) requiring the board to develop a conflict-of-interest policy that applies to the board. (Gov. Code, Sec. 531.0737.)

Source Law

Sec. 531.0737. DRUG UTILIZATION REVIEW BOARD: CONFLICTS OF INTEREST. (a) A voting member of the Drug Utilization Review Board may not have a contractual relationship, ownership interest, or other conflict of interest with a pharmaceutical manufacturer or labeler or with an entity engaged by the commission to assist in the development of the preferred drug lists or in the administration of the Medicaid Drug Utilization Review Program.

(b) The executive commissioner may implement this section by adopting rules that identify prohibited relationships and conflicts or requiring the board to develop a conflict-of-interest policy that applies to the board.

Revised Law

Sec. 549.0304. BOARD MEMBER TERMS. Board members serve staggered four-year terms. (Gov. Code, Sec. 531.0736(e).)

Source Law

(e) Members of the board serve staggered four-year terms.

Revised Law

Sec. 549.0305. PRESIDING OFFICER. The voting board members shall elect from among the voting members a presiding officer. The

presiding officer must be a physician. (Gov. Code, Sec. 531.0736(f).)

Source Law

(f) The voting members of the board shall elect from among the voting members a presiding officer. The presiding officer must be a physician.

Revised Law

Sec. 549.0306. INAPPLICABILITY OF OTHER LAW TO BOARD. Chapter 2110 does not apply to the board. (Gov. Code, Sec. 531.0736(m).)

Source Law

(m) Chapter 2110 does not apply to the board.

Revised Law

Sec. 549.0307. ADMINISTRATIVE SUPPORT FOR BOARD. The commission shall provide administrative support and resources as necessary for the board to perform the board's duties. (Gov. Code, Sec. 531.0736(l).)

Source Law

(l) The commission shall provide administrative support and resources as necessary for the board to perform its duties.

Revised Law

Sec. 549.0308. RULES FOR BOARD OPERATION. (a) The executive commissioner shall adopt rules governing the board's operation, including:

(1) rules governing the procedures the board uses to provide notice of a meeting; and

(2) rules prohibiting the board from discussing confidential information described by Subchapter D in a public meeting.

(b) The board shall comply with the rules adopted under this section and Section 549.0311. (Gov. Code, Sec. 531.0736(i).)

Source Law

(i) The executive commissioner shall adopt rules governing the operation of the board, including rules governing the procedures used by the board for providing notice of a meeting and rules prohibiting the board from discussing confidential information

described by Section 531.071 in a public meeting. The board shall comply with the rules adopted under this subsection and Subsection (j).

Revised Law

Sec. 549.0309. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to performing any other duties required by federal law, the board shall:

(1) develop and submit to the commission recommendations for the preferred drug lists the commission adopts under Subchapter E;

(2) suggest to the commission restrictions or clinical edits on prescription drugs;

(3) recommend to the commission educational interventions for Medicaid providers;

(4) review drug utilization across Medicaid; and

(5) perform other duties that may be specified by law and otherwise make recommendations to the commission.

(b) In developing recommendations for the preferred drug lists, the board shall consider the clinical efficacy, safety, and cost-effectiveness of, and any program benefit associated with, a product.

(c) To the extent feasible, the board:

(1) shall review all drug classes included in the preferred drug lists at least once every 12 months; and

(2) may recommend inclusions in and exclusions from the lists to ensure that the lists provide for a range of clinically effective, safe, cost-effective, and medically appropriate drug therapies for the diverse segments of the Medicaid population, children receiving health benefits coverage under the child health plan program, and any other affected individuals. (Gov. Code, Secs. 531.0736(b), (h), (k).)

Source Law

(b) In addition to performing any other duties required by federal law, the board shall:

(1) develop and submit to the commission recommendations for preferred drug lists adopted by the commission under Section 531.072;

(2) suggest to the commission restrictions

or clinical edits on prescription drugs;

(3) recommend to the commission educational interventions for Medicaid providers;

(4) review drug utilization across Medicaid; and

(5) perform other duties that may be specified by law and otherwise make recommendations to the commission.

(h) In developing its recommendations for the preferred drug lists, the board shall consider the clinical efficacy, safety, and cost-effectiveness of and any program benefit associated with a product.

(k) To the extent feasible, the board shall review all drug classes included in the preferred drug lists adopted under Section 531.072 at least once every 12 months and may recommend inclusions to and exclusions from the lists to ensure that the lists provide for a range of clinically effective, safe, cost-effective, and medically appropriate drug therapies for the diverse segments of the Medicaid population, children receiving health benefits coverage under the child health plan program, and any other affected individuals.

Revisor's Note

Section 531.0736(b)(1), Government Code, refers to preferred drug lists adopted by the Health and Human Services Commission under Section 531.072, Government Code. The revised law substitutes a reference to Subchapter E of this chapter for the reference to Section 531.072, Government Code, for the reason stated in the revisor's note to Section 549.0251 of this chapter.

Revised Law

Sec. 549.0310. BOARD MEETINGS; REVIEW OF CERTAIN PRODUCTS. (a) The board shall hold a public meeting quarterly at the call of the presiding officer and shall permit public comment before voting on any changes in the preferred drug lists the commission adopts under Subchapter E, the adoption of or changes to drug use criteria, or the adoption of prior authorization or drug utilization review proposals. The location of the quarterly public meeting may rotate among different geographic areas across this state, or allow for public input through teleconferencing centers in various geographic areas across this state.

(b) The board shall hold public meetings at other times at

the call of the presiding officer.

(c) Minutes of each meeting shall be made available to the public not later than the 10th business day after the date the minutes are approved.

(d) The board may meet in executive session to discuss confidential information as described by Section 549.0308.

(e) Board members appointed under Section 549.0302(a)(1) may attend quarterly and other regularly scheduled meetings, but may not:

(1) attend executive sessions; or

(2) access confidential drug pricing information.

(f) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 549.0101. The commission shall ensure that a drug that has been approved or had any of the drug's particular uses approved by the United States Food and Drug Administration under a priority review classification is reviewed by the board at the next regularly scheduled board meeting. On receiving notice from a manufacturer or labeler of the availability of a new product, the commission, to the extent possible, shall schedule a review for the product at the next regularly scheduled board meeting. (Gov. Code, Secs. 531.072(e) (part), 531.0736(b) (part), (d), (g).)

Source Law

[Sec. 531.072]

(e) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 531.070. The commission shall ensure that:

. . .

(2) any drug that has been approved or has had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the Drug Utilization Review Board at the next regularly scheduled meeting of the board. On receiving notice from a manufacturer or labeler of the availability of a new product, the commission, to the extent possible, shall schedule a review for the product at the next regularly scheduled meeting of the board.

[Sec. 531.0736]

(b) . . . [the board shall:

(1) develop and submit . . . recommendations for] preferred drug lists adopted by the commission under Section 531.072;

. . .

(d) Members appointed under Subsection (c)(2) may attend quarterly and other regularly scheduled meetings, but may not:

(1) attend executive sessions; or

(2) access confidential drug pricing information.

(g) The board shall hold a public meeting quarterly at the call of the presiding officer and shall permit public comment before voting on any changes in the preferred drug lists, the adoption of or changes to drug use criteria, or the adoption of prior authorization or drug utilization review proposals. The location of the quarterly public meeting may rotate among different geographic areas across this state, or allow for public input through teleconferencing centers in various geographic areas across this state. The board shall hold public meetings at other times at the call of the presiding officer. Minutes of each meeting shall be made available to the public not later than the 10th business day after the date the minutes are approved. The board may meet in executive session to discuss confidential information as described by Subsection (i).

Revised Law

Sec. 549.0311. BOARD SUMMARY OF CERTAIN INFORMATION REQUIRED. (a) The executive commissioner by rule shall require the board or the board's designee to present a summary of any clinical efficacy and safety information or analyses regarding a drug under consideration for a preferred drug list the commission adopts under Subchapter E that is provided to the board by a private entity that contracted with the commission to provide the information. Confidential information described by Subchapter D must be omitted from the summary.

(b) The board or the board's designee shall provide the summary in electronic form before the public meeting at which consideration of the drug occurs.

(c) The summary must be posted on the commission's Internet website. (Gov. Code, Secs. 531.0736(b) (part), (j).)

Source Law

(b) . . . [the board shall:

(1) develop and submit . . . recommendations for] preferred drug lists adopted by the commission under Section 531.072;

. . .

(j) In addition to the rules under Subsection (i), the executive commissioner by rule shall require the board or the board's designee to present a summary of any clinical efficacy and safety information or

analyses regarding a drug under consideration for a preferred drug list that is provided to the board by a private entity that has contracted with the commission to provide the information. The board or the board's designee shall provide the summary in electronic form before the public meeting at which consideration of the drug occurs. Confidential information described by Section 531.071 must be omitted from the summary. The summary must be posted on the commission's Internet website.

Revisor's Note

Section 531.0736(j), Government Code, states that "[i]n addition to the rules under Subsection (i)," which is revised as Section 549.0308 of this chapter, the executive commissioner of the Health and Human Services Commission by rule shall require the Drug Utilization Review Board to perform certain other acts. The revised law omits the quoted language as unnecessary because each requirement to adopt rules applies by its own terms and because the absence of the language does not imply that the requirement to adopt rules under this section negates the executive commissioner's duty to adopt rules under other law.

Revised Law

Sec. 549.0312. PUBLIC DISCLOSURE OF CERTAIN BOARD RECOMMENDATIONS REQUIRED. (a) The commission or the commission's agent shall publicly disclose, immediately after the board's deliberations conclude, each specific drug recommended for or against preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The disclosure must include:

(1) the general basis for the recommendation for each drug class; and

(2) for each recommendation, whether a supplemental rebate agreement or program benefit agreement was reached under Subchapter C.

(b) The disclosure must be posted on the commission's Internet website not later than the 10th business day after the date of conclusion of board deliberations that result in recommendations

made to the executive commissioner regarding the placement of drugs on the preferred drug list. (Gov. Code, Sec. 531.0736(n).)

Source Law

> (n) The commission or the commission's agent shall publicly disclose, immediately after the board's deliberations conclude, each specific drug recommended for or against preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The disclosure must be posted on the commission's Internet website not later than the 10th business day after the date of conclusion of board deliberations that result in recommendations made to the executive commissioner regarding the placement of drugs on the preferred drug list. The public disclosure must include:
>
> (1) the general basis for the recommendation for each drug class; and
>
> (2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Section 531.070.

SUBCHAPTER H. MEDICAID DRUG UTILIZATION REVIEW PROGRAM

Revised Law

Sec. 549.0351. DEFINITIONS. In this subchapter:

(1) "Medicaid Drug Utilization Review Program" means the program the vendor drug program operates to improve the quality of pharmaceutical care under Medicaid.

(2) "Prospective drug use review" means the review of a patient's drug therapy and prescription drug order or medication order before dispensing or distributing a drug to the patient.

(3) "Retrospective drug use review" means the review of prescription drug claims data to identify patterns of prescribing. (Gov. Code, Sec. 531.0735(a).)

Source Law

> Sec. 531.0735. MEDICAID DRUG UTILIZATION REVIEW PROGRAM: DRUG USE REVIEWS AND ANNUAL REPORT. (a) In this section:
>
> (1) "Medicaid Drug Utilization Review Program" means the program operated by the vendor drug program to improve the quality of pharmaceutical care under Medicaid.
>
> (2) "Prospective drug use review" means the review of a patient's drug therapy and prescription drug order or medication order before dispensing or distributing a drug to the patient.
>
> (3) "Retrospective drug use review" means the review of prescription drug claims data to identify patterns of prescribing.

Revised Law

Sec. 549.0352. DRUG USE REVIEWS. (a) The commission shall provide for an increase in the number and types of retrospective drug use reviews performed each year under the Medicaid Drug Utilization Review Program in comparison to the number and types of reviews performed in the state fiscal year ending August 31, 2009.

(b) In determining the number and types of drug use reviews to be performed, the commission shall:

(1) allow for the repeat of retrospective drug use reviews that address ongoing drug therapy problems and that, in previous years, improved client outcomes and reduced Medicaid spending;

(2) consider implementing disease-specific retrospective drug use reviews that:

(A) address ongoing drug therapy problems in this state; and

(B) reduced Medicaid prescription drug use expenditures in another state; and

(3) regularly examine Medicaid prescription drug claims data to identify occurrences of potential drug therapy problems that may be addressed by repeating successful retrospective drug use reviews performed in this state or another state. (Gov. Code, Secs. 531.0735(b), (c).)

Source Law

(b) The commission shall provide for an increase in the number and types of retrospective drug use reviews performed each year under the Medicaid Drug Utilization Review Program, in comparison to the number and types of reviews performed in the state fiscal year ending August 31, 2009.

(c) In determining the number and types of drug use reviews to be performed, the commission shall:

(1) allow for the repeat of retrospective drug use reviews that address ongoing drug therapy problems and that, in previous years, improved client outcomes and reduced Medicaid spending;

(2) consider implementing disease-specific retrospective drug use reviews that address ongoing drug therapy problems in this state and that reduced Medicaid prescription drug use expenditures in other states; and

(3) regularly examine Medicaid prescription drug claims data to identify occurrences

of potential drug therapy problems that may be addressed by repeating successful retrospective drug use reviews performed in this state and other states.

Revised Law

Sec. 549.0353. ANNUAL REPORT. (a) In addition to any other information required by federal law, the commission shall include the following information in the annual report regarding the Medicaid Drug Utilization Review Program:

(1) a detailed description of the program's activities; and

(2) estimates of cost savings anticipated to result from the program's performance of prospective and retrospective drug use reviews.

(b) The cost-saving estimates for prospective drug use reviews under Subsection (a) must include savings attributed to drug use reviews performed through the vendor drug program's electronic claims processing system and clinical edits screened through the prior authorization system implemented under Subchapter F.

(c) The commission shall post the annual report regarding the Medicaid Drug Utilization Review Program on the commission's Internet website. (Gov. Code, Secs. 531.0735(d), (e), (f).)

Source Law

(d) In addition to any other information required by federal law, the commission shall include the following information in the annual report regarding the Medicaid Drug Utilization Review Program:

(1) a detailed description of the program's activities; and

(2) estimates of cost savings anticipated to result from the program's performance of prospective and retrospective drug use reviews.

(e) The cost-saving estimates for prospective drug use reviews under Subsection (d) must include savings attributed to drug use reviews performed through the vendor drug program's electronic claims processing system and clinical edits screened through the prior authorization system implemented under Section 531.073.

(f) The commission shall post the annual report regarding the Medicaid Drug Utilization Review Program on the commission's website.

Revisor's Note

Section 531.0735(e), Government Code, refers to

the prior authorization system implemented under Section 531.073, Government Code, which is revised in this chapter in Subchapter F. That subchapter also includes the revision of Section 531.072(f), Government Code. The revised law substitutes a reference to Subchapter F in its entirety for the reference to Section 531.073 because the provision of that subchapter derived from Section 531.072(f) relates to the same prior authorization system, and its inclusion in the reference has no substantive effect.

SUBCHAPTER I. PHARMACEUTICAL PATIENT ASSISTANCE PROGRAM INFORMATION

Revised Law

Sec. 549.0401. DEFINITION. In this subchapter, "patient assistance program" means a program a pharmaceutical company offers under which the company provides a drug to individuals in need of assistance at no charge or at a substantially reduced cost. The term does not include the provision of a drug as part of a clinical trial. (Gov. Code, Sec. 531.351.)

Source Law

Sec. 531.351. DEFINITION. In this subchapter, "patient assistance program" means a program offered by a pharmaceutical company under which the company provides a drug to persons in need of assistance at no charge or at a substantially reduced cost. The term does not include the provision of a drug as part of a clinical trial.

Revised Law

Sec. 549.0402. PROVISION OF PROGRAM INFORMATION BY PHARMACEUTICAL COMPANY. Each pharmaceutical company that does business in this state and that offers a patient assistance program shall inform the commission of:

(1) the existence of the program;

(2) the eligibility requirements for the program;

(3) the drugs covered by the program; and

(4) information used for applying for the program,

such as a telephone number. (Gov. Code, Sec. 531.352.)

Source Law

Sec. 531.352. PROVIDING INFORMATION TO COMMISSION. Each pharmaceutical company that does business in this state and that offers a patient assistance program shall inform the commission of the existence of the program, the eligibility requirements for the program, the drugs covered by the program, and information such as a telephone number used for applying for the program.

Revised Law

Sec. 549.0403. PUBLIC ACCESS TO PROGRAM INFORMATION. (a) The commission shall establish a system under which members of the public can call a toll-free telephone number to obtain information about available patient assistance programs. The commission shall ensure that the system is staffed at least during normal business hours with individuals who can:

(1) determine whether a patient assistance program is offered for a particular drug;

(2) determine whether an individual may be eligible to participate in a program; and

(3) assist an individual who wishes to apply for a program.

(b) The commission shall publicize the telephone number to pharmacies and drug prescribers. (Gov. Code, Sec. 531.353.)

Source Law

Sec. 531.353. TOLL-FREE TELEPHONE NUMBER. (a) The commission shall establish a system under which members of the public can call a toll-free telephone number to obtain information about available patient assistance programs. The commission shall ensure that the system is staffed at least during normal business hours with persons who can:

(1) determine whether a patient assistance program is offered for a particular drug;

(2) determine whether a person may be eligible to participate in a program; and

(3) assist persons who wish to apply for a program.

(b) The commission shall publicize the telephone number to pharmacies and prescribers of drugs.

SUBCHAPTER J. STATE PRESCRIPTION DRUG PROGRAM

Revised Law

Sec. 549.0451. DEVELOPMENT AND IMPLEMENTATION OF STATE

PRESCRIPTION DRUG PROGRAM. The commission shall develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to Medicaid recipients. (Gov. Code, Sec. 531.301(a).)

Source Law

> Sec. 531.301. DEVELOPMENT AND IMPLEMENTATION OF STATE PROGRAM; FUNDING. (a) The commission shall develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to Medicaid recipients.

Revised Law

Sec. 549.0452. PROGRAM ELIGIBILITY. An individual is eligible for prescription drug benefits under the state prescription drug program if the individual is:

(1) a qualified Medicare beneficiary, as defined by 42 U.S.C. Section 1396d(p)(1);

(2) a specified low-income Medicare beneficiary who is eligible for assistance under Medicaid for Medicare cost-sharing payments under 42 U.S.C. Section 1396a(a)(10)(E)(iii);

(3) a qualified disabled and working individual, as defined by 42 U.S.C. Section 1396d(s); or

(4) a qualifying individual who is eligible for assistance under Medicaid under 42 U.S.C. Section 1396a(a)(10)(E)(iv). (Gov. Code, Sec. 531.301(b).)

Source Law

> (b) A person is eligible for prescription drug benefits under the state program if the person is:
>
> (1) a qualified Medicare beneficiary, as defined by 42 U.S.C. Section 1396d(p)(1), as amended;
>
> (2) a specified low-income Medicare beneficiary who is eligible for assistance under Medicaid for Medicare cost-sharing payments under 42 U.S.C. Section 1396a(a)(10)(E)(iii), as amended;
>
> (3) a qualified disabled and working individual, as defined by 42 U.S.C. Section 1396d(s), as amended; or
>
> (4) a qualifying individual who is eligible for that assistance under 42 U.S.C. Section 1396a(a)(10)(E)(iv).

Revisor's Note

Sections 531.301(b)(1), (2), and (3), Government

Code, refer to 42 U.S.C. Section 1396d(p)(1), 42 U.S.C. Section 1396a(a)(10)(E)(iii), and 42 U.S.C. Section 1396d(s), respectively, "as amended." The revised law omits "as amended" for the reason stated in Revisor's Note (2) to Section 549.0101 of this chapter.

Revised Law

Sec. 549.0453. RULES. (a) The executive commissioner shall adopt rules necessary for implementing the state prescription drug program.

(b) In adopting rules for the state prescription drug program, the executive commissioner:

(1) shall consult with an advisory panel composed of an equal number of physicians, pharmacists, and pharmacologists the executive commissioner appoints; and

(2) may:

(A) require an individual who is eligible for prescription drug benefits to pay a cost-sharing payment;

(B) authorize the use of a prescription drug formulary to specify which prescription drugs the state prescription drug program will cover;

(C) to the extent possible, require clinically appropriate prior authorization for prescription drug benefits in the same manner as prior authorization is required under the vendor drug program; and

(D) establish a drug utilization review program to ensure the appropriate use of prescription drugs under the state prescription drug program. (Gov. Code, Sec. 531.302.)

Source Law

Sec. 531.302. RULES. (a) The executive commissioner shall adopt all rules necessary for implementation of the state prescription drug program.

(b) In adopting rules for the state prescription drug program, the executive commissioner may:

(1) require a person who is eligible for prescription drug benefits to pay a cost-sharing payment;

(2) authorize the use of a prescription drug formulary to specify which prescription drugs the state program will cover;

(3) to the extent possible, require clinically appropriate prior authorization for prescription drug benefits in the same manner as prior authorization is required under the vendor drug program; and

(4) establish a drug utilization review program to ensure the appropriate use of prescription drugs under the state program.

(c) In adopting rules for the state prescription drug program, the executive commissioner shall consult with an advisory panel composed of an equal number of physicians, pharmacists, and pharmacologists appointed by the executive commissioner.

Revised Law

Sec. 549.0454. GENERIC EQUIVALENT AUTHORIZED. In rules adopted for the state prescription drug program, the executive commissioner may require that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, a pharmacist may select a generic equivalent of the prescribed drug. (Gov. Code, Sec. 531.303.)

Source Law

Sec. 531.303. GENERIC EQUIVALENT AUTHORIZED. In adopting rules under the state program, the executive commissioner may require that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, the pharmacist may select a generic equivalent of the prescribed drug.

Revised Law

Sec. 549.0455. PROGRAM FUNDING AND FUNDING PRIORITIES. (a) Prescription drugs under the state prescription drug program may be funded only with state money unless funds are available under federal law to fund all or part of the program.

(b) If money available for the state prescription drug program is insufficient to provide prescription drug benefits to all individuals who are eligible under Section 549.0452, the commission shall:

(1) limit the number of enrollees based on available funding; and

(2) provide the prescription drug benefits to eligible individuals in the following order of priority:

(A) individuals eligible under Section 549.0452(1);

(B) individuals eligible under Section 549.0452(2); and

(C) individuals eligible under Sections 549.0452(3) and (4). (Gov. Code, Secs. 531.301(c), 531.304.)

Source Law

[Sec. 531.301]

(c) Prescription drugs under the state program may be funded only with state money, unless funds are available under federal law to fund all or part of the program.

Sec. 531.304. PROGRAM FUNDING PRIORITIES. If money available for the state prescription drug program is insufficient to provide prescription drug benefits to all persons who are eligible under Section 531.301(b), the commission shall limit the number of enrollees based on available funding and shall provide the prescription drug benefits to eligible persons in the following order of priority:

(1) persons eligible under Section 531.301(b)(1);

(2) persons eligible under Section 531.301(b)(2); and

(3) persons eligible under Sections 531.301(b)(3) and (4).

CHAPTER 550. HUMAN SERVICES AND OTHER SOCIAL SERVICES PROVIDED THROUGH FAITH- AND COMMUNITY-BASED ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 550.0001. DEFINITIONS . . . . . 1094
Sec. 550.0002. PURPOSE OF CHAPTER . . . . . 1095
Sec. 550.0003. CONSTRUCTION OF CHAPTER . . . . . 1096
Sec. 550.0004. CONSISTENT APPLICATION WITH FEDERAL LAW . . . 1096

SUBCHAPTER B. GOVERNMENTAL LIAISONS FOR FAITH- AND COMMUNITY-BASED ORGANIZATIONS

Sec. 550.0051. DEFINITION . . . . . 1096
Sec. 550.0052. DESIGNATION OF FAITH- AND COMMUNITY-BASED LIAISONS . . . . . 1097
Sec. 550.0053. GENERAL POWERS AND DUTIES OF LIAISONS . . . . 1098
Sec. 550.0054. INTERAGENCY COORDINATING GROUP . . . . . 1100
Sec. 550.0055. DUTIES OF INTERAGENCY COORDINATING GROUP . . . . . 1101
Sec. 550.0056. INTERAGENCY COORDINATING GROUP ANNUAL REPORT . . . . . 1102

Sec. 550.0057. TEXAS NONPROFIT COUNCIL . . . . . 1102
Sec. 550.0058. DUTIES OF TEXAS NONPROFIT COUNCIL . . . . . 1104
Sec. 550.0059. TEXAS NONPROFIT COUNCIL BIENNIAL REPORT . . . 1105
SUBCHAPTER C. RENEWING OUR COMMUNITIES ACCOUNT
Sec. 550.0101. DEFINITION . . . . . 1105
Sec. 550.0102. PURPOSES OF SUBCHAPTER . . . . . 1106
Sec. 550.0103. RENEWING OUR COMMUNITIES ACCOUNT . . . . . 1107
Sec. 550.0104. COMMISSION POWERS AND DUTIES REGARDING ACCOUNT . . . . . 1108
Sec. 550.0105. ACCEPTABLE USES OF ACCOUNT FUNDS . . . . . 1109
Sec. 550.0106. ADMINISTRATION OF ACCOUNT FUNDS . . . . . 1112
Sec. 550.0107. ACCOUNT MONITORING . . . . . 1113
Sec. 550.0108. PUBLIC INFORMATION; INTERNET POSTING REQUIREMENT . . . . . 1113
Sec. 550.0109. REPORTS . . . . . 1114
Sec. 550.0110. CONSTRUCTION OF SUBCHAPTER . . . . . 1115
SUBCHAPTER D. FAITH- AND COMMUNITY-BASED ORGANIZATION SUPPLEMENTAL ASSISTANCE PROGRAM FOR CERTAIN INDIVIDUALS RECEIVING PUBLIC ASSISTANCE
Sec. 550.0151. PROGRAM ESTABLISHMENT . . . . . 1116
Sec. 550.0152. RULES . . . . . 1117
SUBCHAPTER D-1. PILOT PROGRAM FOR SELF-SUFFICIENCY OF CERTAIN INDIVIDUALS RECEIVING FINANCIAL ASSISTANCE OR SUPPLEMENTAL NUTRITION ASSISTANCE BENEFITS
Sec. 550.0201. DEFINITIONS . . . . . 1119
Sec. 550.0202. PILOT PROGRAM DEVELOPMENT AND IMPLEMENTATION . . . . . 1120
Sec. 550.0203. PILOT PROGRAM DESIGN . . . . . 1124
Sec. 550.0204. BENEFIT ELIGIBILITY FOR PILOT PROGRAM PARTICIPANTS . . . . . 1126
Sec. 550.0205. FAMILY ELIGIBILITY REQUIREMENTS . . . . . 1127
Sec. 550.0206. CASE MANAGEMENT REQUIREMENTS . . . . . 1128
Sec. 550.0207. PILOT PROGRAM MONITORING AND EVALUATION . . . 1130
Sec. 550.0208. REPORTS . . . . . 1130

Sec. 550.0209. RULES . . . . . 1131
Sec. 550.0210. SUBCHAPTER EXPIRATION . . . . . 1132
SUBCHAPTER E. COMMUNITY-BASED NAVIGATOR PROGRAM
Sec. 550.0251. DEFINITION . . . . . 1132
Sec. 550.0252. ESTABLISHMENT OF COMMUNITY-BASED NAVIGATOR PROGRAM . . . . . 1133
Sec. 550.0253. PROGRAM STANDARDS . . . . . 1134
Sec. 550.0254. NAVIGATOR TRAINING PROGRAM . . . . . 1135
Sec. 550.0255. CERTIFIED NAVIGATOR LIST . . . . . 1136

## CHAPTER 550. HUMAN SERVICES AND OTHER SOCIAL SERVICES PROVIDED THROUGH FAITH- AND COMMUNITY-BASED ORGANIZATIONS

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 550.0001. DEFINITIONS. In this chapter:

(1) "Community-based initiative" includes a social, health, human services, or volunteer income tax assistance initiative a community-based organization operates.

(2) "Community-based organization" means a nonprofit corporation or association that is located in close proximity to the population the organization serves.

(3) "Faith-based initiative" means a social, health, or human services initiative a faith-based organization operates.

(4) "Faith-based organization" means a nonprofit corporation or association that:

(A) operates through a religious or denominational organization, including an organization that is:

(i) operated for a religious, educational, or charitable purpose; and

(ii) operated, supervised, or controlled, wholly or partly, by or in connection with a religious organization; or

(B) clearly demonstrates through the organization's mission statement, policies, or practices that the organization is guided or motivated by religion.

(5) "Interagency coordinating group" means the interagency coordinating group for faith- and community-based initiatives established under Section 550.0054.

(6) "State Commission on National and Community Service" means the entity used as authorized by 42 U.S.C. Section 12638(a) to carry out a state commission's duties under the National and Community Service Act of 1990 (42 U.S.C. Section 12501 et seq.). (Gov. Code, Sec. 535.001; New.)

Source Law

Sec. 535.001. DEFINITIONS. In this chapter:

(1) "Community-based initiative" includes a social, health, human services, or volunteer income tax assistance initiative operated by a community-based organization.

(2) "Community-based organization" means a nonprofit corporation or association that is located in close proximity to the population the organization serves.

(3) "Faith-based initiative" means a social, health, or human services initiative operated by a faith-based organization.

(4) "Faith-based organization" means a nonprofit corporation or association that:

(A) is operated through a religious or denominational organization, including an organization that is operated for religious, educational, or charitable purposes and that is operated, supervised, or controlled, wholly or partly, by or in connection with a religious organization; or

(B) clearly demonstrates through the organization's mission statement, policies, or practices that the organization is guided or motivated by religion.

(5) "State Commission on National and Community Service" means the entity used as authorized by 42 U.S.C. Section 12638(a) to carry out the duties of a state commission under the National and Community Service Act of 1990 (42 U.S.C. Section 12501 et seq.).

Revisor's Note

The definition of "interagency coordinating group" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 550.0002. PURPOSE OF CHAPTER. The purpose of this chapter is to strengthen the capacity of faith- and community-based organizations and forge stronger partnerships between those organizations and state government for the legitimate public

purpose of providing charitable and social services to persons in this state. (Gov. Code, Sec. 535.002.)

Source Law

> Sec. 535.002. PURPOSE. The purpose of this chapter is to strengthen the capacity of faith- and community-based organizations and to forge stronger partnerships between those organizations and state government for the legitimate public purpose of providing charitable and social services to persons in this state.

Revised Law

Sec. 550.0003. CONSTRUCTION OF CHAPTER. This chapter may not be construed to:

(1) exempt a faith- or community-based organization from any applicable state or federal law; or

(2) be an endorsement or sponsorship by this state of a faith-based organization's religious character, expression, beliefs, doctrines, or practices. (Gov. Code, Sec. 535.003.)

Source Law

> Sec. 535.003. CONSTRUCTION. This chapter may not be construed to:
>
> (1) exempt a faith- or community-based organization from any applicable state or federal law; or
>
> (2) be an endorsement or sponsorship by this state of the religious character, expression, beliefs, doctrines, or practices of a faith-based organization.

Revised Law

Sec. 550.0004. CONSISTENT APPLICATION WITH FEDERAL LAW. A power authorized or duty imposed under this chapter must be performed in a manner consistent with 42 U.S.C. Section 604a. (Gov. Code, Sec. 535.004.)

Source Law

> Sec. 535.004. APPLICABILITY OF CERTAIN FEDERAL LAW. A power authorized or duty imposed under this chapter must be performed in a manner that is consistent with 42 U.S.C. Section 604a.

SUBCHAPTER B. GOVERNMENTAL LIAISONS FOR FAITH- AND COMMUNITY-BASED ORGANIZATIONS

Revised Law

Sec. 550.0051. DEFINITION. In this subchapter, "council"

means the Texas Nonprofit Council. (New.)

Revisor's Note

The definition of "council" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 550.0052. DESIGNATION OF FAITH- AND COMMUNITY-BASED LIAISONS. (a) The executive commissioner, in consultation with the governor, shall designate one employee from the commission and from each health and human services agency to serve as a liaison for faith- and community-based organizations.

(b) The chief administrative officer of each of the following state agencies, in consultation with the governor, shall designate one employee from the agency to serve as a liaison for faith- and community-based organizations:

(1) the Department of Agriculture;

(2) the Department of Information Resources;

(3) the Department of Public Safety;

(4) the office of the attorney general;

(5) the office of the comptroller;

(6) the office of the governor;

(7) the office of the secretary of state;

(8) the Office of State-Federal Relations;

(9) the Public Utility Commission of Texas;

(10) the Texas Commission on Environmental Quality;

(11) the Texas Department of Criminal Justice;

(12) the Texas Department of Housing and Community Affairs;

(13) the Texas Department of Insurance;

(14) the Texas Juvenile Justice Department;

(15) the Texas Veterans Commission;

(16) the Texas Workforce Commission; and

(17) other state agencies as the governor determines.

(c) The commissioner of higher education, in consultation with the presiding officer of the interagency coordinating group, shall designate one employee from an institution of higher education, as defined by Section 61.003, Education Code, to serve as a liaison for faith- and community-based organizations. (Gov. Code, Sec. 535.051.)

Source Law

> Sec. 535.051. DESIGNATION OF FAITH- AND COMMUNITY-BASED LIAISONS. (a) The executive commissioner, in consultation with the governor, shall designate one employee from the commission and from each health and human services agency to serve as a liaison for faith- and community-based organizations.
>
> (b) The chief administrative officer of each of the following state agencies, in consultation with the governor, shall designate one employee from the agency to serve as a liaison for faith- and community-based organizations:
>
> (1) the Texas Commission on Environmental Quality;
>
> (2) the Texas Department of Criminal Justice;
>
> (3) the Texas Department of Housing and Community Affairs;
>
> (4) the Texas Juvenile Justice Department;
>
> (5) the Texas Veterans Commission;
>
> (6) the Texas Workforce Commission;
>
> (7) the office of the governor;
>
> (8) the Department of Public Safety;
>
> (9) the Texas Department of Insurance;
>
> (10) the Public Utility Commission of Texas;
>
> (11) the office of the attorney general;
>
> (12) the Department of Agriculture;
>
> (13) the office of the comptroller;
>
> (14) the Department of Information Resources;
>
> (15) the Office of State-Federal Relations;
>
> (16) the office of the secretary of state; and
>
> (17) other state agencies as determined by the governor.
>
> (c) The commissioner of higher education, in consultation with the presiding officer of the interagency coordinating group, shall designate one employee from an institution of higher education, as that term is defined under Section 61.003, Education Code, to serve as a liaison for faith- and community-based organizations.

Revised Law

Sec. 550.0053. GENERAL POWERS AND DUTIES OF LIAISONS. (a) A faith- and community-based liaison designated under Section 550.0052 shall:

(1) identify and remove unnecessary barriers to

partnerships between the state agency the liaison represents and faith- and community-based organizations;

(2) provide any necessary information and training for employees of the represented state agency regarding equal opportunity standards for faith- and community-based organizations seeking to partner with state government;

(3) facilitate the identification of practices with demonstrated effectiveness for faith- and community-based organizations that partner with the represented state agency;

(4) work with the appropriate departments and programs of the represented state agency to conduct outreach efforts to inform and welcome faith- and community-based organizations that have not traditionally formed partnerships with the agency;

(5) coordinate all efforts with the governor's office of faith- and community-based initiatives and provide any requested information, support, and assistance to that office to the extent permitted by law and as feasible; and

(6) attend conferences sponsored by federal agencies and offices and other relevant entities to become and remain informed of issues and developments regarding faith- and community-based initiatives.

(b) A designated faith- and community-based liaison may coordinate and interact with statewide organizations that represent faith- or community-based organizations as necessary to accomplish the purposes of this subchapter and Subchapters A and C. (Gov. Code, Sec. 535.052.)

Source Law

Sec. 535.052. GENERAL DUTIES OF LIAISONS. (a) A faith- and community-based liaison designated under Section 535.051 shall:

(1) identify and remove unnecessary barriers to partnerships between the state agency the liaison represents and faith- and community-based organizations;

(2) provide information and training, if necessary, for employees of the state agency the liaison represents regarding equal opportunity standards for faith- and community-based organizations seeking to partner with state government;

(3) facilitate the identification of practices with demonstrated effectiveness for faith- and community-based organizations that partner with the state agency the liaison represents;

(4) work with the appropriate departments and programs of the state agency the liaison represents to conduct outreach efforts to inform and welcome faith- and community-based organizations that have not traditionally formed partnerships with the agency;

(5) coordinate all efforts with the governor's office of faith-based and community initiatives and provide information, support, and assistance to that office as requested to the extent permitted by law and as feasible; and

(6) attend conferences sponsored by federal agencies and offices and other relevant entities to become and remain informed of issues and developments regarding faith- and community-based initiatives.

(b) A faith- and community-based liaison designated under Section 535.051 may coordinate and interact with statewide organizations that represent faith- or community-based organizations as necessary to accomplish the purposes of this chapter.

Revisor's Note

Section 535.052(b), Government Code, refers to a faith- and community-based liaison coordinating and interacting as necessary to accomplish the purposes of "this chapter," meaning Chapter 535, Government Code. The provisions of Chapter 535 are revised as Subchapters A, B, and C of this chapter, and the revised law is drafted accordingly.

Revised Law

Sec. 550.0054. INTERAGENCY COORDINATING GROUP. (a) The interagency coordinating group for faith- and community-based initiatives is composed of:

(1) each faith- and community-based liaison designated under Section 550.0052; and

(2) a liaison from the State Commission on National and Community Service.

(b) Service on the interagency coordinating group is an additional duty of the office or position held by each liaison designated under Section 550.0052(b).

(c) The liaison from the State Commission on National and Community Service is the presiding officer of the interagency

coordinating group. If the State Commission on National and Community Service is abolished, the liaison from the office of the governor is the presiding officer of the group.

(d) The state agencies described by Section 550.0052(b) shall provide administrative support for the interagency coordinating group as coordinated by the presiding officer. (Gov. Code, Secs. 535.053(a), (a-1), (b).)

Source Law

> Sec. 535.053. INTERAGENCY COORDINATING GROUP. (a) The interagency coordinating group for faith- and community-based initiatives is composed of each faith- and community-based liaison designated under Section 535.051 and a liaison from the State Commission on National and Community Service.
>
> (a-1) Service on the interagency coordinating group is an additional duty of the office or position held by each person designated as a liaison under Section 535.051(b). The state agencies described by Section 535.051(b) shall provide administrative support for the interagency coordinating group as coordinated by the presiding officer.
>
> (b) The liaison from the State Commission on National and Community Service is the presiding officer of the interagency coordinating group. If the State Commission on National and Community Service is abolished, the liaison from the governor's office is the presiding officer of the interagency coordinating group.

Revised Law

Sec. 550.0055. DUTIES OF INTERAGENCY COORDINATING GROUP. The interagency coordinating group shall:

(1) meet periodically at the call of the presiding officer;

(2) work across state agencies and with the State Commission on National and Community Service to facilitate the removal of unnecessary interagency barriers to partnerships between state agencies and faith- and community-based organizations; and

(3) operate in a manner that promotes effective partnerships between those agencies and organizations to serve residents of this state who need assistance. (Gov. Code, Sec. 535.053(c).)

Source Law

(c) The interagency coordinating group shall:

(1) meet periodically at the call of the presiding officer;

(2) work across state agencies and with the State Commission on National and Community Service to facilitate the removal of unnecessary interagency barriers to partnerships between state agencies and faith- and community-based organizations; and

(3) operate in a manner that promotes effective partnerships between those agencies and organizations to serve residents of this state who need assistance.

Revised Law

Sec. 550.0056. INTERAGENCY COORDINATING GROUP ANNUAL REPORT. Not later than December 1 of each year, the interagency coordinating group shall submit to the legislature a report describing in detail the activities, goals, and progress of the group. The report must be made available to the public on the office of the governor's Internet website. (Gov. Code, Sec. 535.054.)

Source Law

Sec. 535.054. REPORT. (a) Not later than December 1 of each year, the interagency coordinating group shall submit a report to the legislature that describes in detail the activities, goals, and progress of the interagency coordinating group.

(b) The report made under Subsection (a) must be made available to the public through posting on the office of the governor's Internet website.

Revised Law

Sec. 550.0057. TEXAS NONPROFIT COUNCIL. (a) The Texas Nonprofit Council is established to help direct the interagency coordinating group in carrying out the group's duties under this subchapter.

(b) The governor, in consultation with the presiding officer of the interagency coordinating group, shall appoint as council members two representatives from each of the following groups and entities to represent each group's and entity's appropriate sector:

(1) community-based groups;

(2) consultants to nonprofit corporations;

(3) faith-based groups, at least one of which must be a

statewide interfaith group;

(4) local governments;

(5) statewide associations of nonprofit organizations; and

(6) statewide nonprofit organizations.

(c) A council member serves a three-year term expiring October 1. A council member may not serve more than two consecutive terms.

(d) The council shall:

(1) elect a presiding officer or presiding officers and a secretary from among the council members; and

(2) assist the executive commissioner in identifying an individual to fill a vacancy on the council.

(e) The state agencies described by Section 550.0052(b) shall provide administrative support to the council as coordinated by the presiding officer of the interagency coordinating group.

(f) Chapter 2110 does not apply to the council. (Gov. Code, Secs. 535.055(a), (b), (c-1), (c-2), (e).)

Source Law

Sec. 535.055. TEXAS NONPROFIT COUNCIL. (a) The Texas Nonprofit Council is established to help direct the interagency coordinating group in carrying out the group's duties under this section. The state agencies of the interagency coordinating group described by Section 535.051(b) shall provide administrative support to the council as coordinated by the presiding officer of the interagency coordinating group.

(b) The governor, in consultation with the presiding officer of the interagency coordinating group, shall appoint as members of the council two representatives from each of the following groups and entities to represent each group's and entity's appropriate sector:

(1) statewide nonprofit organizations;

(2) local governments;

(3) faith-based groups, at least one of which must be a statewide interfaith group;

(4) community-based groups;

(5) consultants to nonprofit corporations; and

(6) statewide associations of nonprofit organizations.

(c-1) The council shall elect a chair or chairs and secretary from among its members and shall assist the executive commissioner in identifying individuals to fill vacant council positions that arise.

(c-2) Council members serve three-year terms.

The terms expire on October 1 of every third year. A council member shall serve a maximum of two consecutive terms.

(e) Chapter 2110 does not apply to the Texas Nonprofit Council.

Revisor's Note

Section 535.055(a), Government Code, refers to the interagency coordinating group's duties under "this section," meaning Section 535.055. The provisions of Section 535.055 are revised in this subchapter, and the revised law is drafted accordingly.

Revised Law

Sec. 550.0058. DUTIES OF TEXAS NONPROFIT COUNCIL. The council, in coordination with the interagency coordinating group, shall:

(1) make recommendations for improving contracting relationships between state agencies and faith- and community-based organizations;

(2) develop best practices for cooperating and collaborating with faith- and community-based organizations; and

(3) identify and address:

(A) duplication of services provided by this state and faith- and community-based organizations; and

(B) gaps in state services that faith- and community-based organizations could fill. (Gov. Code, Sec. 535.055(c).)

Source Law

(c) The council, in coordination with the interagency coordinating group, shall:
(1) make recommendations for improving contracting relationships between state agencies and faith- and community-based organizations;
(2) develop best practices for cooperating and collaborating with faith- and community-based organizations;
(3) identify and address duplication of services provided by the state and faith- and community-based organizations; and
(4) identify and address gaps in state services that faith- and community-based organizations could fill.

Revised Law

Sec. 550.0059. TEXAS NONPROFIT COUNCIL BIENNIAL REPORT. (a) The council shall prepare a biennial report detailing the council's work. The report must include any recommendations relating to legislation necessary to address an issue identified under Section 550.0058.

(b) Not later than December 1 of each even-numbered year, the council shall present the report to:

(1) the House Committee on Human Services or its successor;

(2) the House Committee on Public Health or its successor; and

(3) the Senate Health and Human Services Committee or its successor. (Gov. Code, Sec. 535.055(d).)

Source Law

> (d) The council shall prepare a biennial report detailing the council's work, including in the report any recommendations relating to legislation necessary to address an issue identified under this section. The council shall present the report to the House Committee on Human Services or its successor, the House Committee on Public Health or its successor, and the Senate Health and Human Services Committee or its successor not later than December 1 of each even-numbered year.

Revisor's Note

> Section 535.055(d), Government Code, refers to issues identified under "this section," meaning Section 535.055. The relevant provisions of Section 535.055 are revised in this chapter as Section 550.0058, and the revised law is drafted accordingly.

SUBCHAPTER C. RENEWING OUR COMMUNITIES ACCOUNT

Revised Law

Sec. 550.0101. DEFINITION. In this subchapter, "account" means the renewing our communities account established under Section 550.0103. (Gov. Code, Sec. 535.101.)

Source Law

> Sec. 535.101. DEFINITION. In this subchapter, "account" means the renewing our communities account.

Revised Law

Sec. 550.0102. PURPOSES OF SUBCHAPTER. Recognizing that faith- and community-based organizations provide a range of vital charitable services to persons in this state, the purposes of this subchapter are to:

(1) increase the impact and effectiveness of those organizations;

(2) forge stronger partnerships between those organizations and state government so that:

(A) communities are empowered to serve individuals in need; and

(B) community capacity for providing services is strengthened; and

(3) create a funding mechanism that:

(A) builds on the established efforts of those organizations; and

(B) operates to create new partnerships in local communities for the benefit of this state. (Gov. Code, Sec. 535.102.)

Source Law

Sec. 535.102. PURPOSES OF SUBCHAPTER. Recognizing that faith- and community-based organizations provide a range of vital charitable services to persons in this state, the purposes of this subchapter are to:

(1) increase the impact and effectiveness of those organizations;

(2) forge stronger partnerships between those organizations and state government so that communities are empowered to serve persons in need and community capacity for providing services is strengthened; and

(3) create a funding mechanism that builds on the established efforts of those organizations and operates to create new partnerships in local communities for the benefit of this state.

Revisor's Note

Section 535.102(2), Government Code, refers to "persons" in need. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear

that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to this code.

Revised Law

Sec. 550.0103. RENEWING OUR COMMUNITIES ACCOUNT. (a) The renewing our communities account is an account in the general revenue fund that may be appropriated only to the commission for:

(1) the purposes and activities authorized by this subchapter; and

(2) reasonable administrative expenses under this subchapter.

(b) The purposes of the account are to:

(1) increase the capacity of faith- and community-based organizations to provide charitable services and to manage human resources and funds;

(2) assist local governmental entities in establishing local offices to promote faith- and community-based initiatives; and

(3) foster better partnerships between state government and faith- and community-based organizations.

(c) The account consists of:

(1) all money appropriated for the purposes of this subchapter; and

(2) any gifts, grants, or donations received for the purposes of this subchapter.

(d) The account is exempt from the application of Section 403.095. (Gov. Code, Sec. 535.103.)

Source Law

Sec. 535.103. RENEWING OUR COMMUNITIES ACCOUNT. (a) The renewing our communities account is an account in the general revenue fund that may be appropriated only to the commission for the purposes and activities authorized by this subchapter and for reasonable administrative expenses under this subchapter.

(b) The account consists of:

(1) all money appropriated for the purposes of this subchapter; and

(2) any gifts, grants, or donations received for the purposes of this subchapter.

(c) The account is exempt from the application of Section 403.095.

(d) The purposes of the account are to:

(1) increase the capacity of faith- and community-based organizations to provide charitable services and to manage human resources and funds;

(2) assist local governmental entities in establishing local offices to promote faith- and community-based initiatives; and

(3) foster better partnerships between state government and faith- and community-based organizations.

Revised Law

Sec. 550.0104. COMMISSION POWERS AND DUTIES REGARDING ACCOUNT. (a) The commission shall:

(1) contract with the State Commission on National and Community Service to administer funds appropriated from the account in a manner that:

(A) consolidates the capacity of and strengthens national service and community and faith- and community-based initiatives; and

(B) leverages public and private funds to benefit this state;

(2) develop a competitive process for awarding grants from funds in the account that is consistent with state law and includes objective selection criteria;

(3) oversee the delivery of training and other assistance activities under this subchapter;

(4) develop criteria limiting grant awards under Section 550.0106(a)(1)(A) to small and medium-sized faith- and community-based organizations that provide charitable services to persons in this state;

(5) establish general state priorities for the account;

(6) establish and monitor performance and outcome measures for persons who are awarded grants under this subchapter; and

(7) establish policies and procedures to ensure that any money appropriated from the account to the commission that is

allocated to build the capacity of a faith-based organization or for a faith-based initiative is not used to advance a sectarian purpose or to engage in any form of proselytization.

(b) The commission may award money in the account appropriated to the commission to the State Commission on National and Community Service in the form of a grant instead of contracting with that entity under Subsection (a)(1). (Gov. Code, Secs. 535.104(a), (b).)

Source Law

> Sec. 535.104. POWERS AND DUTIES REGARDING ACCOUNT. (a) The commission shall:
>
> (1) contract with the State Commission on National and Community Service to administer funds appropriated from the account in a manner that:
>
> (A) consolidates the capacity of and strengthens national service and community and faith- and community-based initiatives; and
>
> (B) leverages public and private funds to benefit this state;
>
> (2) develop a competitive process to be used in awarding grants from account funds that is consistent with state law and includes objective selection criteria;
>
> (3) oversee the delivery of training and other assistance activities under this subchapter;
>
> (4) develop criteria limiting awards of grants under Section 535.105(1)(A) to small and medium-sized faith- and community-based organizations that provide charitable services to persons in this state;
>
> (5) establish general state priorities for the account;
>
> (6) establish and monitor performance and outcome measures for persons to whom grants are awarded under this subchapter; and
>
> (7) establish policies and procedures to ensure that any money appropriated from the account to the commission that is allocated to build the capacity of a faith-based organization or for a faith-based initiative is not used to advance a sectarian purpose or to engage in any form of proselytization.
>
> (b) Instead of contracting with the State Commission on National and Community Service under Subsection (a)(1), the commission may award account funds appropriated to the commission to the State Commission on National and Community Service in the form of a grant.

Revised Law

Sec. 550.0105. ACCEPTABLE USES OF ACCOUNT FUNDS. The commission or the State Commission on National and Community Service, in accordance with the terms of a contract or grant, as applicable, may:

(1) directly, or through agreements with one or more entities serving faith- and community-based organizations that provide charitable services to persons in this state:

(A) assist the organizations with:

(i) writing or managing grants through workshops or other forms of guidance;

(ii) obtaining legal assistance related to forming a corporation or obtaining an exemption from taxation under the Internal Revenue Code; and

(iii) obtaining information about or referrals to entities that provide expertise in accounting, legal, or tax issues, program development matters, or other organizational topics;

(B) provide to the organizations information or assistance related to building the organizations' capacity for providing services;

(C) facilitate the formation of networks, the coordination of services, and the sharing of resources among the organizations;

(D) in cooperation with existing efforts, if possible, conduct needs assessments to identify gaps in services in a community that present a need for developing or expanding services;

(E) work with the organizations to identify the organizations' needs for improvements in their internal capacity for providing services;

(F) provide the organizations with information on and assistance in identifying or using practices with demonstrated effectiveness for delivering charitable services to persons, families, and communities and in replicating charitable services programs that have demonstrated effectiveness; and

(G) encourage research into the impact of organizational capacity on program delivery for the organizations;

(2) assist a local governmental entity in creating a

better partnership between government and faith- and community-based organizations to provide charitable services to persons in this state; and

(3) use funds appropriated from the account to provide matching money for federal or private grant programs that further the purposes of the account as described by Section 550.0103(b). (Gov. Code, Sec. 535.104(d).)

Source Law

(d) The commission or the State Commission on National and Community Service, in accordance with the terms of the contract or grant, as applicable, may:

(1) directly, or through agreements with one or more entities that serve faith- and community-based organizations that provide charitable services to persons in this state:

(A) assist faith- and community-based organizations with:

(i) writing or managing grants through workshops or other forms of guidance;

(ii) obtaining legal assistance related to forming a corporation or obtaining an exemption from taxation under the Internal Revenue Code; and

(iii) obtaining information about or referrals to entities that provide expertise in accounting, legal, or tax issues, program development matters, or other organizational topics;

(B) provide information or assistance to faith- and community-based organizations related to building the organizations' capacity for providing services;

(C) facilitate the formation of networks, the coordination of services, and the sharing of resources among faith- and community-based organizations;

(D) in cooperation with existing efforts, if possible, conduct needs assessments to identify gaps in services in a community that present a need for developing or expanding services;

(E) work with faith- and community-based organizations to identify the organizations' needs for improvements in their internal capacity for providing services;

(F) provide faith- and community-based organizations with information on and assistance in identifying or using practices with demonstrated effectiveness for delivering charitable services to persons, families, and communities and in replicating charitable services programs that have demonstrated effectiveness; and

(G) encourage research into the impact of organizational capacity on program delivery for faith- and community-based organizations;

(2) assist a local governmental entity in creating a better partnership between government and faith- and community-based organizations to provide charitable services to persons in this state; and

(3) use funds appropriated from the account to provide matching money for federal or

private grant programs that further the purposes of the account as described by Section 535.103(d).

Revised Law

Sec. 550.0106. ADMINISTRATION OF ACCOUNT FUNDS. (a) If under Section 550.0104 the commission contracts with or awards a grant to the State Commission on National and Community Service, that entity:

(1) may award grants from funds appropriated from the account to:

(A) faith- and community-based organizations that provide charitable services to persons in this state for capacity-building purposes; and

(B) local governmental entities to provide seed money for local offices for faith- and community-based initiatives; and

(2) shall monitor performance and outcome measures for persons to whom that entity awards grants using the measures the commission establishes under Section 550.0104(a)(6).

(b) Any funds awarded to the State Commission on National and Community Service under a contract or through a grant under Section 550.0104 must be administered in the manner required by this subchapter. (Gov. Code, Secs. 535.104(c), 535.105.)

Source Law

[Sec. 535.104]

(c) Any funds awarded to the State Commission on National and Community Service under a contract or through a grant under this section must be administered in the manner required by this subchapter, including Subsection (a)(1).

Sec. 535.105. ADMINISTRATION OF ACCOUNT FUNDS. If under Section 535.104 the commission contracts with or awards a grant to the State Commission on National and Community Service, that entity:

(1) may award grants from funds appropriated from the account to:

(A) faith- and community-based organizations that provide charitable services to persons in this state for capacity-building purposes; and

(B) local governmental entities to provide seed money for local offices for faith- and community-based initiatives; and

(2) shall monitor performance and outcome measures for persons to whom that entity awards grants using the measures established by the commission under

Section 535.104(a)(6).

Revisor's Note

(1) Section 535.104(c), Government Code, refers to funds awarded "under this section," meaning Section 535.104. The relevant provisions of Section 535.104 are revised in this chapter as Section 550.0104, and the revised law is drafted accordingly.

(2) Section 535.104(c), Government Code, refers to grant administration in the manner required by "this subchapter, including Subsection (a)(1)." The revised law omits the reference to Subsection (a)(1) as redundant because that subsection applies by its own terms.

Revised Law

Sec. 550.0107. ACCOUNT MONITORING. The commission shall monitor the use of the funds administered by the State Commission on National and Community Service under a contract or through a grant under Section 550.0104 to ensure that the funds are used in a manner consistent with the requirements of this subchapter. (Gov. Code, Sec. 535.104(e) (part).)

Source Law

(e) The commission shall monitor the use of the funds administered by the State Commission on National and Community Service under a contract or through a grant under this section to ensure that the funds are used in a manner consistent with the requirements of this subchapter. . . .

Revisor's Note

Section 535.104(e), Government Code, refers to "this section," meaning Section 535.104, Government Code. The relevant provisions of Section 535.104 are revised in this chapter as Section 550.0104, and the revised law is drafted accordingly.

Revised Law

Sec. 550.0108. PUBLIC INFORMATION; INTERNET POSTING REQUIREMENT. (a) Records relating to the award of a contract or grant to the State Commission on National and Community Service, or

to grants that entity awards, and records relating to other uses of the awarded funds are public information subject to Chapter 552.

(b) If the commission contracts with or awards a grant to the State Commission on National and Community Service under Section 550.0104, the commission shall provide a link on the commission's Internet website to that entity's Internet website. The entity's Internet website must provide:

(1) a list of the names of each person to whom the entity awards a grant from money appropriated from the account and the amount and purpose of the grant; and

(2) information regarding the methods by which the public may request information about those grants. (Gov. Code, Secs. 535.104(e) (part), 535.106(a).)

Source Law

> [Sec. 535.104]
> (e) . . . Records relating to the award of a contract or grant to the State Commission on National and Community Service, or to grants awarded by that entity, and records relating to other uses of the funds are public information subject to Chapter 552.
>
> Sec. 535.106. REPORTS AND PUBLIC INFORMATION. (a) The commission shall provide a link on the commission's Internet website to the Internet website of the State Commission on National and Community Service if the commission contracts with or awards a grant to that entity under Section 535.104. The entity's Internet website must provide:
> (1) a list of the names of each person to whom the entity awarded a grant from money appropriated from the account and the amount and purpose of the grant; and
> (2) information regarding the methods by which the public may request information about those grants.

Revised Law

Sec. 550.0109. REPORTS. (a) If the State Commission on National and Community Service is awarded a contract or grant under Section 550.0104, that entity must provide to the commission periodic reports on a schedule the executive commissioner determines. The schedule of periodic reports must include an annual report that provides:

(1) a specific accounting of that entity's use of money appropriated from the account, including the names of persons to

whom grants have been awarded and the purposes of those grants; and

(2) a summary of the efforts of the faith- and community-based liaisons designated under Section 550.0052 to comply with the duties imposed by and the purposes of Sections 550.0053 and 550.0055.

(b) The commission shall:

(1) post the annual report submitted under this section on the commission's Internet website; and

(2) provide copies of the report to the governor, the lieutenant governor, and the members of the legislature. (Gov. Code, Secs. 535.106(b), (c).)

Source Law

(b) If awarded a contract or grant under Section 535.104, the State Commission on National and Community Service must provide to the commission periodic reports on a schedule determined by the executive commissioner. The schedule of periodic reports must include an annual report that includes:

(1) a specific accounting with respect to the use by that entity of money appropriated from the account, including the names of persons to whom grants have been awarded and the purposes of those grants; and

(2) a summary of the efforts of the faith- and community-based liaisons designated under Section 535.051 to comply with the duties imposed by and the purposes of Sections 535.052 and 535.053.

(c) The commission shall post the annual report made under Subsection (b) on the commission's Internet website and shall provide copies of the report to the governor, the lieutenant governor, and the members of the legislature.

Revisor's Note

Section 535.106(b), Government Code, refers to duties imposed by and the purposes of "Sections 535.052 and 535.053." The relevant provisions of Sections 535.052 and 535.053, Government Code, are revised in this chapter as Sections 550.0053 and 550.0055, and the revised law is drafted accordingly.

Revised Law

Sec. 550.0110. CONSTRUCTION OF SUBCHAPTER. If the commission contracts with or awards a grant to the State Commission on National and Community Service under Section 550.0104, this subchapter may not be construed to:

(1) release that entity from any regulations or reporting or other requirements applicable to a commission contractor or grantee;

(2) impose regulations or reporting or other requirements on that entity that do not apply to other commission contractors or grantees solely because of the entity's status;

(3) alter the nonprofit status of that entity or the requirements for maintaining that status; or

(4) convert that entity into a governmental entity because of the receipt of account funds through the contract or grant. (Gov. Code, Sec. 535.104(f).)

Source Law

(f) If the commission contracts with or awards a grant to the State Commission on National and Community Service under this section, this subchapter may not be construed to:

(1) release that entity from any regulations or reporting or other requirements applicable to a contractor or grantee of the commission;

(2) impose regulations or reporting or other requirements on that entity that do not apply to other contractors or grantees of the commission solely because of the entity's status;

(3) alter the nonprofit status of that entity or the requirements for maintaining that status; or

(4) convert that entity into a governmental entity because of the receipt of account funds through the contract or grant.

SUBCHAPTER D. FAITH- AND COMMUNITY-BASED ORGANIZATION SUPPLEMENTAL ASSISTANCE PROGRAM FOR CERTAIN INDIVIDUALS RECEIVING PUBLIC ASSISTANCE

Revised Law

Sec. 550.0151. PROGRAM ESTABLISHMENT. (a) The commission shall:

(1) establish a program under which faith- and community-based organizations may, on an applicant's request, contact and offer supplemental assistance to the applicant for benefits under:

(A) the financial assistance program under Chapter 31, Human Resources Code;

(B) the medical assistance program under Chapter 32, Human Resources Code;

(C) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; or

(D) the child health plan program under Chapter 62, Health and Safety Code; and

(2) develop a procedure under which faith- and community-based organizations may apply to participate in the program.

(b) At the time an individual applies for benefits described by Subsection (a), the individual must be:

(1) informed about and given the opportunity to enroll in the program; and

(2) informed that enrolling in the program will not affect the individual's eligibility for benefits. (Gov. Code, Secs. 531.02482(b), (c), (d).)

Source Law

(b) The commission shall establish a program under which faith- and community-based organizations may, on the request of the applicant, contact and offer supplemental assistance to an applicant for benefits under:

(1) the financial assistance program under Chapter 31, Human Resources Code;

(2) the medical assistance program under Chapter 32, Human Resources Code;

(3) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; or

(4) the child health plan program under Chapter 62, Health and Safety Code.

(c) At the time of application for benefits described by Subsection (b), an applicant must:

(1) be informed about and given the opportunity to enroll in the program; and

(2) be informed that enrolling in the program will not affect the person's eligibility for benefits.

(d) The commission shall develop a procedure under which faith- and community-based organizations may apply to participate in the program.

Revised Law

Sec. 550.0152. RULES. The executive commissioner shall adopt rules to implement the program, including rules that:

(1) describe:

(A) the types of faith- and community-based

organizations that may apply to participate in the program; and

(B) the qualifications and standards of service required of a participating organization;

(2) facilitate contact between an individual who enrolls in the program and a participating organization that provides supplemental services that may assist the individual;

(3) establish:

(A) processes for suspending, revoking, and periodically renewing an organization's participation in the program, as appropriate; and

(B) methods to ensure the confidentiality and appropriate use of applicant information shared with a participating organization; and

(4) permit an individual to terminate the individual's enrollment in the program. (Gov. Code, Sec. 531.02482(e).)

Source Law

(e) The executive commissioner shall adopt rules to implement the program established under this section, including rules that:

(1) describe the types of faith- and community-based organizations that may apply to participate in the program and the qualifications and standards of service required of a participating organization;

(2) facilitate contact between a person who enrolls in the program and a faith- and community-based organization participating in the program that provides supplemental services that may be of assistance to the person;

(3) establish processes for the suspension, revocation, and periodic renewal of an organization's participation in the program, as appropriate;

(4) establish methods to ensure the confidentiality and appropriate use of applicant information shared with a participating organization; and

(5) permit a person enrolled in the program to terminate the person's enrollment in the program.

Revisor's Note
(End of Subchapter)

Section 531.02482(a), Government Code, defines "community-based organization" and "faith-based organization." The revised law omits the definitions because they duplicate the chapter-wide definitions

for those terms in Sections 535.001(2) and (4), Government Code, revised in this chapter as Sections 550.0001(2) and (4), which are applicable to the revised law. The omitted law reads:

> Sec. 531.02482. FAITH- AND COMMUNITY-BASED ORGANIZATION SUPPORT FOR CERTAIN PERSONS RECEIVING PUBLIC ASSISTANCE. (a) In this section, "community-based organization" and "faith-based organization" have the meanings assigned by Section 535.001.

SUBCHAPTER D-1. PILOT PROGRAM FOR SELF-SUFFICIENCY OF CERTAIN INDIVIDUALS RECEIVING FINANCIAL ASSISTANCE OR SUPPLEMENTAL NUTRITION ASSISTANCE BENEFITS

Revised Law

Sec. 550.0201. DEFINITIONS. In this subchapter:

(1) "Financial assistance benefits" means money payments under:

(A) the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code; or

(B) the state temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Pilot program" means the pilot program for self-sufficiency of certain individuals receiving financial assistance or supplemental nutrition assistance benefits developed and implemented under this subchapter.

(3) "Self-sufficiency" means:

(A) being employed in a position that pays a sufficient wage;

(B) having financial savings in an amount equal to at least $1,000 per member of a family's household; and

(C) maintaining a debt-to-income ratio that does not exceed 43 percent.

(4) "Slow reduction scale" means a graduated plan for reducing financial assistance or supplemental nutrition assistance benefits that correlates with a phase of the pilot program's

progressive stages toward self-sufficiency.

(5) "Sufficient wage" means an amount of money sufficient to meet a family's minimum necessary spending on basic needs, including food, child care, health insurance, housing, and transportation, as determined by a market-based calculation that uses geographically specific expenditure data.

(6) "Supplemental nutrition assistance benefits" means money payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code. (Gov. Code, Sec. 531.02241(a); New.)

Source Law

Sec. 531.02241. PILOT PROGRAM FOR SELF-SUFFICIENCY OF CERTAIN PERSONS RECEIVING FINANCIAL ASSISTANCE OR SUPPLEMENTAL NUTRITION ASSISTANCE BENEFITS. (a) In this section:

(1) "Financial assistance benefits" means money payments under the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code, or under the state temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Self-sufficiency" means being employed in a position that pays a sufficient wage, having financial savings in an amount that is equal to at least $1,000 per member of a family's household, and maintaining a debt-to-income ratio that does not exceed 43 percent.

(3) "Slow reduction scale" means a graduated plan for reducing financial assistance or supplemental nutrition assistance benefits that correlates with a phase of the pilot program's progressive stages toward self-sufficiency.

(4) "Sufficient wage" means an amount of money, determined by a market-based calculation that uses geographically specific expenditure data, that is sufficient to meet a family's minimum necessary spending on basic needs, including food, child care, health insurance, housing, and transportation.

(5) "Supplemental nutrition assistance benefits" means money payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code.

Revisor's Note

The definition of "pilot program" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 550.0202. PILOT PROGRAM DEVELOPMENT AND

IMPLEMENTATION. (a) The commission shall develop and implement a pilot program to assist not more than 500 eligible families in gaining permanent self-sufficiency and by eliminating the need for financial assistance, supplemental nutrition assistance, or other means-tested public benefits, notwithstanding the limitations and requirements of Section 31.043, Human Resources Code.

(b) If the commission determines the number of families participating in the pilot program during a year reaches capacity for that year, the number of families that may be served under the program in the following year may be increased by 20 percent.

(c) The commission shall develop and implement the pilot program with the assistance of:

(1) faith-based and other relevant public or private organizations;

(2) local workforce development boards;

(3) the Texas Workforce Commission; and

(4) any other person the commission determines appropriate.

(d) The pilot program must operate for at least 24 months. The program must also include 16 additional months for:

(1) planning and designing the program before the program begins operation;

(2) recruiting eligible families to participate in the program;

(3) randomly placing each participating family in one of at least three research groups, including:

(A) a control group;

(B) a group consisting of families for whom the application of income, asset, and time limits described by Section 550.0204 is waived; and

(C) a group consisting of families for whom the application of income, asset, and time limits described by Section 550.0204 is waived and who receive wraparound case management services under the program; and

(4) after the program begins operation, collecting and sharing data that allows for:

(A) obtaining participating families' eligibility and identification data before a family is randomly placed in a research group under Subdivision (3);

(B) conducting surveys or interviews of participating families to obtain information that is not contained in records related to a family's eligibility for financial assistance, supplemental nutrition assistance, or other means-tested public benefits;

(C) providing quarterly reports for not more than 60 months after a participating family's enrollment in the program regarding the program's effect on the family's labor market participation, income, and need for means-tested public benefits;

(D) assessing the interaction of the program's components with the desired outcomes of the program using data collected during the program and data obtained from state agencies concerning means-tested public benefits; and

(E) enlisting a third party to conduct a rigorous experimental impact evaluation of the program.

(e) The pilot program must provide through a community-based provider to each participating family placed in the research group described by Subsection (d)(3)(C) holistic, wraparound case management services that meet all applicable program requirements under 7 C.F.R. Section 273.7(e) or 45 C.F.R. Section 261.10, as applicable. Case management services provided under this subsection must include the strategic use of financial assistance and supplemental nutrition assistance benefits to ensure that the goals included in the family's service plan are achieved. (Gov. Code, Secs. 531.02241(b), (i), (j), (k).)

Source Law

(b) The commission shall develop and implement a pilot program for assisting not more than 500 eligible families to gain permanent self-sufficiency and no longer require financial assistance, supplemental nutrition assistance, or other means-tested public

benefits, notwithstanding the limitations and requirements of Section 31.043, Human Resources Code. If the number of families participating in the program during a year reaches capacity for that year as determined by the commission, the number of families that may be served under the program in the following year may be increased by 20 percent.

(i) The pilot program must provide each participating family placed in the research group described by Subsection (j)(3)(C) with holistic, wraparound case management services that meet all applicable program requirements under 7 C.F.R. Section 273.7(e) or 45 C.F.R. Section 261.10, as applicable. Case management services provided under this subsection must include the strategic use of financial assistance and supplemental nutrition assistance benefits to ensure that the goals included in the family's service plan are achieved. The wraparound case management services must be provided through a community-based provider.

(j) The pilot program must operate for at least 24 months. The program shall also include 16 additional months for:

(1) planning and designing the program before the program begins operation;

(2) recruiting eligible families to participate in the program;

(3) randomly placing each participating family in one of at least three research groups, including:

(A) a control group;

(B) a group consisting of families for whom the application of income, asset, and time limits described by Subsection (c) is waived; and

(C) a group consisting of families for whom the application of income, asset, and time limits described by Subsection (c) is waived and who receive wraparound case management services under the program; and

(4) after the program begins operation, collecting and sharing data that allows for:

(A) obtaining participating families' eligibility and identification data before a family is randomly placed in a research group under Subdivision (3);

(B) conducting surveys or interviews of participating families to obtain information that is not contained in records related to a family's eligibility for financial assistance, supplemental nutrition assistance, or other means-tested public benefits;

(C) providing quarterly reports for not more than 60 months after a participating family is enrolled in the pilot program regarding the program's effect on the family's labor market participation and income and need for means-tested public benefits;

(D) assessing the interaction of the program's components with the desired outcomes of the program using data collected during the program and data obtained from state agencies concerning means-tested public benefits; and

(E) a third party to conduct a rigorous experimental impact evaluation of the pilot program.

(k) The commission shall develop and implement the pilot program with the assistance of the Texas Workforce Commission, local workforce development

boards, faith-based and other relevant public or private organizations, and any other entity or person the commission determines appropriate.

Revisor's Note

Section 531.02241(k), Government Code, refers to "any other entity or person." The revised law omits "entity" as redundant because Section 311.005(2), Government Code (Code Construction Act), which applies to this code, defines "person" to include any legal entity.

Revised Law

Sec. 550.0203. PILOT PROGRAM DESIGN. (a) The commission shall design the pilot program to allow social services providers, public benefit offices, and other community partners to refer potential participating families to the program.

(b) The commission shall design the pilot program to assist eligible participating families in attaining self-sufficiency by:

(1) identifying eligibility requirements for the continuation of financial assistance or supplemental nutrition assistance benefits and time limits for the benefits, the application of which may be waived for a limited period and that, if applied, would impede self-sufficiency;

(2) implementing strategies, including waiving the application of the eligibility requirements and time limits identified in Subdivision (1), to remove barriers to self-sufficiency; and

(3) moving eligible participating families toward self-sufficiency through progressive stages that include the following phases:

(A) an initial phase in which a family transitions out of an emergent crisis by securing housing, medical care, and financial assistance and supplemental nutrition assistance benefits, as necessary;

(B) a second phase in which:

(i) the family transitions toward stability

by securing employment and any necessary child care and by participating in services that build the financial management skills necessary to meet financial goals; and

(ii) the family's financial assistance and supplemental nutrition assistance benefits are reduced according to the following scale:

(a) on reaching 25 percent of the family's sufficient wage, the amount of benefits is reduced by 10 percent;

(b) on reaching 50 percent of the family's sufficient wage, the amount of benefits is reduced by 25 percent; and

(c) on reaching 75 percent of the family's sufficient wage, the amount of benefits is reduced by 50 percent;

(C) a third phase in which the family:

(i) transitions to self-sufficiency by securing employment that pays a sufficient wage, reducing debt, and building savings; and

(ii) becomes ineligible for financial assistance and supplemental nutrition assistance benefits on reaching 100 percent of the family's sufficient wage; and

(D) a final phase in which the family attains self-sufficiency by retaining employment that pays a sufficient wage, amassing at least $1,000 per member of the family's household, and having manageable debt so that the family will no longer be dependent on financial assistance, supplemental nutrition assistance, or other means-tested public benefits for at least six months following the date the family stops participating in the program. (Gov. Code, Secs. 531.02241(d), (f).)

Source Law

(d) The pilot program must be designed to allow social services providers, public benefit offices, and other community partners to refer potential participating families to the program.

(f) The pilot program must be designed to assist eligible participating families in attaining self-sufficiency by:

(1) identifying eligibility requirements for the continuation of financial assistance or supplemental nutrition assistance benefits and time limits for the benefits, the application of which may be waived for a limited period and that, if applied, would impede self-sufficiency;

(2) implementing strategies, including waiving the application of the eligibility requirements and time limits identified in Subdivision (1), to remove barriers to self-sufficiency; and

(3) moving eligible participating families through progressive stages toward self-sufficiency that include the following phases:

(A) an initial phase in which a family moves out of an emergent crisis by securing housing, medical care, and financial assistance and supplemental nutrition assistance benefits, as necessary;

(B) a second phase in which:

(i) the family moves toward stability by securing employment and, if necessary, child care and by participating in services that build the financial management skills necessary to meet financial goals; and

(ii) the family's financial assistance and supplemental nutrition assistance benefits are reduced according to the following scale:

(a) on reaching 25 percent of the family's sufficient wage, the amount of benefits is reduced by 10 percent;

(b) on reaching 50 percent of the family's sufficient wage, the amount of benefits is reduced by 25 percent; and

(c) on reaching 75 percent of the family's sufficient wage, the amount of benefits is reduced by 50 percent;

(C) a third phase in which the family:

(i) transitions to self-sufficiency by securing employment that pays a sufficient wage, reducing debt, and building savings; and

(ii) becomes ineligible for financial assistance and supplemental nutrition assistance benefits on reaching 100 percent of the family's sufficient wage; and

(D) a final phase in which the family attains self-sufficiency by retaining employment that pays a sufficient wage, amassing at least $1,000 per member of the family's household, and having manageable debt so that the family will no longer be dependent on financial assistance, supplemental nutrition assistance, or other means-tested public benefits for at least six months following the date the family stops participating in the program.

Revised Law

Sec. 550.0204. BENEFIT ELIGIBILITY FOR PILOT PROGRAM PARTICIPANTS. (a) To allow for continuation of financial assistance and supplemental nutrition assistance benefits and reduction of the benefits using a slow reduction scale, the pilot

program will test extending the benefits for at least 24 months but not more than 60 months by waiving:

(1) the application of income and asset limit eligibility requirements for financial assistance and supplemental nutrition assistance benefits; and

(2) the time limits specified by Section 31.0065, Human Resources Code, for financial assistance benefits.

(b) The commission shall freeze a participating family's eligibility status for financial assistance and supplemental nutrition assistance benefits beginning on the date the participating family enters the pilot program and ending on the date the family ceases participating in the program.

(c) The waiver of the application of any asset limit requirement under this section must allow the participating family to have assets in an amount equal to at least $1,000 per member of the family's household. (Gov. Code, Sec. 531.02241(c).)

Source Law

> (c) The pilot program will test extending, for at least 24 months but not more than 60 months, financial assistance and supplemental nutrition assistance benefits by waiving the application of income and asset limit eligibility requirements for those benefits and the time limits under Section 31.0065, Human Resources Code, for financial assistance benefits to allow for continuation of financial assistance and supplemental nutrition assistance benefits and reduction of the benefits using a slow reduction scale. The commission shall freeze a participating family's eligibility status for the benefits beginning on the date the participating family enters the pilot program and ending on the date the family ceases participating in the program. The waiver of the application of any asset limit requirement must allow the family to have assets in an amount that is at least $1,000 per member of the family's household.

Revised Law

Sec. 550.0205. FAMILY ELIGIBILITY REQUIREMENTS. A family is eligible to participate in the pilot program if the family:

(1) includes one or more members who are recipients of financial assistance or supplemental nutrition assistance benefits, at least one of whom is:

(A) at least 18 years of age but not older than 62

years of age; and

(B) willing, physically able, and legally able to be employed; and

(2) has a total household income that is less than a sufficient wage based on the family's makeup and geographical area of residence. (Gov. Code, Sec. 531.02241(e).)

Source Law

(e) A family is eligible to participate in the pilot program established under this section if the family:

(1) includes one or more members who are recipients of financial assistance or supplemental nutrition assistance benefits, at least one of whom is:

(A) at least 18 but not more than 62 years of age; and

(B) willing, and physically and legally able, to be employed; and

(2) has a total household income that is less than a sufficient wage based on the family's makeup and geographical area of residence.

Revisor's Note

Section 531.02241(e), Government Code, refers to the pilot program "established under this section," meaning Section 531.02241, Government Code, which is revised as this subchapter. The revised law omits the quoted language as unnecessary. Section 550.0201 of this chapter defines "pilot program" and that definition applies by its own terms.

Revised Law

Sec. 550.0206. CASE MANAGEMENT REQUIREMENTS. (a) An individual from a family that wishes to participate in the pilot program must attend an in-person intake meeting with a program case manager. During the intake meeting the case manager shall:

(1) determine whether:

(A) the individual's family meets the eligibility requirements under Section 550.0205; and

(B) the application of income or asset limit eligibility requirements for continuation of financial assistance and supplemental nutrition assistance benefits and the time limits

specified by Section 31.0065, Human Resources Code, for financial assistance benefits may be waived under the program;

(2) review the family's demographic information and household financial budget;

(3) assess the family members' current financial and career situations;

(4) collaborate with the individual to develop and implement strategies for removing barriers to the family attaining self-sufficiency, including waiving the application of income and asset limit eligibility requirements and time limits described by Subdivision (1)(B) to allow for continuation of financial assistance and supplemental nutrition assistance benefits; and

(5) if the individual's family is determined eligible for and chooses to participate in the program, schedule a follow-up meeting to:

(A) further assess the family's crisis;

(B) review available referral services; and

(C) create a service plan.

(b) A participating family must be assigned a program case manager who shall:

(1) if the family is determined eligible, provide the family with a verification of the waived application of asset, income, and time limits described by Section 550.0204, allowing the family to continue receiving financial assistance and supplemental nutrition assistance benefits on a slow reduction scale;

(2) during the initial phase of the program, create medium- and long-term goals consistent with the strategies developed under Subsection (a)(4); and

(3) assess, at the follow-up meeting scheduled under Subsection (a)(5), the family's crisis, review available referral services, and create a service plan. (Gov. Code, Secs. 531.02241(g), (h).)

Source Law

(g) A person from a family that wishes to

participate in the pilot program must attend an in-person intake meeting with a program case manager. During the intake meeting the case manager shall:

(1) determine whether:

(A) the person's family meets the eligibility requirements under Subsection (e); and

(B) the application of income or asset limit eligibility requirements for continuation of financial assistance and supplemental nutrition assistance benefits and the time limits under Section 31.0065, Human Resources Code, for financial assistance benefits may be waived under the program;

(2) review the family's demographic information and household financial budget;

(3) assess the family members' current financial and career situations;

(4) collaborate with the person to develop and implement strategies for removing barriers to the family attaining self-sufficiency, including waiving the application of income and asset limit eligibility requirements and time limits described by Subdivision (1)(B) to allow for continuation of financial assistance and supplemental nutrition assistance benefits; and

(5) if the person's family is determined to be eligible for and chooses to participate in the program, schedule a follow-up meeting to further assess the family's crisis, review available referral services, and create a service plan.

(h) A participating family must be assigned a program case manager who shall:

(1) if the family is determined to be eligible, provide the family with a verification of the waived application of asset, income, and time limits described by Subsection (c), allowing the family to continue receiving financial assistance and supplemental nutrition assistance benefits on a slow reduction scale;

(2) assess, at the follow-up meeting scheduled under Subsection (g)(5), the family's crisis, review available referral services, and create a service plan; and

(3) during the initial phase of the program, create medium- and long-term goals consistent with the strategies developed under Subsection (g)(4).

Revised Law

Sec. 550.0207. PILOT PROGRAM MONITORING AND EVALUATION. The commission shall monitor and evaluate the pilot program in a manner that allows for promoting research-informed results of the program. (Gov. Code, Sec. 531.02241(l).)

Source Law

(l) The commission shall monitor and evaluate the pilot program in a manner that allows for promoting research-informed results of the program.

Revised Law

Sec. 550.0208. REPORTS. (a) On the conclusion of the pilot program but not later than 48 months following the date of the last

participating family's enrollment in the program, the commission shall report to the legislature on the results of the program. The report must include:

(1) an evaluation of the program's effect on participating families in achieving self-sufficiency and eliminating the need for means-tested public benefits;

(2) the impact to this state on the costs of the financial assistance and supplemental nutrition assistance programs and of the child-care services program operated by the Texas Workforce Commission;

(3) a cost-benefit analysis of the program; and

(4) recommendations on the feasibility and continuation of the program.

(b) During the operation of the pilot program, the commission shall provide to the legislature additional reports concerning the program that the commission determines appropriate. (Gov. Code, Secs. 531.02241(m), (n).)

Source Law

> (m) On the conclusion of the pilot program but not later than 48 months following the date the last participating family is enrolled in the program, the commission shall report to the legislature on the results of the program. The report must include:
>
> (1) an evaluation of the program's effect on participating families in achieving self-sufficiency and no longer requiring means-tested public benefits;
>
> (2) the impact to this state on the costs of the financial assistance and supplemental nutrition assistance programs and of the child-care services program operated by the Texas Workforce Commission;
>
> (3) a cost-benefit analysis of the program; and
>
> (4) recommendations on the feasibility and continuation of the program.
>
> (n) During the operation of the pilot program, the commission shall provide to the legislature additional reports concerning the program that the commission determines to be appropriate.

Revised Law

Sec. 550.0209. RULES. The executive commissioner and the Texas Workforce Commission may adopt rules to implement this subchapter. (Gov. Code, Sec. 531.02241(o).)

Source Law

(o) The executive commissioner and the Texas Workforce Commission may adopt rules to implement this section.

Revisor's Note

Section 531.02241(o), Government Code, refers to rules to implement "this section," meaning Section 531.02241. The provisions of Section 531.02241 are revised as this subchapter, and the revised law is drafted accordingly.

Revised Law

Sec. 550.0210. SUBCHAPTER EXPIRATION. This subchapter expires September 1, 2026. (Gov. Code, Sec. 531.02241(p).)

Source Law

(p) This section expires September 1, 2026.

Revisor's Note

Section 531.02241(p), Government Code, refers to "this section," meaning Section 531.02241. The provisions of Section 531.02241 are revised as this subchapter, and the revised law is drafted accordingly.

SUBCHAPTER E. COMMUNITY-BASED NAVIGATOR PROGRAM

Revised Law

Sec. 550.0251. DEFINITION. In this subchapter, "navigator" means an individual who is:

(1) a volunteer or other representative of a faith- or community-based organization; and

(2) certified by the commission to provide or facilitate the provision of information or assistance through the faith- or community-based organization to individuals applying or seeking to apply online for public assistance benefits administered by the commission through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system. (Gov. Code, Sec. 531.751(2).)

Source Law

Sec. 531.751. DEFINITIONS. In this subchapter:

(2) "Navigator" means a person who is:

(A) a volunteer or other representative of a faith- or community-based organization; and

(B) certified by the commission to provide or facilitate the provision of information or assistance through the faith- or community-based organization to individuals applying or seeking to apply online through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system for public assistance benefits administered by the commission.

Revisor's Note

Section 531.751(1), Government Code, defines "community-based organization" and "faith-based organization." The revised law omits the definitions for the reason stated in the revisor's note at the end of Subchapter D. The omitted law reads:

(1) "Community-based organization" and "faith-based organization" have the meanings assigned by Section 535.001.

Revised Law

Sec. 550.0252. ESTABLISHMENT OF COMMUNITY-BASED NAVIGATOR PROGRAM. (a) The commission shall establish a statewide community-based navigator program if the executive commissioner determines the program can be established and operated using existing resources and without disrupting other commission functions.

(b) Under the statewide community-based navigator program, the commission will train and certify as navigators volunteers and other representatives of faith- and community-based organizations. The navigators will assist individuals applying or seeking to apply online for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system.

(c) In establishing the navigator program, the commission:

(1) shall solicit the expertise and assistance of

interested persons, including faith- and community-based organizations; and

(2) may establish a work group or other temporary, informal group of interested persons to provide input and assistance. (Gov. Code, Sec. 531.752.)

Source Law

Sec. 531.752. ESTABLISHMENT OF COMMUNITY-BASED NAVIGATOR PROGRAM. If the executive commissioner determines that a statewide community-based navigator program can be established and operated using existing resources and without disrupting other commission functions, the commission shall establish a statewide community-based navigator program through which the commission will train and certify as navigators volunteers and other representatives of faith- and community-based organizations to assist individuals applying or seeking to apply online for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system. In establishing the navigator program, the commission shall solicit the expertise and assistance of interested persons, including faith- and community-based organizations, and may establish a work group or other temporary, informal group of interested persons to provide input and assistance.

Revised Law

Sec. 550.0253. PROGRAM STANDARDS. The executive commissioner shall adopt standards to implement this subchapter, including standards:

(1) subject to Section 550.0254, regarding the qualifications and training required for navigator certification;

(2) regarding the suspension, revocation, and, if appropriate, periodic renewal of a navigator certificate;

(3) to protect the confidentiality of applicant information handled by navigators; and

(4) regarding any other issues the executive commissioner determines are appropriate. (Gov. Code, Sec. 531.753.)

Source Law

Sec. 531.753. PROGRAM STANDARDS. The executive commissioner shall adopt standards to implement this subchapter, including standards:

(1) subject to Section 531.754, regarding the qualifications and training required for

certification as a navigator;

(2) regarding the suspension, revocation, and, if appropriate, periodic renewal of a navigator certificate;

(3) to protect the confidentiality of applicant information handled by navigators; and

(4) regarding any other issues the executive commissioner determines are appropriate.

Revised Law

Sec. 550.0254. NAVIGATOR TRAINING PROGRAM. The commission shall develop and administer a navigator training program that includes training on:

(1) the manner of completing an online application for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS);

(2) the importance of maintaining the confidentiality of information a navigator handles;

(3) the importance of obtaining and submitting complete and accurate information when completing an application for public assistance benefits online through the Texas Integrated Eligibility Redesign System (TIERS);

(4) the financial assistance program, the supplemental nutrition assistance program, Medicaid, the child health plan program, and any other public assistance benefits program for which an individual may complete an online application through the Texas Integrated Eligibility Redesign System (TIERS); and

(5) the method by which an individual may apply for other public assistance benefits for which the individual may not complete an online application through the Texas Integrated Eligibility Redesign System (TIERS). (Gov. Code, Sec. 531.754.)

Source Law

Sec. 531.754. TRAINING PROGRAM. The commission shall develop and administer a training program for navigators. The program must include training on:

(1) how to complete an online application for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS);

(2) the importance of maintaining the confidentiality of information handled by a navigator;

(3) the importance of obtaining and submitting complete and accurate information when completing an application for public assistance

benefits online through the Texas Integrated Eligibility Redesign System (TIERS);

(4) the financial assistance program, the supplemental nutrition assistance program, Medicaid, the child health plan program, and any other public assistance benefits program for which an individual may complete an online application through the Texas Integrated Eligibility Redesign System (TIERS); and

(5) how an individual may apply for other public assistance benefits for which an individual may not complete an online application through the Texas Integrated Eligibility Redesign System (TIERS).

Revised Law

Sec. 550.0255. CERTIFIED NAVIGATOR LIST. The commission shall publish and maintain on the commission's Internet website a list of certified navigators. (Gov. Code, Sec. 531.755.)

Source Law

Sec. 531.755. PUBLICATION OF NAVIGATOR LIST. The commission shall maintain and publish on the commission's Internet website a list of certified navigators.

APPENDIX A

CONFORMING AMENDMENTS

SECTION 2.01. Section 20.038, Business & Commerce Code, is amended to read as follows:

Sec. 20.038. EXEMPTION FROM SECURITY FREEZE. A security freeze does not apply to a consumer report provided to:

(1) a state or local governmental entity, including a law enforcement agency or court or private collection agency, if the entity, agency, or court is acting under a court order, warrant, subpoena, or administrative subpoena;

(2) a child support agency as defined by Section 101.004, Family Code, acting to investigate or collect child support payments or acting under Title IV-D of the Social Security Act (42 U.S.C. Section 651 et seq.);

(3) the Health and Human Services Commission acting under the following provisions of the [~~Section 531.102,~~] Government Code:

(A) Section 544.0052;

(B) Section 544.0101;

(C) Section 544.0102;

(D) Section 544.0103;

(E) Section 544.0104;

(F) Section 544.0105;

(G) Section 544.0106;

(H) Section 544.0108;

(I) Sections 544.0109(b) and (d);

(J) Section 544.0110;

(K) Section 544.0113;

(L) Section 544.0114;

(M) Section 544.0251;

(N) Section 544.0252(b);

(O) Section 544.0254;

(P) Section 544.0255;

(Q) Section 544.0257;

(R) Section 544.0301;

(S) Section 544.0302;

(T) Section 544.0303; and

(U) Section 544.0304;

(4) the comptroller acting to investigate or collect delinquent sales or franchise taxes;

(5) a tax assessor-collector acting to investigate or collect delinquent ad valorem taxes;

(6) a person for the purposes of prescreening as provided by the Fair Credit Reporting Act (15 U.S.C. Section 1681 et seq.), as amended;

(7) a person with whom the consumer has an account or contract or to whom the consumer has issued a negotiable instrument, or the person's subsidiary, affiliate, agent, assignee, prospective assignee, or private collection agency, for purposes related to that account, contract, or instrument;

(8) a subsidiary, affiliate, agent, assignee, or prospective assignee of a person to whom access has been granted under Section 20.037(b);

(9) a person who administers a credit file monitoring subscription service to which the consumer has subscribed;

(10) a person for the purpose of providing a consumer with a copy of the consumer's report on the consumer's request;

(11) a check service or fraud prevention service company that issues consumer reports:

(A) to prevent or investigate fraud; or

(B) for purposes of approving or processing negotiable instruments, electronic funds transfers, or similar methods of payment;

(12) a deposit account information service company that issues consumer reports related to account closures caused by fraud, substantial overdrafts, automated teller machine abuses, or similar negative information regarding a consumer to an inquiring financial institution for use by the financial institution only in

reviewing a consumer request for a deposit account with that institution; or

(13) a consumer reporting agency that:

(A) acts only to resell credit information by assembling and merging information contained in a database of another consumer reporting agency or multiple consumer reporting agencies; and

(B) does not maintain a permanent database of credit information from which new consumer reports are produced.

SECTION 2.02. Section 140.002(f), Civil Practice and Remedies Code, is amended to read as follows:

(f) This chapter does not apply to:

(1) a workers' compensation insurance policy or any other source of medical benefits under Title 5, Labor Code;

(2) Medicare;

(3) the Medicaid program under Chapter 32, Human Resources Code;

(4) a Medicaid managed care program operated under Chapter 540 or Chapter 540A [~~533~~], Government Code, as applicable;

(5) the state child health plan or any other program operated under Chapter 62 or 63, Health and Safety Code; or

(6) a self-funded plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

SECTION 2.03. Section 33.096(b), Education Code, is amended to read as follows:

(b) A student may request an electrocardiogram from any health care professional, including a health care professional provided through the student's patient-centered medical home, as defined by Section 540.0712 [~~533.0029~~], Government Code, a health care professional provided through a school district program, or another health care professional chosen by the parent or person standing in parental relation to the student, provided that the health care professional is:

(1) appropriately licensed in this state; and

(2) authorized to administer and interpret electrocardiograms under the health care professional's scope of practice, as established by the health care professional's Texas licensing act.

SECTION 2.04. Section 114.106(b), Estates Code, is amended to read as follows:

(b) Notwithstanding Subsection (a), real property transferred at the transferor's death by a transfer on death deed is not considered property of the probate estate for any purpose, including for purposes of Section 546.0403 [~~531.077~~], Government Code.

SECTION 2.05. Section 53.011(a), Family Code, is amended to read as follows:

(a) In this section:

(1) "Community resource coordination group" has the meaning assigned by Section 547.0101 [~~531.421~~], Government Code.

(2) "Local-level interagency staffing group" means a group established under the memorandum of understanding described by Subchapter D, Chapter 522 [~~Section 531.055~~], Government Code.

SECTION 2.06. Section 58.0051(a)(2), Family Code, is amended to read as follows:

(2) "Juvenile service provider" means a governmental entity that provides juvenile justice or prevention, medical, educational, or other support services to a juvenile. The term includes:

(A) a state or local juvenile justice agency as defined by Section 58.101;

(B) health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, and the Health and Human Services Commission;

(C) the Department of Family and Protective Services;

(D) the Department of Public Safety;

(E) the Texas Education Agency;

(F) an independent school district;

(G) a juvenile justice alternative education program;

(H) a charter school;

(I) a local mental health or mental retardation authority;

(J) a court with jurisdiction over juveniles;

(K) a district attorney's office;

(L) a county attorney's office; and

(M) a children's advocacy center established under Section 264.402.

SECTION 2.07. Section 261.401(b), Family Code, is amended to read as follows:

(b) Except as provided by Section 261.404 of this code and former Section 531.02013(1)(D), Government Code, a state agency that operates, licenses, certifies, registers, or lists a facility in which children are located or provides oversight of a program that serves children shall make a prompt, thorough investigation of a report that a child has been or may be abused, neglected, or exploited in the facility or program. The primary purpose of the investigation shall be the protection of the child.

SECTION 2.08. Sections 261.404(a-1) and (a-2), Family Code, are amended to read as follows:

(a-1) For an investigation of a child living in a residence owned, operated, or controlled by a provider of services under the home and community-based services waiver program described by Section 542.0001(11)(B) [~~534.001(11)(B)~~], Government Code, the department, in accordance with Subchapter E, Chapter 48, Human Resources Code, may provide emergency protective services necessary to immediately protect the child from serious physical harm or death and, if necessary, obtain an emergency order for protective services under Section 48.208, Human Resources Code.

(a-2) For an investigation of a child living in a residence

owned, operated, or controlled by a provider of services under the home and community-based services waiver program described by Section 542.0001(11)(B) [~~534.001(11)(B)~~], Government Code, regardless of whether the child is receiving services under that waiver program from the provider, the department shall provide protective services to the child in accordance with Subchapter E, Chapter 48, Human Resources Code.

SECTION 2.09. Section 264.019(b), Family Code, is amended to read as follows:

(b) Not later than November 1 of each year, the department shall:

(1) prepare for the preceding year a report containing:

(A) the information collected under Subsection (a); and

(B) the data collected under Section 532.0204 [~~531.02143~~], Government Code;

(2) post a copy of the report prepared under Subdivision (1) on the department's Internet website; and

(3) electronically submit to the legislature a copy of the report.

SECTION 2.10. Section 264.1212(a), Family Code, is amended to read as follows:

(a) In this section, "community resource coordination group" means a coordination group established under a memorandum of understanding under Subchapter D, Chapter 522 [~~Section 531.055~~], Government Code.

SECTION 2.11. Section 264.757, Family Code, is amended to read as follows:

Sec. 264.757. COORDINATION WITH OTHER AGENCIES. The department shall coordinate with other health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, to provide assistance and services under this subchapter.

SECTION 2.12. Section 14.1025(a)(2), Finance Code, is

amended to read as follows:

(2) "Health and human services agencies" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.13. Section 322.020(f), Government Code, is amended to read as follows:

(f) In this section, "state agency" has the meaning assigned by Section 2054.003, except that the term does not include a university system or institution of higher education, the Health and Human Services Commission, an agency identified in Section 521.0001(5) [~~531.001(4)~~], or the Texas Department of Transportation.

SECTION 2.14. Section 411.1143(a), Government Code, is amended to read as follows:

(a) The Health and Human Services Commission, an agency operating part of the medical assistance program under Chapter 32, Human Resources Code, or the office of inspector general established under Subchapter C, Chapter 544 [~~Chapter 531~~], Government Code, is entitled to obtain from the department the criminal history record information maintained by the department that relates to a provider under the medical assistance program or a person applying to enroll as a provider under the medical assistance program.

SECTION 2.15. Section 418.043, Government Code, is amended to read as follows:

Sec. 418.043. OTHER POWERS AND DUTIES. The division shall:

(1) determine requirements of the state and its political subdivisions for food, clothing, and other necessities in event of a disaster;

(2) procure and position supplies, medicines, materials, and equipment;

(3) adopt standards and requirements for local and interjurisdictional emergency management plans;

(4) periodically review local and interjurisdictional emergency management plans;

(5) coordinate deployment of mobile support units;

(6) establish and operate training programs and programs of public information or assist political subdivisions and emergency management agencies to establish and operate the programs;

(7) make surveys of public and private industries, resources, and facilities in the state that are necessary to carry out the purposes of this chapter;

(8) plan and make arrangements for the availability and use of any private facilities, services, and property and provide for payment for use under terms and conditions agreed on if the facilities are used and payment is necessary;

(9) establish a register of persons with types of training and skills important in disaster mitigation, preparedness, response, and recovery;

(10) establish a register of mobile and construction equipment and temporary housing available for use in a disaster;

(11) assist political subdivisions in developing plans for the humane evacuation, transport, and temporary sheltering of service animals and household pets in a disaster;

(12) prepare, for issuance by the governor, executive orders and regulations necessary or appropriate in coping with disasters;

(13) cooperate with the federal government and any public or private agency or entity in achieving any purpose of this chapter and in implementing programs for disaster mitigation, preparation, response, and recovery;

(14) develop a plan to raise public awareness and expand the capability of the information and referral network under Section 526.0004 [~~531.0312~~];

(15) improve the integration of volunteer groups, including faith-based organizations, into emergency management plans;

(16) cooperate with the Federal Emergency Management

Agency to create uniform guidelines for acceptable home repairs following disasters and promote public awareness of the guidelines;

(17) cooperate with state agencies to:

(A) encourage the public to participate in volunteer emergency response teams and organizations that respond to disasters; and

(B) provide information on those programs in state disaster preparedness and educational materials and on Internet websites;

(18) establish a liability awareness program for volunteers, including medical professionals;

(19) define "individuals with special needs" in the context of a disaster;

(20) establish and operate, subject to the availability of funds, a search and rescue task force in each field response region established by the division to assist in search, rescue, and recovery efforts before, during, and after a natural or man-made disaster; and

(21) do other things necessary, incidental, or appropriate for the implementation of this chapter.

SECTION 2.16. Section 441.203(j), Government Code, is amended to read as follows:

(j) The council shall categorize state agency programs and telephone numbers by subject matter as well as by agency. The council shall cooperate with the Texas Information and Referral Network under Section 526.0004 [~~531.0312~~] to ensure that the council and the network use a single method of defining and organizing information about health and human services.

SECTION 2.17. Section 2001.223, Government Code, is amended to read as follows:

Sec. 2001.223. EXCEPTIONS FROM DECLARATORY JUDGMENT, COURT ENFORCEMENT, AND CONTESTED CASE PROVISIONS. Section 2001.038 and Subchapters C through H do not apply to:

(1) except as provided by Subchapter D, Chapter 545

[~~Section 531.019~~], the granting, payment, denial, or withdrawal of financial or medical assistance or benefits under service programs that were operated by the former Texas Department of Human Services before September 1, 2003, and are operated on and after that date by the Health and Human Services Commission or a health and human services agency, as defined by Section 521.0001 [~~531.001~~];

(2) action by the Banking Commissioner or the Finance Commission of Texas regarding the issuance of a state bank or state trust company charter for a bank or trust company to assume the assets and liabilities of a financial institution that the commissioner considers to be in hazardous condition as defined by Section 31.002(a) or 181.002(a), Finance Code, as applicable;

(3) a hearing or interview conducted by the Board of Pardons and Paroles or the Texas Department of Criminal Justice relating to the grant, rescission, or revocation of parole or other form of administrative release; or

(4) the suspension, revocation, or termination of the certification of a breath analysis operator or technical supervisor under the rules of the Department of Public Safety.

SECTION 2.18. Section 2055.001(4), Government Code, is amended to read as follows:

(4) "State agency" has the meaning assigned by Section 2054.003, except that the term does not include a university system or institution of higher education or an agency identified in Section 521.0001(5) [~~531.001(4)~~].

SECTION 2.19. Section 2055.002(a), Government Code, is amended to read as follows:

(a) Except as provided by Subsection (b), the requirements of this chapter regarding electronic government projects do not apply to institutions of higher education or a health and human services agency identified in Section 521.0001(5) [~~531.001(4)~~], Government Code.

SECTION 2.20. Sections 2155.144(i), (j), (k), (m), and (p), Government Code, are amended to read as follows:

(i) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission shall develop a single statewide risk analysis procedure. Each health and human services agency shall comply with the procedure. The procedure must provide for:

(1) assessing the risk of fraud, abuse, or waste in health and human services agencies contractor selection processes, contract provisions, and payment and reimbursement rates and methods for the different types of goods and services for which health and human services agencies contract;

(2) identifying contracts that require enhanced contract monitoring; and

(3) coordinating contract monitoring efforts among health and human services agencies.

(j) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission shall publish a contract management handbook that establishes consistent contracting policies and practices to be followed by health and human services agencies. The handbook may include standard contract provisions and formats for health and human services agencies to incorporate as applicable in their contracts.

(k) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission, in cooperation with the comptroller, shall establish a central contract management database that identifies each contract made with a health and human services agency. The comptroller may use the database to monitor health and human services agency contracts, and health and human services agencies may use the database in contracting. A state agency shall send to the comptroller in the manner prescribed by the comptroller the information the agency possesses that the comptroller requires for inclusion in the database.

(m) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission shall develop and implement a statewide plan to ensure that each entity that contracts with a

health and human services agency and any subcontractor of the entity complies with the accessibility requirements of the Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.).

(p) In this section, "health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~].

SECTION 2.21. Section 2167.004(c), Government Code, is amended to read as follows:

(c) In this section, "health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~].

SECTION 2.22. Section 2306.252(g), Government Code, is amended to read as follows:

(g) The center shall provide information regarding the department's housing and community affairs programs to the Texas Information and Referral Network for inclusion in the statewide information and referral network as required by Section 526.0004 [~~531.0312~~].

SECTION 2.23. Section 12.0001, Health and Safety Code, is amended to read as follows:

Sec. 12.0001. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this title or another law conflicts with any of the following provisions of the Government Code, the [~~Section 531.0055,~~] Government Code provision[~~, Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.24. Section 32.101, Health and Safety Code, is amended to read as follows:

Sec. 32.101. ENHANCED PRENATAL SERVICES FOR CERTAIN WOMEN. The commission, in collaboration with managed care organizations that contract with the commission to provide health

care services to medical assistance recipients under Chapter 540 or 540A [~~533~~], Government Code, as applicable, shall develop and implement cost-effective, evidence-based, and enhanced prenatal services for high-risk pregnant women covered under the medical assistance program.

SECTION 2.25. Section 32.151(3), Health and Safety Code, is amended to read as follows:

(3) "Medicaid managed care organization" means a managed care organization as defined by Section 540.0001 [~~533.001~~], Government Code, that contracts with the commission under Chapter 540 or 540A [~~533~~], Government Code, as applicable, to provide health care services to medical assistance program recipients.

SECTION 2.26. Section 32.155(e), Health and Safety Code, is amended to read as follows:

(e) The commission may submit the report required under Subsection (d) with the report required under Section 543A.0008 [~~536.008~~], Government Code.

SECTION 2.27. Section 33.018(a)(4), Health and Safety Code, is amended to read as follows:

(4) "Health agency" means the commission and the health and human services agencies listed in Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.28. Section 34.0159, Health and Safety Code, is amended to read as follows:

Sec. 34.0159. PROGRAM EVALUATIONS. The commission, in collaboration with the task force and other interested parties, shall:

(1) explore options for expanding the pilot program for pregnancy medical homes established under former Section 531.0996, Government Code;

(2) explore methods for increasing the benefits provided under Medicaid, including specialty care and prescriptions, for women at greater risk of a high-risk pregnancy or premature delivery;

(3) evaluate the impact of supplemental payments made to obstetrics providers for pregnancy risk assessments on increasing access to maternal health services;

(4) evaluate a waiver to fund managed care organization payments for case management and care coordination services for women at high risk of severe maternal morbidity on conclusion of their eligibility for Medicaid;

(5) evaluate the average time required for pregnant women to complete the Medicaid enrollment process;

(6) evaluate the use of Medicare codes for Medicaid care coordination;

(7) study the impact of programs funded from the Teen Pregnancy Prevention Program federal grant and evaluate whether the state should continue funding the programs; and

(8) evaluate the use of telemedicine medical services for women during pregnancy and the postpartum period.

SECTION 2.29. Section 34.020(c), Health and Safety Code, is amended to read as follows:

(c) The commission shall develop criteria for selecting participants for the program by analyzing information in the reports prepared by the task force under this chapter and the outcomes of the study conducted under former Section 531.02163, Government Code.

SECTION 2.30. Section 35.0021(5), Health and Safety Code, is amended to read as follows:

(5) "Family support services" means support, resources, or other assistance provided to the family of a child with special health care needs. The term may include services described by Part A of the Individuals with Disabilities Education Act (20 U.S.C. Section 1400 et seq.), as amended, and permanency planning, as that term is defined by Section 546.0201 [~~531.151~~], Government Code.

SECTION 2.31. Section 62.1571, Health and Safety Code, as amended by Chapters 624 (H.B. 4) and 811 (H.B. 2056), Acts of the

87th Legislature, Regular Session, 2021, is reenacted and amended to read as follows:

Sec. 62.1571. TELEMEDICINE MEDICAL SERVICES, [~~AND~~] TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES. (a) In providing covered benefits to a child, a health plan provider must permit benefits to be provided through telemedicine medical services, [~~and~~] teledentistry dental services, and telehealth services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services, [~~and~~] teledentistry dental services, and [~~or~~] telehealth services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services, [~~and~~] teledentistry dental services, and [~~or~~] telehealth services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single session of telemedicine medical services, teledentistry dental services, or both services, or of telehealth services, if the executive commissioner determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services, [~~or~~] teledentistry dental services, or telehealth services, including the costs of transportation and lodging and other direct costs.

(c) In this section, "teledentistry dental service," [~~and~~] "telehealth service," and "telemedicine medical service" have the meanings assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.32. Section 75.151, Health and Safety Code, is amended to read as follows:

Sec. 75.151. DEFINITION. In this subchapter, "health opportunity pool trust fund" means the trust fund established under Subchapter D [~~N~~], Chapter 526 [~~531~~], Government Code.

SECTION 2.33. Section 75.153, Health and Safety Code, is

amended to read as follows:

Sec. 75.153. ELIGIBILITY FOR FUNDS; STATEWIDE ELIGIBILITY CRITERIA. To be eligible for funding from money in the health opportunity pool trust fund, a regional or local health care program must:

(1) comply with any requirement imposed under the waiver obtained under Section 526.0152 [~~531.502~~], Government Code, including, to the extent applicable, any requirement that health care benefits or services provided under the program be provided in accordance with statewide eligibility criteria; and

(2) provide health care benefits or services under the program to a person receiving premium payment assistance for health benefits coverage through a program established under Section 526.0157 [~~531.507~~], Government Code, regardless of whether the person is an employee, or dependent of an employee, of a small employer.

SECTION 2.34. Section 94.001(b), Health and Safety Code, is amended to read as follows:

(b) In developing the plan, the department shall seek the input of:

(1) the public, including members of the public that have hepatitis C;

(2) each state agency that provides services to persons with hepatitis C or the functions of which otherwise involve hepatitis C, including any appropriate health and human services agency described by Section 521.0001 [~~531.001~~], Government Code;

(3) any advisory body that addresses issues related to hepatitis C;

(4) public advocates concerned with issues related to hepatitis C; and

(5) providers of services to persons with hepatitis C.

SECTION 2.35. Section 94A.001(b), Health and Safety Code, is amended to read as follows:

(b) In developing the plan, the department shall seek the advice of:

(1) the public, including members of the public who have been infected with Streptococcus pneumoniae;

(2) each state agency that provides services to persons infected with Streptococcus pneumoniae or that is assigned duties related to diseases caused by Streptococcus pneumoniae, including any appropriate health and human services agency described by Section 521.0001 [~~531.001~~], Government Code, the Employees Retirement System of Texas, and the Teacher Retirement System of Texas;

(3) any advisory body that addresses issues related to diseases caused by Streptococcus pneumoniae;

(4) public advocates concerned with issues related to diseases caused by Streptococcus pneumoniae;

(5) providers of services to persons with diseases caused by Streptococcus pneumoniae;

(6) a statewide professional association of physicians; and

(7) a statewide professional association of nurses.

SECTION 2.36. Section 98.110(a), Health and Safety Code, is amended to read as follows:

(a) Notwithstanding any other law, the department may disclose information reported by health care facilities under Section 98.103 or 98.1045 to other programs within the department, to the commission, to other health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, and to the federal Centers for Disease Control and Prevention, or any other agency of the United States Department of Health and Human Services, for public health research or analysis purposes only, provided that the research or analysis relates to health care-associated infections or preventable adverse events. The privilege and confidentiality provisions contained in this chapter apply to such disclosures.

SECTION 2.37. Section 103.0131(a), Health and Safety Code, is amended to read as follows:

(a) In conjunction with developing each state plan described in Section 103.013, the council shall conduct a statewide assessment of existing programs for the prevention of diabetes and treatment of individuals with diabetes that are administered by the commission or a health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code. As part of the assessment, the council shall collect data regarding:

(1) the number of individuals served by the programs;

(2) the areas where services to prevent diabetes and treat individuals with diabetes are unavailable; and

(3) the number of health care providers treating individuals with diabetes under the programs.

SECTION 2.38. Section 108.0065(a), Health and Safety Code, is amended to read as follows:

(a) In this section, "Medicaid managed care organization" means a managed care organization, as defined by Section 540.0001 [~~533.001~~], Government Code, that is contracting with the commission to implement the Medicaid managed care program under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.39. Section 142.001(11-c), Health and Safety Code, is amended to read as follows:

(11-c) "Habilitation" means habilitation services, as defined by Section 542.0001 [~~534.001~~], Government Code, delivered by a licensed home and community support services agency.

SECTION 2.40. Section 142.003(a), Health and Safety Code, is amended to read as follows:

(a) The following persons need not be licensed under this chapter:

(1) a physician, dentist, registered nurse, occupational therapist, or physical therapist licensed under the laws of this state who provides home health services to a client only as a part of and incidental to that person's private office

practice;

(2) a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech therapist, medical social worker, or any other health care professional as determined by the department who provides home health services as a sole practitioner;

(3) a registry that operates solely as a clearinghouse to put consumers in contact with persons who provide home health, hospice, habilitation, or personal assistance services and that does not maintain official client records, direct client services, or compensate the person who is providing the service;

(4) an individual whose permanent residence is in the client's residence;

(5) an employee of a person licensed under this chapter who provides home health, hospice, habilitation, or personal assistance services only as an employee of the license holder and who receives no benefit for providing the services, other than wages from the license holder;

(6) a home, nursing home, convalescent home, assisted living facility, special care facility, or other institution for individuals who are elderly or who have disabilities that provides home health or personal assistance services only to residents of the home or institution;

(7) a person who provides one health service through a contract with a person licensed under this chapter;

(8) a durable medical equipment supply company;

(9) a pharmacy or wholesale medical supply company that does not furnish services, other than supplies, to a person at the person's house;

(10) a hospital or other licensed health care facility that provides home health or personal assistance services only to inpatient residents of the hospital or facility;

(11) a person providing home health or personal assistance services to an injured employee under Title 5, Labor

Code;

(12) a visiting nurse service that:

(A) is conducted by and for the adherents of a well-recognized church or religious denomination; and

(B) provides nursing services by a person exempt from licensing by Section 301.004, Occupations Code, because the person furnishes nursing care in which treatment is only by prayer or spiritual means;

(13) an individual hired and paid directly by the client or the client's family or legal guardian to provide home health or personal assistance services;

(14) a business, school, camp, or other organization that provides home health or personal assistance services, incidental to the organization's primary purpose, to individuals employed by or participating in programs offered by the business, school, or camp that enable the individual to participate fully in the business's, school's, or camp's programs;

(15) a person or organization providing sitter-companion services or chore or household services that do not involve personal care, health, or health-related services;

(16) a licensed health care facility that provides hospice services under a contract with a hospice;

(17) a person delivering residential acquired immune deficiency syndrome hospice care who is licensed and designated as a residential AIDS hospice under Chapter 248;

(18) the Texas Department of Criminal Justice;

(19) a person that provides home health, hospice, habilitation, or personal assistance services only to persons receiving benefits under:

(A) the home and community-based services (HCS) waiver program;

(B) the Texas home living (TxHmL) waiver program;

(C) the STAR + PLUS or other Medicaid managed care program under the program's HCS or TxHmL certification; or

(D) Section 542.0152 [~~534.152~~], Government Code;

(20) a person who provides intellectual and developmental disabilities habilitative specialized services under Medicaid and is:

(A) a certified HCS or TxHmL provider; or

(B) a local intellectual and developmental disability authority contracted under Section 534.105; or

(21) an individual who provides home health or personal assistance services as the employee of a consumer or an entity or employee of an entity acting as a consumer's fiscal agent under Subchapter C, Chapter 546 [~~Section 531.051~~], Government Code.

SECTION 2.41. Section 161.0095(b), Health and Safety Code, is amended to read as follows:

(b) The department shall establish a work group to assist the department in developing the continuing education programs and educational information. The work group shall include physicians, nurses, department representatives, representatives of managed care organizations that provide health care services under Chapter 540 or 540A [~~533~~], Government Code, as applicable, representatives of health plan providers that provide health care services under Chapter 62, and members of the public.

SECTION 2.42. Section 191.0048(d), Health and Safety Code, is amended to read as follows:

(d) Notwithstanding Section 191.005, the local registrar or county clerk who collects the voluntary contribution under this section shall send the voluntary contribution to the comptroller, who shall deposit the voluntary contribution in the Texas Home Visiting Program trust fund under Section 523.0306 [~~531.287~~], Government Code.

SECTION 2.43. Section 242.0395(a), Health and Safety Code, is amended to read as follows:

(a) An institution licensed under this chapter shall register with the Texas Information and Referral Network under Section 526.0004 [~~531.0312~~], Government Code, to assist the state

in identifying persons needing assistance if an area is evacuated because of a disaster or other emergency.

SECTION 2.44. Section 242.061(a-3), Health and Safety Code, is amended to read as follows:

(a-3) The executive commissioner may not revoke a license under Subsection (a-2) due to a violation described by Subsection (a-2)(1), if:

(1) the violation and the determination of immediate threat to health and safety are not included on the written list of violations left with the facility at the time of the initial exit conference under Section 242.0445(b) for a survey, inspection, or investigation;

(2) the violation is not included on the final statement of violations described by Section 242.0445; or

(3) the violation has been reviewed under the informal dispute resolution process established by Section 526.0202 [~~531.058~~], Government Code, and a determination was made that:

(A) the violation should be removed from the license holder's record; or

(B) the violation is reduced in severity so that the violation is no longer cited as an immediate threat to health and safety related to the abuse or neglect of a resident.

SECTION 2.45. Section 247.0275(a), Health and Safety Code, is amended to read as follows:

(a) An assisted living facility licensed under this chapter shall register with the Texas Information and Referral Network under Section 526.0004 [~~531.0312~~], Government Code, to assist the state in identifying persons needing assistance if an area is evacuated because of a disaster or other emergency.

SECTION 2.46. Section 247.043(b), Health and Safety Code, is amended to read as follows:

(b) If the thorough investigation reveals that abuse, exploitation, or neglect has occurred, the department shall:

(1) implement enforcement measures, including closing

the facility, revoking the facility's license, relocating residents, and making referrals to law enforcement agencies;

(2) notify the Department of Family and Protective Services of the results of the investigation;

(3) notify a health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code, that contracts with the facility for the delivery of personal care services of the results of the investigation; and

(4) provide to a contracting health and human services agency access to the department's documents or records relating to the investigation.

SECTION 2.47. Sections 250.001(1-b) and (3-a), Health and Safety Code, are amended to read as follows:

(1-b) "Consumer-directed service option" has the meaning assigned by Section 546.0101 [~~531.051~~], Government Code.

(3-a) "Financial management services agency" means an entity that contracts with the commission [~~Department of Aging and Disability Services~~] to serve as a fiscal and employer agent for an individual employer in the consumer-directed service option described by Section 546.0101 [~~531.051~~], Government Code.

SECTION 2.48. Section 253.001(1-b), Health and Safety Code, is amended to read as follows:

(1-b) "Consumer-directed service option" has the meaning assigned by Section 546.0101 [~~531.051~~], Government Code.

SECTION 2.49. Section 322.001(2), Health and Safety Code, is amended to read as follows:

(2) "Health and human services agency" means an agency listed in Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.50. Section 461A.005, Health and Safety Code, is amended to read as follows:

Sec. 461A.005. CONFLICT WITH OTHER LAW. To the extent a power or duty given to the department or commissioner by this chapter conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision

[~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.51. Section 461A.052(b), Health and Safety Code, is amended to read as follows:

(b) The department may establish regional alcohol advisory committees consistent with the regions established under Section 525.0151 [~~531.024~~], Government Code.

SECTION 2.52. Section 461A.056(a), Health and Safety Code, is amended to read as follows:

(a) The department shall develop and adopt a statewide service delivery plan. The department shall update the plan not later than February 1 of each even-numbered year. The plan must include:

(1) a statement of the department's mission, goals, and objectives regarding chemical dependency prevention, intervention, and treatment;

(2) a statement of how chemical dependency services and chemical dependency case management services should be organized, managed, and delivered;

(3) a comprehensive assessment of:

(A) chemical dependency services available in this state at the time the plan is prepared; and

(B) future chemical dependency services needs;

(4) a service funding process that ensures equity in the availability of chemical dependency services across this state and within each service region established under Section 525.0151 [~~531.024~~], Government Code;

(5) a provider selection and monitoring process that emphasizes quality in the provision of services;

(6) a description of minimum service levels for each

region;

(7) a mechanism for the department to obtain and consider local public participation in identifying and assessing regional needs for chemical dependency services;

(8) a process for coordinating and assisting administration and delivery of services among federal, state, and local public and private chemical dependency programs that provide similar services; and

(9) a process for coordinating the department's activities with those of other state health and human services agencies and criminal justice agencies to avoid duplications and inconsistencies in the efforts of the agencies in chemical dependency prevention, intervention, treatment, rehabilitation, research, education, and training.

SECTION 2.53. Section 533.0002, Health and Safety Code, is amended to read as follows:

Sec. 533.0002. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this title or another law conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.54. Section 533.016(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human services agency," as that term is defined by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.55. Section 533.017(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human

services agency," as that term is defined by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.56. Section 533.032(a), Health and Safety Code, is amended to read as follows:

(a) The department shall have a long-range plan relating to the provision of services under this title covering at least six years that includes at least the provisions required by Sections 525.0154, 525.0155, [~~531.022~~] and 525.0156 [~~531.023~~], Government Code, and Chapter 2056, Government Code. The plan must cover the provision of services in and policies for state-operated institutions and ensure that the medical needs of the most medically fragile persons with mental illness the department serves are met.

SECTION 2.57. Section 533A.002, Health and Safety Code, is amended to read as follows:

Sec. 533A.002. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this title or another law conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.58. Section 533A.016(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human services agency," as that term is defined by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.59. Section 533A.017(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human services agency," as that term is defined by Section 521.0001

[~~531.001~~], Government Code.

SECTION 2.60. Section 533A.032(a), Health and Safety Code, is amended to read as follows:

(a) The department shall have a long-range plan relating to the provision of services under this title covering at least six years that includes at least the provisions required by Sections 525.0154, 525.0155, [~~531.022~~] and 525.0156 [~~531.023~~], Government Code, and Chapter 2056, Government Code. The plan must cover the provision of services in and policies for state-operated institutions and ensure that the medical needs of the most medically fragile persons with an intellectual disability the department serves are met.

SECTION 2.61. Section 533A.0335(a), Health and Safety Code, is amended to read as follows:

(a) In this section:

(1) "Advisory committee" means the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052 [~~534.053~~], Government Code.

(2) "Functional need," "ICF-IID program," and "Medicaid waiver program" have the meanings assigned those terms by Section 542.0001 [~~534.001~~], Government Code.

SECTION 2.62. Section 533A.03551(b), Health and Safety Code, is amended to read as follows:

(b) The department, in cooperation with the Texas Department of Housing and Community Affairs, the Department of Agriculture, the Texas State Affordable Housing Corporation, and the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052 [~~534.053~~], Government Code, shall coordinate with federal, state, and local public housing entities as necessary to expand opportunities for accessible, affordable, and integrated housing to meet the complex needs of individuals with disabilities, including individuals with intellectual and developmental disabilities.

SECTION 2.63. Section 773.05711(a), Health and Safety Code,

is amended to read as follows:

(a) In addition to the requirements for obtaining or renewing an emergency medical services provider license under this subchapter, a person who applies for a license or for a renewal of a license must:

(1) provide the department with a letter of credit issued by a federally insured bank or savings institution in the amount of:

(A) $100,000 for the initial license and for renewal of the license on the second anniversary of the date the initial license is issued;

(B) $75,000 for renewal of the license on the fourth anniversary of the date the initial license is issued;

(C) $50,000 for renewal of the license on the sixth anniversary of the date the initial license is issued; and

(D) $25,000 for renewal of the license on the eighth anniversary of the date the initial license is issued;

(2) if the applicant participates in the medical assistance program operated under Chapter 32, Human Resources Code, the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code, or the child health plan program operated under Chapter 62 of this code, provide the Health and Human Services Commission with a surety bond in the amount of $50,000; and

(3) submit for approval by the department the name and contact information of the provider's administrator of record who satisfies the requirements under Section 773.05712.

SECTION 2.64. Section 773.06141(a), Health and Safety Code, is amended to read as follows:

(a) The department may suspend, revoke, or deny an emergency medical services provider license on the grounds that the provider's administrator of record, employee, or other representative:

(1) has been convicted of, or placed on deferred

adjudication community supervision or deferred disposition for, an offense that directly relates to the duties and responsibilities of the administrator, employee, or representative, other than an offense described by Section 542.304, Transportation Code;

(2) has been convicted of or placed on deferred adjudication community supervision or deferred disposition for an offense, including:

(A) an offense listed in Article 42A.054(a)(2), (3), (4), (7), (8), (9), (11), or (16), Code of Criminal Procedure; or

(B) an offense, other than an offense described by Subdivision (1), for which the person is subject to registration under Chapter 62, Code of Criminal Procedure; or

(3) has been convicted of Medicare or Medicaid fraud, has been excluded from participation in the state Medicaid program, or has a hold on payment for reimbursement under the state Medicaid program under Subchapter G [~~C~~], Chapter 544 [~~531~~], Government Code.

SECTION 2.65. Sections 1001.002(a) and (c), Health and Safety Code, are amended to read as follows:

(a) In this section, "function" includes a power, duty, program, or activity and an administrative support services function associated with the power, duty, program, or activity, unless consolidated under former Section 531.02012, Government Code.

(c) In accordance with former Subchapter A-1, Chapter 531, Government Code, and notwithstanding any other law, the department performs only functions related to public health, including health care data collection and maintenance of the Texas Health Care Information Collection program.

SECTION 2.66. Section 1001.004, Health and Safety Code, is amended to read as follows:

Sec. 1001.004. REFERENCES IN LAW MEANING DEPARTMENT. In this code or any other law, a reference to the department in relation to a function described by Section 1001.002(c) means the

department. A reference in law to the department in relation to any other function has the meaning assigned by Section 521.0002 [~~531.0011~~], Government Code.

SECTION 2.67. Section 1001.005, Health and Safety Code, is amended to read as follows:

Sec. 1001.005. REFERENCES IN LAW MEANING COMMISSIONER OR DESIGNEE. In this code or in any other law, a reference to the commissioner in relation to a function described by Section 1001.002(c) means the commissioner. A reference in law to the commissioner in relation to any other function has the meaning assigned by Section 521.0003 [~~531.0012~~], Government Code.

SECTION 2.68. Sections 1001.051(a-1), (c), and (d), Health and Safety Code, are amended to read as follows:

(a-1) The executive commissioner shall employ the commissioner in accordance with Subchapter B, Chapter 524, Government Code, and Section 524.0101(b) [~~531.0056~~], Government Code.

(c) Subject to the control of the executive commissioner, the commissioner shall:

(1) act as the department's chief administrative officer;

(2) in accordance with the procedures prescribed by Section 524.0152 [~~531.00551~~], Government Code, assist the executive commissioner in the development and implementation of policies and guidelines needed for the administration of the department's functions;

(3) in accordance with the procedures adopted by the executive commissioner under Section 524.0152 [~~531.00551~~], Government Code, assist the executive commissioner in the development of rules relating to the matters within the department's jurisdiction, including the delivery of services to persons and the rights and duties of persons who are served or regulated by the department; and

(4) serve as a liaison between the department and

commission.

(d) The commissioner shall administer this chapter under operational policies established by the executive commissioner and in accordance with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.69. Section 1001.075, Health and Safety Code, is amended to read as follows:

Sec. 1001.075. RULES. The executive commissioner may adopt rules reasonably necessary for the department to administer this chapter, consistent with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.70. Sections 1001.084(a) and (d), Health and Safety Code, as added by Chapter 1 (S.B. 219), Acts of the 84th Legislature, Regular Session, 2015, are amended to read as follows:

(a) The executive commissioner, as authorized by Section 524.0002 [~~531.0055~~], Government Code, may delegate to the department the executive commissioner's authority under that section for contracting and auditing relating to the department's powers, duties, functions, and activities.

(d) It is the legislature's intent that the executive commissioner retain the authority over and responsibility for contracting and auditing at each health and human services agency as provided by Section 524.0002 [~~531.0055~~], Government Code. A statute enacted on or after January 1, 2015, that references the contracting or auditing authority of the department does not give the department direct contracting or auditing authority unless the statute expressly provides that the contracting or auditing authority:

(1) is given directly to the department; and

(2) is an exception to the exclusive contracting and auditing authority given to the executive commissioner under Section 524.0002 [~~531.0055~~], Government Code.

SECTION 2.71. Section 1001.085, Health and Safety Code, is amended to read as follows:

Sec. 1001.085. MANAGEMENT AND DIRECTION BY EXECUTIVE COMMISSIONER. The department's powers and duties prescribed by this chapter and other law, including enforcement activities and functions, are subject to the executive commissioner's oversight under the revised provisions derived from Chapter 531, Government Code, as that chapter existed on March 31, 2025, to manage and direct the operations of the department.

SECTION 2.72. Section 11.004, Human Resources Code, is amended to read as follows:

Sec. 11.004. POWERS AND FUNCTIONS NOT AFFECTED. The provisions of this title are not intended to interfere with the powers and functions of the commission, the health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, or county juvenile boards.

SECTION 2.73. Section 22.0001, Human Resources Code, is amended to read as follows:

Sec. 22.0001. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner of aging and disability services by this title or another law conflicts with any of the following provisions of the Government Code, the [~~Section 531.0055,~~] Government Code provision [~~, Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524, Government Code;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b), Government Code;

(4) Section 524.0202, Government Code; and

(5) Section 525.0254, Government Code.

SECTION 2.74. Section 31.0032(d), Human Resources Code, is amended to read as follows:

(d) This section does not prohibit the Texas Workforce Commission, the commission, or any health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code,

from providing child care or any other related social or support services for an individual who is eligible for financial assistance but to whom that assistance is not paid because of the individual's failure to cooperate.

SECTION 2.75. Sections 31.0127(b) and (e), Human Resources Code, are amended to read as follows:

(b) The Health and Human Services Commission shall require the Texas Workforce Commission to comply with the revised provisions derived from Chapter 531, Government Code, as that chapter existed on March 31, 2025, solely for:

(1) the promulgation of rules relating to the programs described by Subsection (a);

(2) the expenditure of funds relating to the programs described by Subsection (a), within the limitations established by and subject to the General Appropriations Act and federal and other law applicable to the use of the funds;

(3) data collection and reporting relating to the programs described by Subsection (a); and

(4) evaluation of services relating to the programs described by Subsection (a).

(e) Subsection (b) does not authorize the Health and Human Services Commission to require a state agency, other than a health and human services agency, to comply with revised provisions derived from Chapter 531, Government Code, as that chapter existed on March 31, 2025, except as specifically provided by Subsection (b). The authority granted under Subsection (b) does not affect Section 301.041, Labor Code.

SECTION 2.76. Section 32.003(1), Human Resources Code, is amended to read as follows:

(1) "Health and human services agencies" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.77. Section 32.021(d), Human Resources Code, is amended to read as follows:

(d) The commission shall include in its contracts for the

delivery of medical assistance by nursing facilities provisions for monetary penalties to be assessed for violations as required by 42 U.S.C. Section 1396r, including without limitation the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, Nursing Home Reform Amendments of 1987, provided that the executive commissioner shall:

(1) provide for an informal dispute resolution process in the commission as provided by Section 526.0202 [~~531.058~~], Government Code; and

(2) develop rules to adjudicate claims in contested cases, including claims unresolved by the informal dispute resolution process of the commission.

SECTION 2.78. Section 32.0212, Human Resources Code, is amended to read as follows:

Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE. Notwithstanding any other law and subject to Sections 540.0502, 540.0701, and 540.0753 [~~Section 533.0025~~], Government Code, the commission shall provide medical assistance for acute care services through the Medicaid managed care system implemented under Chapters 540 and 540A [~~Chapter 533~~], Government Code, or another Medicaid capitated managed care program.

SECTION 2.79. Section 32.0214(b), Human Resources Code, is amended to read as follows:

(b) A recipient who receives medical assistance through a Medicaid managed care model or arrangement under Chapter 540 or 540A [~~533~~], Government Code, as applicable, that requires the designation of a primary care provider shall designate the recipient's primary care provider as required by that model or arrangement.

SECTION 2.80. Section 32.0246, Human Resources Code, is amended to read as follows:

Sec. 32.0246. MEDICAL ASSISTANCE REIMBURSEMENT FOR CERTAIN BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES. (a) In this section, "behavioral health services" has the meaning assigned by

Section 540.0703(a) [~~533.00255(a)~~], Government Code, and includes targeted case management and psychiatric rehabilitation services.

(b) The commission shall provide to a public or private provider of behavioral health services medical assistance reimbursement through a fee-for-service delivery model for behavioral health or physical health services provided to a recipient before that recipient's enrollment with and receipt of medical assistance services through a managed care organization under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

(c) The commission shall ensure that a public or private provider of behavioral health services who is reimbursed under Subsection (b) through a fee-for-service delivery model is provided medical assistance reimbursement through a managed care model for behavioral health or physical health services provided to a recipient after that recipient's enrollment with and receipt of medical assistance services through a managed care organization under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.81. Sections 32.0291(b) and (c), Human Resources Code, are amended to read as follows:

(b) Subject to Sections 544.0104 and 544.0105 and Subchapter G, Chapter 544 [~~Section 531.102~~], Government Code, and notwithstanding any other law, the commission may impose a payment hold on future claims submitted by a provider.

(c) A payment hold authorized by this section is governed by the requirements and procedures specified for a payment hold under Sections 544.0104 and 544.0105 and Subchapter G, Chapter 544 [~~Section 531.102~~], Government Code, including the notice requirements under Section 544.0302 [~~Subsection (g) of that section~~].

SECTION 2.82. Section 32.03115(b), Human Resources Code, as added by Chapters 640 (S.B. 1564) and 1167 (H.B. 3285), Acts of the 86th Legislature, Regular Session, 2019, is amended to read as follows:

(b) Notwithstanding Subchapters E [~~Sections 531.072~~] and F,

Chapter 549 [~~531.073~~], Government Code, or any other law and subject to Subsections (c) and (d), the commission shall provide medical assistance reimbursement for medication-assisted opioid or substance use disorder treatment without requiring a recipient of medical assistance or health care provider to obtain prior authorization or precertification for the treatment.

SECTION 2.83. Section 32.0322(a), Human Resources Code, is amended to read as follows:

(a) The commission or the office of inspector general established under Subchapter C, Chapter 544 [~~Chapter 531~~], Government Code, may obtain from any law enforcement or criminal justice agency the criminal history record information that relates to a provider under the medical assistance program or a person applying to enroll as a provider under the medical assistance program.

SECTION 2.84. Section 32.046(a), Human Resources Code, is amended to read as follows:

(a) The executive commissioner shall adopt rules governing sanctions and penalties that apply to a provider who participates in the vendor drug program or is enrolled as a network pharmacy provider of a managed care organization contracting with the commission under Chapter 540 [~~533~~], Government Code, or its subcontractor and who submits an improper claim for reimbursement under the program.

SECTION 2.85. Section 32.053(b), Human Resources Code, is amended to read as follows:

(b) The executive commissioner shall adopt rules as necessary to implement this section. In adopting rules, the executive commissioner shall:

(1) use the Bienvivir Senior Health Services of El Paso initiative as a model for the program;

(2) ensure that a person is not required to hold a certificate of authority as a health maintenance organization under Chapter 843, Insurance Code, to provide services under the PACE

program;

(3) ensure that participation in the PACE program is available as an alternative to enrollment in a Medicaid managed care plan under Chapter 540 [~~533~~], Government Code, for eligible recipients, including recipients eligible for assistance under both the medical assistance and Medicare programs;

(4) ensure that managed care organizations that contract under Chapter 540 [~~533~~], Government Code, consider the availability of the PACE program when considering whether to refer a recipient to a nursing facility or other long-term care facility; and

(5) establish protocols for the referral of eligible persons to the PACE program.

SECTION 2.86. Section 32.057(c-1), Human Resources Code, is amended to read as follows:

(c-1) A managed care health plan that develops and implements a disease management program under Section 540.0708 [~~533.009~~], Government Code, and a provider of a disease management program under this section shall coordinate during a transition period beneficiary care for patients that move from one disease management program to another program.

SECTION 2.87. Section 32.064(a), Human Resources Code, is amended to read as follows:

(a) To the extent permitted under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), as amended, and any other applicable law or regulations, the executive commissioner shall adopt provisions requiring recipients of medical assistance to share the cost of medical assistance, including provisions requiring recipients to pay:

(1) an enrollment fee;

(2) a deductible; or

(3) coinsurance or a portion of the plan premium, if the recipients receive medical assistance under the Medicaid managed care program under Chapter 540 or 540A [~~533~~], Government

Code, as applicable.

SECTION 2.88. Section 32.0705(a), Human Resources Code, is amended to read as follows:

(a) In this section, "Medicaid contractor" means an entity that:

(1) is not a health and human services agency as defined by Section 521.0001 [~~531.001~~], Government Code; and

(2) under a contract with the commission or otherwise on behalf of the commission, performs one or more administrative services in relation to the commission's operation of Medicaid, such as claims processing, utilization review, client enrollment, provider enrollment, quality monitoring, or payment of claims.

SECTION 2.89. Sections 32.101(3) and (4), Human Resources Code, are amended to read as follows:

(3) "Managed care organization" has the meaning assigned by Section 540.0001 [~~533.001~~], Government Code.

(4) "Managed care plan" has the meaning assigned by Section 540.0001 [~~533.001~~], Government Code.

SECTION 2.90. Section 36.005(a), Human Resources Code, is amended to read as follows:

(a) A health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code:

(1) shall suspend or revoke:

(A) a provider agreement between the agency and a person, other than a person who operates a nursing facility or an ICF-IID, found liable under Section 36.052; and

(B) a permit, license, or certification granted by the agency to a person, other than a person who operates a nursing facility or an ICF-IID, found liable under Section 36.052; and

(2) may suspend or revoke:

(A) a provider agreement between the agency and a person who operates a nursing facility or an ICF-IID and who is found liable under Section 36.052; or

(B) a permit, license, or certification granted by the agency to a person who operates a nursing facility or an ICF-IID and who is found liable under Section 36.052.

SECTION 2.91. Section 40.0025, Human Resources Code, is amended to read as follows:

Sec. 40.0025. AGENCY FUNCTIONS. (a) In this section, "function" includes a power, duty, program, or activity and an administrative support services function associated with the power, duty, program, or activity, unless consolidated under former Section 531.02012, Government Code.

(b) In accordance with former Subchapter A-1, Chapter 531, Government Code, and notwithstanding any other law, the department performs only functions, including the statewide intake of reports and other information, related to the following services:

(1) child protective services, including services that are required by federal law to be provided by this state's child welfare agency;

(2) adult protective services, other than investigations of the alleged abuse, neglect, or exploitation of an elderly person or person with a disability:

(A) in a facility operated, or in a facility or by a person licensed, certified, or registered, by a state agency; or

(B) by a provider that has contracted to provide home and community-based services; and

(3) prevention and early intervention services functions, including:

(A) prevention and early intervention services as defined under Section 265.001, Family Code; and

(B) programs that:

(i) provide parent education;

(ii) promote healthier parent-child relationships; or

(iii) prevent family violence.

SECTION 2.92. Section 40.021(c), Human Resources Code, is

amended to read as follows:

(c) The council shall study and make recommendations to the commissioner regarding the management and operation of the department, including policies and rules governing the delivery of services to persons who are served by the department, the rights and duties of persons who are served or regulated by the department, and the consolidation of the provision of administrative support services as provided by Subchapter E, Chapter 524 [~~Section 531.00553~~], Government Code. The council may not develop policies or rules relating to administrative support services provided by the commission for the department.

SECTION 2.93. Sections 40.0515(d) and (e), Human Resources Code, are amended to read as follows:

(d) A performance review conducted under Subsection (b)(3) is considered a performance evaluation for purposes of Section 40.032(c) of this code or Section 523.0055(b) [~~531.009(c)~~], Government Code, as applicable. The department shall ensure that disciplinary or other corrective action is taken against a supervisor or other managerial employee who is required to conduct a performance evaluation for adult protective services personnel under Section 40.032(c) of this code or Section 523.0055(b) [~~531.009(c)~~], Government Code, as applicable, or a performance review under Subsection (b)(3) and who fails to complete that evaluation or review in a timely manner.

(e) The annual performance evaluation required under Section 40.032(c) of this code or Section 523.0055(b) [~~531.009(c)~~], Government Code, as applicable, of the performance of a supervisor in the adult protective services division must:

(1) be performed by an appropriate program administrator; and

(2) include:

(A) an evaluation of the supervisor with respect to the job performance standards applicable to the supervisor's assigned duties; and

(B) an evaluation of the supervisor with respect to the compliance of employees supervised by the supervisor with the job performance standards applicable to those employees' assigned duties.

SECTION 2.94. Section 48.103(a), Human Resources Code, is amended to read as follows:

(a) Except as otherwise provided by Subsection (c), on determining after an investigation that an elderly person or a person with a disability has been abused, exploited, or neglected by an employee of a home and community support services agency licensed under Chapter 142, Health and Safety Code, the department shall:

(1) notify the state agency responsible for licensing the home and community support services agency of the department's determination;

(2) notify any health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code, that contracts with the home and community support services agency for the delivery of health care services of the department's determination; and

(3) provide to the licensing state agency and any contracting health and human services agency access to the department's records or documents relating to the department's investigation.

SECTION 2.95. Sections 48.251(a)(4), (8), and (9), Human Resources Code, are amended to read as follows:

(4) "Health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

(8) "Managed care organization" has the meaning assigned by Section 540.0001 [~~533.001~~], Government Code.

(9) "Provider" means:

(A) a facility;

(B) a community center, local mental health authority, and local intellectual and developmental disability

authority;

(C) a person who contracts with a health and human services agency or managed care organization to provide home and community-based services;

(D) a person who contracts with a Medicaid managed care organization to provide behavioral health services;

(E) a managed care organization;

(F) an officer, employee, agent, contractor, or subcontractor of a person or entity listed in Paragraphs (A)-(E); and

(G) an employee, fiscal agent, case manager, or service coordinator of an individual employer participating in the consumer-directed service option, as defined by Section 546.0101 [~~531.051~~], Government Code.

SECTION 2.96. Section 48.252(c), Human Resources Code, is amended to read as follows:

(c) The department shall receive and investigate under this subchapter reports of abuse, neglect, or exploitation of an individual who lives in a residence that is owned, operated, or controlled by a provider who provides home and community-based services under the home and community-based services waiver program described by Section 542.0001(11)(B) [~~534.001(11)(B)~~], Government Code, regardless of whether the individual is receiving services under that waiver program from the provider.

SECTION 2.97. Section 48.256(c), Human Resources Code, is amended to read as follows:

(c) A provider of home and community-based services under the home and community-based services waiver program described by Section 542.0001(11)(B) [~~534.001(11)(B)~~], Government Code, shall post in a conspicuous location inside any residence owned, operated, or controlled by the provider in which home and community-based waiver services are provided, a sign that states:

(1) the name, address, and telephone number of the provider;

(2) the effective date of the provider's contract with the applicable health and human services agency to provide home and community-based services; and

(3) the name of the legal entity that contracted with the applicable health and human services agency to provide those services.

SECTION 2.98. Section 48.401(3), Human Resources Code, is amended to read as follows:

(3) "Employee" means a person who:

(A) works for:

(i) an agency; or

(ii) an individual employer participating in the consumer-directed service option, as defined by Section 546.0101 [~~531.051~~], Government Code;

(B) provides personal care services, active treatment, or any other services to an individual receiving agency services, an individual who is a child for whom an investigation is authorized under Section 261.404, Family Code, or an individual receiving services through the consumer-directed service option, as defined by Section 546.0101 [~~531.051~~], Government Code; and

(C) is not licensed by the state to perform the services the person performs for the agency or the individual employer participating in the consumer-directed service option, as defined by Section 546.0101 [~~531.051~~], Government Code.

SECTION 2.99. Section 73.0045, Human Resources Code, is amended to read as follows:

Sec. 73.0045. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner of assistive and rehabilitative services by this chapter or another law conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.100. Section 81.0055, Human Resources Code, is amended to read as follows:

Sec. 81.0055. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner of assistive and rehabilitative services by this chapter, or another law relating to services for persons who are deaf or hard of hearing, conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.101. Section 91.0205, Human Resources Code, is amended to read as follows:

Sec. 91.0205. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this chapter, or another law relating to services for the blind or persons with visual disabilities, conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.102. Section 101A.002, Human Resources Code, is amended to read as follows:

Sec. 101A.002. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF

CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this chapter or another law relating to state services for the aging conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.103. Section 111.0505, Human Resources Code, is amended to read as follows:

Sec. 111.0505. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this chapter, or another law relating to rehabilitation services for individuals with disabilities, conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.104. Section 117.003, Human Resources Code, is amended to read as follows:

Sec. 117.003. SUNSET PROVISION. Unless the commission is continued in existence as provided by Chapter 325, Government Code, after the review required by Section 523.0003 [~~531.004~~], Government Code, this chapter expires on the date the commission is abolished under that section.

SECTION 2.105. Section 117.073, Human Resources Code, is amended to read as follows:

Sec. 117.073. RULES. The executive commissioner may adopt

rules reasonably necessary for the department to administer this chapter, consistent with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.106. Section 121.0014(b), Human Resources Code, is amended to read as follows:

(b) In this section, "health and human services agency" means an agency listed by Section 521.0001(5) [~~531.001(4)~~], Government Code.

SECTION 2.107. Section 122.0057(k), Human Resources Code, is amended to read as follows:

(k) The advisory committee shall provide input to the workforce commission in adopting rules applicable to the program administered under this chapter relating to the employment-first policies described by Sections 546.0003 [~~531.02447~~] and 546.0451 [~~531.02448~~], Government Code.

SECTION 2.108. Section 161.003, Human Resources Code, is amended to read as follows:

Sec. 161.003. SUNSET PROVISION. Unless the commission is continued in existence as provided by Chapter 325, Government Code, after the review required by Section 523.0003 [~~531.004~~], Government Code, this chapter expires on the date the commission is abolished under that section.

SECTION 2.109. Section 161.073, Human Resources Code, is amended to read as follows:

Sec. 161.073. RULES. The executive commissioner may adopt rules reasonably necessary for the department to administer this chapter, consistent with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.110. Section 161.080(e), Human Resources Code, is amended to read as follows:

(e) Notwithstanding Subsection (c), a state supported living center, based on negotiations between the center and a

managed care organization, as defined by Section 540.0001 [~~533.001~~], Government Code, may charge a fee for a service other than the fee provided by the schedule of fees created by the commission under this section.

SECTION 2.111. Sections 161.081(a), (c), and (d), Human Resources Code, are amended to read as follows:

(a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

(c) The department shall ensure that actions taken under Subsection (b) do not conflict with any requirements of the commission under Sections 546.0402(a), (b), and (c) [~~Section 531.0218~~], Government Code.

(d) The department and the commission shall jointly explore the development of uniform licensing and contracting standards that would:

(1) apply to all contracts for the delivery of Section 1915(c) waiver program services;

(2) promote competition among providers of those program services; and

(3) integrate with other department and commission efforts to streamline and unify the administration and delivery of the program services, including those required by this section or Sections 546.0402(a), (b), and (c) [~~Section 531.0218~~], Government Code.

SECTION 2.112. Section 161.082(a), Human Resources Code, is amended to read as follows:

(a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.113. Sections 161.084(a) and (b), Human Resources Code, are amended to read as follows:

(a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 521.0001 [~~531.001~~], Government

Code.

(b) The department, in cooperation with the commission, shall educate the public on:

(1) the availability of home and community-based services under a Medicaid state plan program, including the primary home care and community attendant services programs, and under a Section 1915(c) waiver program; and

(2) the various service delivery options available under the Medicaid program, including the consumer direction models available to recipients under Subchapter C, Chapter 546 [~~Section 531.051~~], Government Code.

SECTION 2.114. Section 161.251(2), Human Resources Code, is amended to read as follows:

(2) "Health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.115. Section 38.254(a), Insurance Code, is amended to read as follows:

(a) Upon request from the commissioner, the Texas Health and Human Services Commission shall provide to the commissioner data, including utilization and cost data, which is related to the mandate being assessed to the population covered by the Medicaid program, including a program administered under Chapter 32, Human Resources Code, and a program administered under Chapter 540 or 540A [~~533~~], Government Code, as applicable, even if the program is not necessarily subject to the mandate.

SECTION 2.116. Section 38.353(d), Insurance Code, is amended to read as follows:

(d) This subchapter does not apply to:

(1) standard health benefit plans provided under Chapter 1507;

(2) children's health benefit plans provided under Chapter 1502;

(3) health care benefits provided under a workers' compensation insurance policy;

(4) Medicaid managed care programs operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(5) Medicaid programs operated under Chapter 32, Human Resources Code; or

(6) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

SECTION 2.117. Section 38.402(7), Insurance Code, is amended to read as follows:

(7) "Payor" means any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:

(A) an insurance company providing health or dental insurance;

(B) the sponsor or administrator of a health or dental plan;

(C) a health maintenance organization operating under Chapter 843;

(D) the state Medicaid program, including the Medicaid managed care program operating under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(E) a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including:

(i) a basic coverage plan under Chapter 1551;

(ii) a basic plan under Chapter 1575; and

(iii) a primary care coverage plan under Chapter 1579; or

(F) any other entity providing a health insurance or health benefit plan subject to regulation by the department.

SECTION 2.118. Section 222.001(a), Insurance Code, is amended to read as follows:

(a) This chapter applies to any insurer, including a group hospital service corporation, any health maintenance organization, and any managed care organization that receives gross premiums or revenues subject to taxation under Section 222.002, including companies operating under Chapter 841, 842, 843, 861, 881, 882, 883, 884, 941, 942, 982, or 984, Insurance Code, Chapter 540 or 540A [~~533~~], Government Code, as applicable, or Title XIX of the federal Social Security Act.

SECTION 2.119. Section 843.010, Insurance Code, is amended to read as follows:

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:

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

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.120. Section 1217.002(d), Insurance Code, is amended to read as follows:

(d) Notwithstanding any other law, this chapter applies to coverage under:

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

(2) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.121. Section 1222.0002(b), Insurance Code, is amended to read as follows:

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group

cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

SECTION 2.122. Section 1301.0041(c), Insurance Code, is amended to read as follows:

(c) This chapter does not apply to:

(1) the child health plan program under Chapter 62, Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.123. Section 1356.002(i), Insurance Code, is amended to read as follows:

(i) To the extent allowed by federal law, this chapter applies to:

(1) the state Medicaid program operated under Chapter

32, Human Resources Code; and

(2) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.124. Section 1367.252, Insurance Code, is amended to read as follows:

Sec. 1367.252. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.251; or

(6) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code.

SECTION 2.125. Section 1369.053, Insurance Code, is amended to read as follows:

Sec. 1369.053. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.052;

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

(7) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.126. Section 1369.212(b), Insurance Code, is amended to read as follows:

(b) Notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to

Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

SECTION 2.127. Section 1369.352, Insurance Code, is amended to read as follows:

Sec. 1369.352. CERTAIN BENEFITS EXCLUDED. This subchapter does not apply to maximum allowable costs for pharmacy benefits provided under:

(1) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the child health plan program under Chapter 62, Health and Safety Code;

(4) the health benefits plan for children under Chapter 63, Health and Safety Code;

(5) a health benefit plan issued under Chapter 1551, 1575, 1579, or 1601; or

(6) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

SECTION 2.128. Section 1369.452(f), Insurance Code, is amended to read as follows:

(f) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, and the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code, shall provide the coverage required under this subchapter to a recipient.

SECTION 2.129. Section 1369.552, Insurance Code, as added by Chapter 1012 (H.B. 1919), Acts of the 87th Legislature, Regular Session, 2021, is amended to read as follows:

Sec. 1369.552. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. Notwithstanding the definition of "health benefit plan" provided by Section 1369.551, this subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

(1) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(2) the child health plan program under Chapter 62, Health and Safety Code;

(3) the TRICARE military health system;

(4) a basic coverage plan under Chapter 1551;

(5) a basic plan under Chapter 1575;

(6) a coverage plan under Chapter 1579;

(7) a plan providing basic coverage under Chapter 1601; or

(8) a workers' compensation insurance policy or other

form of providing medical benefits under Title 5, Labor Code.

SECTION 2.130. Section 1451.109(d), Insurance Code, is amended to read as follows:

(d) This section does not apply to:

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

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

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

(4) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.131. Section 1451.1261(b), Insurance Code, is amended to read as follows:

(b) This section does not apply to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579;

(4) a plan providing basic coverage under Chapter 1601;

(5) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code; or

(6) the child health plan program under Chapter 62, Health and Safety Code.

SECTION 2.132. Section 1451.451(a), Insurance Code, is amended to read as follows:

(a) An insurance company, health maintenance organization, or preferred provider organization that contracts with a health care provider to provide services in connection with Chapter 540 or 540A [~~533~~], Government Code, as applicable, or Chapter 62, Health

and Safety Code, may not require the health care provider to provide access to or transfer the provider's name and contracted discounted fee for use with health benefit plans issued to individuals and groups under Chapter 1271 or 1301.

SECTION 2.133. Section 1451.503, Insurance Code, is amended to read as follows:

Sec. 1451.503. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1451.502;

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

under Chapter 63, Health and Safety Code; or

(7) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.134. Section 1456.002(c), Insurance Code, is amended to read as follows:

(c) This chapter does not apply to:

(1) Medicaid managed care programs operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) Medicaid programs operated under Chapter 32, Human Resources Code; or

(3) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

SECTION 2.135. Section 1460.002, Insurance Code, is amended to read as follows:

Sec. 1460.002. EXEMPTION. This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

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

(4) a Medicare supplement benefit plan, as defined by Chapter 1652.

SECTION 2.136. Section 1510.003(b), Insurance Code, is amended to read as follows:

(b) The pool may not be used to expand the Medicaid program, including the program administered under Chapter 32, Human Resources Code, and the program administered under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.137. Section 1660.003(b), Insurance Code, is amended to read as follows:

(b) This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the state child health plan or any similar plan operated under Chapter 62 or 63, Health and Safety Code; or

(4) a health benefit plan offered by an insurer or health maintenance organization that provides coverage only for dental services.

SECTION 2.138. Section 1661.003, Insurance Code, is amended to read as follows:

Sec. 1661.003. EXCEPTIONS. This chapter does not apply to:

(1) a health benefit plan that provides coverage only:

(A) for a specified disease or diseases or under a limited benefit policy;

(B) for accidental death or dismemberment;

(C) as a supplement to a liability insurance policy; or

(D) for dental or vision care;

(2) disability income insurance coverage;

(3) credit insurance coverage;

(4) a hospital confinement indemnity policy;

(5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(6) a workers' compensation insurance policy;

(7) medical payment insurance coverage provided under a motor vehicle insurance policy;

(8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section;

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

under Chapter 63, Health and Safety Code; or

(10) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.139. Section 4201.053(b), Insurance Code, is amended to read as follows:

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to:

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

(2) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under Chapter 1551;

(3) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 or 1579;

(4) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter 1601; and

(5) a managed care organization providing a Medicaid managed care plan under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.140. Section 4201.652, Insurance Code, is amended to read as follows:

Sec. 4201.652. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843, except that this subchapter does not apply to:

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

(B) the state Medicaid program, including the Medicaid managed care program operated under Chapter 540 or 540A

[~~533~~], Government Code, as applicable;

(2) a preferred provider benefit plan or exclusive provider benefit plan offered by an insurer under Chapter 1301; and

(3) a person who contracts with a health maintenance organization or insurer to issue preauthorization determinations or perform the functions described in this subchapter for a health benefit plan to which this subchapter applies.

SECTION 2.141. Section 310.005(b), Labor Code, is amended to read as follows:

(b) In addition to providing referrals to child-care and early childhood education services, the network, through its members, shall provide:

(1) referrals to available support services, including:

(A) parenting education classes; and

(B) services for parents or children offered by health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, or otherwise available in the community; and

(2) information for consumers of child-care and early childhood education services, including:

(A) information regarding early childhood development;

(B) criteria for identifying quality child-care and early childhood education services that support the healthy development of children; and

(C) other information that will assist consumers in making informed and effective choices regarding child-care and early childhood education services.

SECTION 2.142. Sections 352.105(b) and (c), Labor Code, are amended to read as follows:

(b) The training program must provide employees with information regarding:

(1) supports and services available from health and

human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, for:

(A) youth with disabilities who are transitioning into post-schooling activities, services for adults, or community living; and

(B) adults with disabilities;

(2) community resources available to improve the quality of life for:

(A) youth with disabilities who are transitioning into post-schooling activities, services for adults, or community living; and

(B) adults with disabilities; and

(3) other available resources that may remove transitional barriers for youth with disabilities who are transitioning into post-schooling activities, services for adults, or community living.

(c) In developing the training program required by this section, the commission shall collaborate with health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, as necessary.

SECTION 2.143. Section 118.022(d), Local Government Code, is amended to read as follows:

(d) The comptroller shall deposit the money received under Subsection (a)(3) in the Texas Home Visiting Program trust fund under Section 523.0306 [~~531.287~~], Government Code.

SECTION 2.144. Section 157.101(g), Occupations Code, is amended to read as follows:

(g) In this section, "federally qualified health center" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(B) [~~531.02192, Government Code~~].

REPEALER

SECTION 3.01. The following laws are repealed:

(1) Sections 531.021 through 531.083 and Sections 531.0841 through 531.0999, Government Code;

(2) Subchapters A, C, D, D-1, E, F, G, G-1, H, I, J, J-1, L, M, M-1, N, O, S, U, V, W, and X, Chapter 531, Government Code; and

(3) Chapters 533, 534, 535, 536, 537, 538, 539, and 541, Government Code.

GENERAL MATTERS

SECTION 4.01. This Act is enacted under Section 43, Article III, Texas Constitution. This Act is intended as a recodification only, and no substantive change in the law is intended by this Act.

SECTION 4.02. This Act takes effect April 1, 2025.

# APPENDIX B

## CHAPTER 311. CODE CONSTRUCTION ACT

(current as of end of 87th Legislature, Regular Session, 2021)

### SUBCHAPTER A. GENERAL PROVISIONS

Sec. 311.001. SHORT TITLE. This chapter may be cited as the Code Construction Act.

Sec. 311.002. APPLICATION. This chapter applies to:

(1) each code enacted by the 60th or a subsequent legislature as part of the state's continuing statutory revision program;

(2) each amendment, repeal, revision, and reenactment of a code or code provision by the 60th or a subsequent legislature;

(3) each repeal of a statute by a code; and

(4) each rule adopted under a code.

Sec. 311.003. RULES NOT EXCLUSIVE. The rules provided in this chapter are not exclusive but are meant to describe and clarify common situations in order to guide the preparation and construction of codes.

Sec. 311.004. CITATION OF CODES. A code may be cited by its name preceded by the specific part concerned. Examples of citations are:

(1) Title 1, Business & Commerce Code;

(2) Chapter 5, Business & Commerce Code;

(3) Section 9.304, Business & Commerce Code;

(4) Section 15.06(a), Business & Commerce Code; and

(5) Section 17.18(b)(1)(B)(ii), Business & Commerce Code.

Sec. 311.005. GENERAL DEFINITIONS. The following definitions apply unless the statute or context in which the word or phrase is used requires a different definition:

(1) "Oath" includes affirmation.

(2) "Person" includes corporation, organization, government or governmental subdivision or agency, business trust, estate, trust, partnership, association, and any other legal

entity.

(3) "Population" means the population shown by the most recent federal decennial census.

(4) "Property" means real and personal property.

(5) "Rule" includes regulation.

(6) "Signed" includes any symbol executed or adopted by a person with present intention to authenticate a writing.

(7) "State," when referring to a part of the United States, includes any state, district, commonwealth, territory, and insular possession of the United States and any area subject to the legislative authority of the United States of America.

(8) "Swear" includes affirm.

(9) "United States" includes a department, bureau, or other agency of the United States of America.

(10) "Week" means seven consecutive days.

(11) "Written" includes any representation of words, letters, symbols, or figures.

(12) "Year" means 12 consecutive months.

(13) "Includes" and "including" are terms of enlargement and not of limitation or exclusive enumeration, and use of the terms does not create a presumption that components not expressed are excluded.

Sec. 311.006. INTERNAL REFERENCES. In a code:

(1) a reference to a title, chapter, or section without further identification is a reference to a title, chapter, or section of the code; and

(2) a reference to a subtitle, subchapter, subsection, subdivision, paragraph, or other numbered or lettered unit without further identification is a reference to a unit of the next larger unit of the code in which the reference appears.

SUBCHAPTER B. CONSTRUCTION OF WORDS AND PHRASES

Sec. 311.011. COMMON AND TECHNICAL USAGE OF WORDS. (a) Words and phrases shall be read in context and construed according to the rules of grammar and common usage.

(b) Words and phrases that have acquired a technical or particular meaning, whether by legislative definition or otherwise, shall be construed accordingly.

Sec. 311.012. TENSE, NUMBER, AND GENDER. (a) Words in the present tense include the future tense.

(b) The singular includes the plural and the plural includes the singular.

(c) Words of one gender include the other genders.

Sec. 311.013. AUTHORITY AND QUORUM OF PUBLIC BODY. (a) A grant of authority to three or more persons as a public body confers the authority on a majority of the number of members fixed by statute.

(b) A quorum of a public body is a majority of the number of members fixed by statute.

Sec. 311.014. COMPUTATION OF TIME. (a) In computing a period of days, the first day is excluded and the last day is included.

(b) If the last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday.

(c) If a number of months is to be computed by counting the months from a particular day, the period ends on the same numerical day in the concluding month as the day of the month from which the computation is begun, unless there are not that many days in the concluding month, in which case the period ends on the last day of that month.

Sec. 311.015. REFERENCE TO A SERIES. If a statute refers to a series of numbers or letters, the first and last numbers or letters are included.

Sec. 311.016. "MAY," "SHALL," "MUST," ETC. The following constructions apply unless the context in which the word or phrase appears necessarily requires a different construction or unless a different construction is expressly provided by statute:

(1) "May" creates discretionary authority or grants

permission or a power.

(2) "Shall" imposes a duty.

(3) "Must" creates or recognizes a condition precedent.

(4) "Is entitled to" creates or recognizes a right.

(5) "May not" imposes a prohibition and is synonymous with "shall not."

(6) "Is not entitled to" negates a right.

(7) "Is not required to" negates a duty or condition precedent.

SUBCHAPTER C. CONSTRUCTION OF STATUTES

Sec. 311.021. INTENTION IN ENACTMENT OF STATUTES. In enacting a statute, it is presumed that:

(1) compliance with the constitutions of this state and the United States is intended;

(2) the entire statute is intended to be effective;

(3) a just and reasonable result is intended;

(4) a result feasible of execution is intended; and

(5) public interest is favored over any private interest.

Sec. 311.022. PROSPECTIVE OPERATION OF STATUTES. A statute is presumed to be prospective in its operation unless expressly made retrospective.

Sec. 311.023. STATUTE CONSTRUCTION AIDS. In construing a statute, whether or not the statute is considered ambiguous on its face, a court may consider among other matters the:

(1) object sought to be attained;

(2) circumstances under which the statute was enacted;

(3) legislative history;

(4) common law or former statutory provisions, including laws on the same or similar subjects;

(5) consequences of a particular construction;

(6) administrative construction of the statute; and

(7) title (caption), preamble, and emergency

provision.

Sec. 311.024. HEADINGS. The heading of a title, subtitle, chapter, subchapter, or section does not limit or expand the meaning of a statute.

Sec. 311.025. IRRECONCILABLE STATUTES AND AMENDMENTS. (a) Except as provided by Section 311.031(d), if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails.

(b) Except as provided by Section 311.031(d), if amendments to the same statute are enacted at the same session of the legislature, one amendment without reference to another, the amendments shall be harmonized, if possible, so that effect may be given to each. If the amendments are irreconcilable, the latest in date of enactment prevails.

(c) In determining whether amendments are irreconcilable, text that is reenacted because of the requirement of Article III, Section 36, of the Texas Constitution is not considered to be irreconcilable with additions or omissions in the same text made by another amendment. Unless clearly indicated to the contrary, an amendment that reenacts text in compliance with that constitutional requirement does not indicate legislative intent that the reenacted text prevail over changes in the same text made by another amendment, regardless of the relative dates of enactment.

(d) In this section, the date of enactment is the date on which the last legislative vote is taken on the bill enacting the statute.

(e) If the journals or other legislative records fail to disclose which of two or more bills in conflict is latest in date of enactment, the date of enactment of the respective bills is considered to be, in order of priority:

(1) the date on which the last presiding officer signed the bill;

(2) the date on which the governor signed the bill; or

(3) the date on which the bill became law by operation

of law.

Sec. 311.026. SPECIAL OR LOCAL PROVISION PREVAILS OVER GENERAL. (a) If a general provision conflicts with a special or local provision, the provisions shall be construed, if possible, so that effect is given to both.

(b) If the conflict between the general provision and the special or local provision is irreconcilable, the special or local provision prevails as an exception to the general provision, unless the general provision is the later enactment and the manifest intent is that the general provision prevail.

Sec. 311.027. STATUTORY REFERENCES. Unless expressly provided otherwise, a reference to any portion of a statute or rule applies to all reenactments, revisions, or amendments of the statute or rule.

Sec. 311.028. UNIFORM CONSTRUCTION OF UNIFORM ACTS. A uniform act included in a code shall be construed to effect its general purpose to make uniform the law of those states that enact it.

Sec. 311.029. ENROLLED BILL CONTROLS. If the language of the enrolled bill version of a statute conflicts with the language of any subsequent printing or reprinting of the statute, the language of the enrolled bill version controls.

Sec. 311.030. REPEAL OF REPEALING STATUTE. The repeal of a repealing statute does not revive the statute originally repealed nor impair the effect of any saving provision in it.

Sec. 311.031. SAVING PROVISIONS. (a) Except as provided by Subsection (b), the reenactment, revision, amendment, or repeal of a statute does not affect:

(1) the prior operation of the statute or any prior action taken under it;

(2) any validation, cure, right, privilege, obligation, or liability previously acquired, accrued, accorded, or incurred under it;

(3) any violation of the statute or any penalty,

forfeiture, or punishment incurred under the statute before its amendment or repeal; or

(4) any investigation, proceeding, or remedy concerning any privilege, obligation, liability, penalty, forfeiture, or punishment; and the investigation, proceeding, or remedy may be instituted, continued, or enforced, and the penalty, forfeiture, or punishment imposed, as if the statute had not been repealed or amended.

(b) If the penalty, forfeiture, or punishment for any offense is reduced by a reenactment, revision, or amendment of a statute, the penalty, forfeiture, or punishment, if not already imposed, shall be imposed according to the statute as amended.

(c) The repeal of a statute by a code does not affect an amendment, revision, or reenactment of the statute by the same legislature that enacted the code. The amendment, revision, or reenactment is preserved and given effect as part of the code provision that revised the statute so amended, revised, or reenacted.

(d) If any provision of a code conflicts with a statute enacted by the same legislature that enacted the code, the statute controls.

Sec. 311.032. SEVERABILITY OF STATUTES. (a) If any statute contains a provision for severability, that provision prevails in interpreting that statute.

(b) If any statute contains a provision for nonseverability, that provision prevails in interpreting that statute.

(c) In a statute that does not contain a provision for severability or nonseverability, if any provision of the statute or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the statute that can be given effect without the invalid provision or application, and to this end the provisions of the statute are severable.

Sec. 311.034. WAIVER OF SOVEREIGN IMMUNITY. In order to preserve the legislature's interest in managing state fiscal matters through the appropriations process, a statute shall not be construed as a waiver of sovereign immunity unless the waiver is effected by clear and unambiguous language. In a statute, the use of "person," as defined by Section 311.005 to include governmental entities, does not indicate legislative intent to waive sovereign immunity unless the context of the statute indicates no other reasonable construction. Statutory prerequisites to a suit, including the provision of notice, are jurisdictional requirements in all suits against a governmental entity.

Sec. 311.035. CONSTRUCTION OF STATUTE OR RULE INVOLVING CRIMINAL OFFENSE OR PENALTY. (a) In this section, "actor" and "element of offense" have the meanings assigned by Section 1.07, Penal Code.

(b) Except as provided by Subsection (c), a statute or rule that creates or defines a criminal offense or penalty shall be construed in favor of the actor if any part of the statute or rule is ambiguous on its face or as applied to the case, including:

(1) an element of offense; or

(2) the penalty to be imposed.

(c) Subsection (b) does not apply to a criminal offense or penalty under the Penal Code or under the Texas Controlled Substances Act.

(d) The ambiguity of a part of a statute or rule to which this section applies is a matter of law to be resolved by the judge.

Sec. 311.036. CONSTRUCTION OF ABORTION STATUTES. (a) A statute that regulates or prohibits abortion may not be construed to repeal any other statute that regulates or prohibits abortion, either wholly or partly, unless the repealing statute explicitly states that it is repealing the other statute.

(b) A statute may not be construed to restrict a political subdivision from regulating or prohibiting abortion in a manner that is at least as stringent as the laws of this state unless the

statute explicitly states that political subdivisions are prohibited from regulating or prohibiting abortion in the manner described by the statute.

(c) Every statute that regulates or prohibits abortion is severable in each of its applications to every person and circumstance. If any statute that regulates or prohibits abortion is found by any court to be unconstitutional, either on its face or as applied, then all applications of that statute that do not violate the United States Constitution and Texas Constitution shall be severed from the unconstitutional applications and shall remain enforceable, notwithstanding any other law, and the statute shall be interpreted as if containing language limiting the statute's application to the persons, group of persons, or circumstances for which the statute's application will not violate the United States Constitution and Texas Constitution.

# APPENDIX C
## DISPOSITION TABLE
## GOVERNMENT CODE

| GOV. CODE | CODE SECTION |
|---|---|
| Ch. 531 | |
| Sec. 531.001(1) | 526.0401 |
| (1-a) | 521.0001 |
| (2) | 521.0001 |
| (3) | 521.0001 |
| (3-a) | 521.0001 |
| (4) | 521.0001 |
| (4-a) | 521.0001 |
| (4-b) | 521.0001 |
| (4-c) | 521.0001 |
| (4-d) | 521.0001 |
| (5) | 526.0401 |
| (6) | 521.0001 |
| (6-a) | 521.0001 |
| (7) | 521.0001 |
| (8) | 521.0001 |
| Sec. 531.0011 | 521.0002 |
| Sec. 531.0012 | 521.0003 |
| Sec. 531.002 | 523.0001 |
| Sec. 531.0025 | 526.0051 |
| Sec. 531.003 | 523.0002 |
| Sec. 531.004 | 523.0003 |
| Sec. 531.005 | 523.0051 |
| Sec. 531.0051(a) (part) | 523.0101 |
| (part) | 523.0102 |
| (b) | 523.0102 |
| (c) | 523.0103 |
| (c-1) | 523.0103 |
| (d) | 523.0105 |
| (e) (part) | 523.0103 |
| (part) | 523.0104 |
| (f) | 523.0106 |
| (g) | 523.0106 |
| (h) | 523.0106 |
| (i) | 523.0107 |
| (j) | 523.0108 |
| (k) | 523.0106 |
| (l) | 523.0109 |
| (m) | 523.0110 |
| Sec. 531.0055(a) (part) | 524.0002 |
| (part) | 524.0004 |
| (part) | 524.0051 |
| (part) | 524.0052 |
| (part) | 524.0101 |
| (b) | 524.0001 |
| (c) | 524.0001 |
| (d) (part) | 524.0001 |
| (part) | 524.0202 |
| (e) (part) | 524.0002 |
| (part) | 524.0151 |
| (f) | 524.0002 |
| (g) | 524.0003 |
| (h) | 524.0004 |
| (i) | (repealed) |
| (j) | 524.0005; 524.0202; 525.0254 |
| (k) | 524.0101 |
| (l) | 524.0151 |
| (m) | 525.0254 |
| Sec. 531.00551 | 524.0152 |
| Sec. 531.00552 | 525.0003 |
| Sec. 531.005522 | 525.0054 |
| Sec. 531.00553(a) | 524.0201 |
| (b) | 524.0202 |
| (c) | 524.0203 |

(d) . . . . . 524.0203
Sec. 531.00554 . . . . . 523.0060
Sec. 531.0056(a) . . . . . 524.0051
(b) . . . . . 524.0051
(c) (part) . . . . . 524.0052
(c) . . . . . 524.0101
(d) . . . . . 524.0101
(e) . . . . . 524.0052
(f) . . . . . 524.0052
(g) . . . . . RN Subch. B 524.0052
Sec. 531.00561 . . . . . 523.0152
Sec. 531.00562 . . . . . 523.0153
Sec. 531.0057 . . . . . 526.0352
Sec. 531.006(a) . . . . . 523.0052; 523.0104
(a-1) (part) . . . . . 523.0052
(part) . . . . . 523.0104
(b) . . . . . 523.0052
(c) . . . . . 523.0052
Sec. 531.007 . . . . . 523.0053
Sec. 531.008(a) . . . . . 523.0151
(b) . . . . . 523.0151
Sec. 531.0081 . . . . . 532.0205
Sec. 531.0082 . . . . . 523.0154
Sec. 531.0083 . . . . . 523.0155
Sec. 531.0084 . . . . . 526.0506
Sec. 531.009(a) . . . . . 523.0054
(b) . . . . . 523.0055
(c) . . . . . 523.0055
(d) . . . . . 523.0057
(e) . . . . . 523.0058
(f) . . . . . 523.0058
(g) . . . . . 523.0058
Sec. 531.010 . . . . . 523.0056
Sec. 531.011(a) . . . . . 523.0251
(b) . . . . . 523.0251
(c) (part) . . . . . 523.0251
(part) . . . . . 523.0254
(d) . . . . . 523.0254
(e) . . . . . 523.0254
(f) . . . . . 523.0254
(g) . . . . . 523.0254
Sec. 531.012(a) . . . . . 523.0201
(b) . . . . . 523.0202
(c) . . . . . 523.0203
(d)(as added 84th Leg., R.S., Ch. 946) . 523.0205
(d)(as added 84th Leg., R.S.,
Ch. 837). . . . . RN 523.0205
Sec. 531.0121 . . . . . 523.0204
Sec. 531.013 . . . . . 526.0009
Sec. 531.014 . . . . . 525.0302
Sec. 531.0141 . . . . . 526.0057
Sec. 531.015 . . . . . 522.0253
Sec. 531.0161 . . . . . 524.0153
Sec. 531.0162(a) . . . . . 525.0252
(b) . . . . . 525.0252
(c) . . . . . 525.0253
(d) . . . . . 525.0253
(e) . . . . . 525.0257
(f) . . . . . 525.0257
(g) . . . . . 532.0156
(h) (part) . . . . . 525.0257
(h) (part) . . . . . 532.0156
Sec. 531.0163 . . . . . 524.0102
Sec. 531.0164 . . . . . 525.0255
Sec. 531.0165(a) . . . . . 522.0201
(b) . . . . . 522.0203
(c) . . . . . 522.0203
(d) . . . . . 522.0204

(e) . . . . . 522.0203
(f) . . . . . 522.0205
(g) . . . . . 522.0206
(h) . . . . . 522.0202
Sec. 531.017 . . . . . 523.0156
Sec. 531.0171 . . . . . 523.0255
Sec. 531.018 . . . . . 522.0051
Sec. 531.019(a) . . . . . 545.0151
(b) (part) . . . . . 545.0152
(part) . . . . . 545.0154
(c) . . . . . 545.0153
(d) . . . . . 545.0154
(e) . . . . . 545.0154
(f) . . . . . 545.0154
(g) . . . . . 545.0154
(h) . . . . . 545.0154
(i) . . . . . 545.0154
Sec. 531.0191 . . . . . 522.0052
Sec. 531.0192 . . . . . 525.0159
Sec. 531.020 . . . . . 532.0054
Sec. 531.021(a) . . . . . 532.0051
(b) . . . . . 532.0051
(b-1) . . . . . 532.0057
(c) . . . . . 532.0057
(d) . . . . . 532.0057
(e) . . . . . 532.0057
(f) . . . . . 532.0057
(g) . . . . . 532.0057
Sec. 531.0211 . . . . . 540.0054
Sec. 531.02111 . . . . . 532.0103
Sec. 531.02113 . . . . . 532.0101
Sec. 531.021135 . . . . . 532.0102
Sec. 531.02114 . . . . . 532.0060
Sec. 531.02115 . . . . . 545.0202
Sec. 531.02118 . . . . . 532.0151
Sec. 531.021182 . . . . . 532.0152
Sec. 531.021191 . . . . . 532.0153
Sec. 531.0212 . . . . . 532.0301
Sec. 531.0213 . . . . . 532.0303
Sec. 531.02131 . . . . . 532.0053
Sec. 531.0214 . . . . . 532.0201
Sec. 531.02141 . . . . . 532.0202
Sec. 531.02142 . . . . . 532.0203
Sec. 531.02143 . . . . . 532.0204
Sec. 531.0215 . . . . . 544.0202
Sec. 531.0216(a) . . . . . 548.0051
(b) . . . . . (repealed)
(c) . . . . . 548.0054
(c-1) . . . . . 548.0054
(d) . . . . . 548.0057
(e) . . . . . (repealed)
(f) . . . . . 548.0056
(g) (part) . . . . . 548.0052
(part) . . . . . 548.0055
(h) . . . . . 548.0055
(i) . . . . . 548.0053
(j) . . . . . 548.0052
Sec. 531.02161 . . . . . 548.0001
Sec. 531.02162 . . . . . 548.0201
Sec. 531.02164(a) . . . . . 548.0251
(b) . . . . . 548.0252
(c) . . . . . 548.0253
(c-1) . . . . . 548.0253
(d) . . . . . 548.0254
(e) . . . . . 548.0255
(f) . . . . . 548.0256
Sec. 531.0217(a) . . . . . 548.0101
(a)(2) . . . . . 548.0202

(b) . . . . . 548.0102
(c) . . . . . 548.0102
(c-1) . . . . . (repealed)
(c-2) . . . . . (repealed)
(c-3) . . . . . (repealed)
(c-4) . . . . . 548.0202
(d) (part) . . . . . 548.0102
(part) . . . . . 548.0104
(part) . . . . . 548.0103
(e) . . . . . 548.0105
(f) . . . . . (repealed)
(g) (part) . . . . . 548.0106
(part) . . . . . 548.0202
(g-1) . . . . . 548.0202
(h) . . . . . 548.0107; 548.0202
(i) . . . . . 548.0108; 548.0202
(i-1) . . . . . (repealed)
(j) . . . . . (repealed)
(k) . . . . . 548.0109; 548.0202
Sec. 531.02171. . . . . 548.0203
Sec. 531.02172(a) . . . . . 548.0151
(b) (part) . . . . . 548.0151
(part) . . . . . 548.0153
(part) . . . . . 548.0152
(c) . . . . . 548.0154
Sec. 531.02174. . . . . 548.0002
Sec. 531.02175(a) . . . . . 548.0301
(b) . . . . . 548.0302
(c) . . . . . 548.0303
(d) . . . . . 548.0303
Sec. 531.0218 . . . . . 546.0402
Sec. 531.02191. . . . . 546.0402
Sec. 531.02192(a) (part) . . . . . 532.0307
(part) . . . . . RN 532.0307
(b) . . . . . 532.0307
Sec. 531.02193. . . . . 532.0154
Sec. 531.02194. . . . . 532.0155
Sec. 531.022(a) . . . . . 525.0154
(b). . . . . 525.0154
(c). . . . . 525.0154
(d). . . . . 525.0154
(e). . . . . 525.0155
Sec. 531.0222 . . . . . 547.0005
Sec. 531.0224 . . . . . 525.0152
Sec. 531.02241(a). . . . . 550.0201
(b) . . . . . 550.0202
(c) . . . . . 550.0204
(d) . . . . . 550.0203
(e) . . . . . 550.0205
(f) . . . . . 550.0203
(g) . . . . . 550.0206
(h) . . . . . 550.0206
(i) . . . . . 550.0202
(j) . . . . . 550.0202
(k) . . . . . 550.0202
(l) . . . . . 550.0207
(m) . . . . . 550.0208
(n) . . . . . 550.0208
(o) . . . . . 550.0209
(p) . . . . . 550.0210
Sec. 531.0225 . . . . . 547.0001
Sec. 531.02251 . . . . . 547.0002
Sec. 531.02253. . . . . 548.0401
Sec. 531.0226 . . . . . 532.0352
Sec. 531.0227 . . . . . 524.0154
Sec. 531.023. . . . . 525.0156
Sec. 531.024(a) (part). . . . . 525.0151
(a) (part) . . . . . 525.0256

(a) (part) . . . . . 532.0302
(a-1) . . . . . 522.0101
(b) . . . . . 532.0302
(c) . . . . . 532.0302
Sec. 531.0241 . . . . . 525.0158
Sec. 531.02411 . . . . . 532.0052
Sec. 531.024115 . . . . . 545.0053
Sec. 531.02412 . . . . . 532.0055
Sec. 531.02413(a) (part) . . . . . 532.0058
(a) (part) . . . . . RN 532.0058
(a-1) . . . . . 532.0058
(b) . . . . . 532.0058
(c) . . . . . 532.0058
(d) . . . . . 532.0058
(e) . . . . . 532.0058
Sec. 531.024131 . . . . . 545.0052
Sec. 531.02414(a) . . . . . 526.0351
(a-1) . . . . . 526.0353
(b) . . . . . 526.0354
(c) . . . . . 526.0354
(d) . . . . . 526.0355
(e) . . . . . 526.0356
(f) . . . . . 526.0356
(g) . . . . . 526.0357
(h) . . . . . 526.0357
(i) . . . . . 526.0359
(j) . . . . . 526.0358
(k) . . . . . 526.0358
(l) . . . . . 526.0358
(m) . . . . . 526.0360
Sec. 531.02415 . . . . . RN Subch. C 545.0104
Sec. 531.024161 . . . . . 545.0203
Sec. 531.024162 . . . . . 532.0403
Sec. 531.024163 . . . . . 532.0402
Sec. 531.024164 . . . . . 532.0404
Sec. 531.02417 . . . . . 532.0304
Sec. 531.024171 . . . . . 532.0305
Sec. 531.024172(a) (part) . . . . . 532.0252
(a) (part) . . . . . RN 532.0252
(b) (part) . . . . . 532.0253
(b) (part) . . . . . 532.0254
(c) . . . . . 532.0256
(d) . . . . . 532.0255
(e) . . . . . 532.0255
(f) . . . . . 532.0257
(g) . . . . . 532.0258
(g-1) . . . . . 532.0258
(g-2) . . . . . 532.0258
(h) . . . . . 532.0259
(i) . . . . . 532.0260
Sec. 531.02418 . . . . . 545.0101
Sec. 531.024181 . . . . . 545.0102
Sec. 531.024182 . . . . . 545.0103
Sec. 531.0242 . . . . . 523.0059
Sec. 531.0244 . . . . . 546.0052
Sec. 531.02442(a)(1) . . . . . RN(1) 546.0054
(1-a) . . . . . 546.0054
(2) . . . . . RN(3) 546.0054
(3) . . . . . RN(4) 546.0054
(b) . . . . . 546.0054
(c) . . . . . 546.0054
(d) . . . . . 546.0054
(e) . . . . . 546.0054
Sec. 531.02443(a)(1) . . . . . 546.0055
(2) . . . . . RN(1) 546.0055
(3) . . . . . RN(2) 546.0055
(4) . . . . . RN(3) 546.0055
(5) . . . . . 546.0055

(b) . . . . . 546.0055
(c) . . . . . 546.0055
(d) . . . . . 546.0055
(e) . . . . . 546.0055
(f) . . . . . 546.0055
Sec. 531.02444 . . . . . 532.0353
Sec. 531.02445 . . . . . 546.0057
Sec. 531.02447 . . . . . 546.0003
Sec. 531.02448 . . . . . 546.0451
Sec. 531.0245(a) . . . . . 546.0204
(b)(1) . . . . . 546.0204
(2) . . . . . RN(1) 546.0204
Sec. 531.0246 . . . . . 525.0002
Sec. 531.0247 . . . . . 525.0153
Sec. 531.0248 . . . . . 525.0160
Sec. 531.02481(a) . . . . . 546.0152
(b) . . . . . 546.0160
(c) . . . . . 546.0155
(d) . . . . . 546.0152
(e) . . . . . 546.0153
(f) (part) . . . . . 546.0154
(part) . . . . . 546.0151
(g) (part) . . . . . 546.0156
(part) . . . . . 546.0157
(part) . . . . . 546.0158
(part) . . . . . 546.0159
Sec. 531.02482(a) . . . . . RN 550.0152
(b) . . . . . 550.0151
(c) . . . . . 550.0151
(d) . . . . . 550.0151
(e) . . . . . 550.0152
Sec. 531.02491 . . . . . 526.0402
Sec. 531.02492 . . . . . 526.0502
Sec. 531.025 . . . . . 525.0157
Sec. 531.027 . . . . . 522.0001
Sec. 531.0271 . . . . . 525.0053
Sec. 531.0273 . . . . . 525.0251
Sec. 531.02731 . . . . . 526.0010
Sec. 531.0274 . . . . . 526.0403
Sec. 531.028 . . . . . 525.0052
Sec. 531.031 . . . . . 525.0051
Sec. 531.0312 . . . . . 526.0004
Sec. 531.0313(a) . . . . . 526.0005
(b) . . . . . 526.0005
(c) . . . . . 526.0005
(d) . . . . . 526.0005
(e) . . . . . RN 526.0005
Sec. 531.03131 . . . . . 526.0006
Sec. 531.03132 . . . . . 526.0007
Sec. 531.0315 . . . . . 526.0008
Sec. 531.0317(a) . . . . . RN(1) 526.0002
(b) . . . . . 526.0002
(c) . . . . . 526.0002
(d) . . . . . 526.0002
(e) . . . . . 526.0002
(f) . . . . . 526.0002
Sec. 531.0318 . . . . . 526.0003
Sec. 531.0319(a) . . . . . 526.0751
(b) . . . . . 526.0753
(c) . . . . . 526.0752
Sec. 531.032 . . . . . 523.0004
Sec. 531.033 . . . . . 524.0151
Sec. 531.0335 . . . . . 526.0505
Sec. 531.035 . . . . . 525.0004
Sec. 531.036 . . . . . 523.0252
Sec. 531.037 . . . . . 523.0253
Sec. 531.038 . . . . . 525.0055
Sec. 531.0381 . . . . . 522.0002

Sec. 531.039 . . . . . 525.0101
Sec. 531.0391 . . . . . 525.0102
Sec. 531.0392 . . . . . 532.0059
Sec. 531.040 . . . . . 525.0301
Sec. 531.041 . . . . . 525.0001
Sec. 531.0411 . . . . . 526.0058
Sec. 531.042 . . . . . 546.0053
Sec. 531.043 . . . . . 546.0002
Sec. 531.044 . . . . . 545.0057
Sec. 531.047 . . . . . 526.0501
Sec. 531.048 . . . . . 526.0401
Sec. 531.050 . . . . . 545.0055
Sec. 531.0501(a) . . . . . (expired)
(b) . . . . . (expired)
(c) . . . . . (expired)
(d) . . . . . 546.0453
Sec. 531.051(a) . . . . . 546.0101
(b) . . . . . 546.0102
(c) . . . . . 546.0103
(d) . . . . . 546.0102
(e) . . . . . 546.0104
(f) . . . . . 546.0105
Sec. 531.0511 . . . . . 546.0502
Sec. 531.0512 . . . . . 546.0106
Sec. 531.0515 . . . . . 546.0452
Sec. 531.053 . . . . . 522.0251
Sec. 531.054 . . . . . 522.0252
Sec. 531.055(a) (part) . . . . . 522.0152
(part) . . . . . 522.0153
(part) . . . . . 522.0154
(b) . . . . . 522.0155
(c) . . . . . 522.0154
(d) . . . . . 522.0156
(e) . . . . . 522.0157
(f) . . . . . 522.0151
Sec. 531.056 . . . . . 546.0301
Sec. 531.057(a) . . . . . 546.0601
(c) . . . . . 546.0602
(d) . . . . . 546.0603
(e) . . . . . 546.0604
(f) . . . . . 546.0604
(g) . . . . . 546.0605
Sec. 531.058 . . . . . 526.0202
Sec. 531.0581(a)(1) . . . . . 526.0201
(2) . . . . . 526.0203; 526.0204
(b) . . . . . 526.0203
(c) . . . . . 526.0203
(d) . . . . . 526.0203
(e) . . . . . 526.0203
(f) . . . . . 526.0203
(g) . . . . . 526.0204
(h) . . . . . 526.0204
(i) . . . . . 526.0203
Sec. 531.0585 . . . . . 546.0302
Sec. 531.059 . . . . . 546.0056
Sec. 531.060(a) . . . . . 546.0252
(b) . . . . . 546.0252
(c) . . . . . 546.0251
(d) . . . . . 546.0255
(e) . . . . . 546.0255
(f) . . . . . 546.0252
(g) (part) . . . . . 546.0257
(part) . . . . . 546.0258
(h) . . . . . 546.0252
(i) . . . . . 546.0253
(j) . . . . . 546.0253
(k) . . . . . 546.0256
(l) . . . . . 546.0259

(m) . . . . . 546.0253
(n) . . . . . 546.0254
(o) . . . . . 546.0260
Sec. 531.0601 . . . . . 546.0455
Sec. 531.06011 . . . . . 546.0454
Sec. 531.0602 . . . . . 546.0503
Sec. 531.06021(a) . . . . . 546.0504
(b) . . . . . 546.0505
Sec. 531.0603 . . . . . 546.0456
Sec. 531.0604 . . . . . 546.0501
Sec. 531.0605(a) . . . . . 546.0652
(b) . . . . . 546.0653
(c) . . . . . 546.0654
(d) . . . . . 546.0655
Sec. 531.061 . . . . . 526.0504
Sec. 531.062 . . . . . 532.0206
Sec. 531.063 . . . . . 545.0104
Sec. 531.064 . . . . . 526.0053
Sec. 531.066 . . . . . 545.0204
Sec. 531.067 . . . . . 545.0054
Sec. 531.069 . . . . . 549.0051
Sec. 531.0693 . . . . . 549.0052
Sec. 531.0694 . . . . . 549.0003
Sec. 531.0696 . . . . . 526.0059
Sec. 531.0697 . . . . . 549.0005
Sec. 531.070(a) . . . . . 549.0101
(b) . . . . . 549.0101
(c) . . . . . 549.0106
(d) . . . . . 549.0106
(e) . . . . . 549.0108
(f) . . . . . 549.0107
(g) . . . . . 549.0106
(h) . . . . . 549.0102
(i) . . . . . 549.0102
(j) . . . . . 549.0103
(k) . . . . . 549.0104
(l) . . . . . (repealed)
(m) . . . . . 549.0104
(n) . . . . . 549.0105
Sec. 531.0701 . . . . . 549.0002
Sec. 531.071(a) . . . . . 549.0151
(b) . . . . . 549.0151
(c) . . . . . 549.0152
(d) . . . . . 549.0153
Sec. 531.072(a) (part) . . . . . 549.0202
(part) . . . . . 549.0203
(b) . . . . . 549.0204
(b-1) . . . . . 549.0204
(b-2) . . . . . 549.0205
(c) . . . . . 549.0205
(c-1) . . . . . 549.0205
(d) . . . . . 549.0207
(e) (part) . . . . . 549.0206
(part) . . . . . 549.0310
(f) . . . . . 549.0260
Sec. 531.073(a) . . . . . 549.0251
(a-1) . . . . . 549.0255
(a-2) . . . . . 549.0256
(a-3) . . . . . 549.0253
(a-4) . . . . . 549.0253
(a-5) . . . . . 549.0258
(b) . . . . . 549.0257
(c) . . . . . 549.0259
(d) . . . . . 549.0257
(e) . . . . . 549.0254
(f) . . . . . 549.0254
(g) . . . . . 549.0257
(h) . . . . . 549.0257

(i) . . . . . .(repealed)
(j) . . . . . .549.0252
Sec. 531.0735(a) . . . . . .549.0351
(b) . . . . . .549.0352
(c) . . . . . .549.0352
(d) . . . . . .549.0353
(e) . . . . . .549.0353
(f) . . . . . .549.0353
Sec. 531.0736(a) . . . . . .549.0301
(b) . . . . . .549.0309
(b) (part) . . . . . 549.0310; 549.0311
(c) . . . . . .549.0302
(c-1) . . . . . .549.0302
(d) . . . . . .549.0310
(e) . . . . . .549.0304
(f) . . . . . .549.0305
(g) . . . . . .549.0310
(h) . . . . . .549.0309
(i) . . . . . .549.0308
(j) . . . . . .549.0311
(k) . . . . . .549.0309
(l) . . . . . .549.0307
(m) . . . . . .549.0306
(n) . . . . . .549.0312
Sec. 531.0737 . . . . . .549.0303
Sec. 531.0741 . . . . . .549.0207
Sec. 531.075 . . . . . .526.0054
Sec. 531.076 . . . . . .532.0401
Sec. 531.077 . . . . . .546.0403
Sec. 531.078 . . . . . .546.0551
Sec. 531.079 . . . . . .546.0552
Sec. 531.080 . . . . . .546.0553
Sec. 531.081 . . . . . .546.0554
Sec. 531.082 . . . . . .546.0555
Sec. 531.083 . . . . . .546.0401
Sec. 531.0841 . . . . . .546.0004
Sec. 531.0843(a) . . . . . .532.0455
(b) . . . . . .532.0455
(c) . . . . . .532.0455
(d) . . . . . .532.0455
(e) . . . . . RN 532.0455
Sec. 531.085 . . . . . .532.0451
Sec. 531.0861 . . . . . .532.0452
Sec. 531.0862 . . . . . .532.0453
Sec. 531.087 . . . . . .545.0056
Sec. 531.088 . . . . . .526.0503
Sec. 531.089 . . . . . .549.0004
Sec. 531.090 . . . . . .549.0001
Sec. 531.091 . . . . . .545.0051
Sec. 531.092 . . . . . .546.0058
Sec. 531.0925(a) . . . . . .547.0004
(b) . . . . . .547.0004
(c) (part) . . . . . .547.0004
(part) . . . . . RN(2) 547.0004
(d) . . . . . .547.0004
(e) . . . . . .547.0004
Sec. 531.093 . . . . . .526.0601
Sec. 531.0931 . . . . . .526.0602
Sec. 531.0941 . . . . . .532.0454
Sec. 531.097 . . . . . .532.0351
Sec. 531.0971 . . . . . .526.0055
Sec. 531.0972 . . . . . .526.0056
Sec. 531.0973 . . . . . .526.0404
Sec. 531.0981 . . . . . .532.0306
Sec. 531.099 . . . . . .532.0061
Sec. 531.0991(a) . . . . . .547.0252
(b) . . . . . .547.0253
(c) . . . . . .547.0257

(d) . . . . . 547.0256
(e) . . . . . 547.0254
(f) . . . . . 547.0255
(g) . . . . . 547.0253
(h) . . . . . 547.0253
(i) . . . . . 547.0257
(j) . . . . . 547.0257
(k) . . . . . 547.0259
(l) . . . . . 547.0258
(m) . . . . . 547.0201
(n) . . . . . 547.0257
Sec. 531.0992(a) . . . . . 547.0302
(b) . . . . . (repealed)
(c) . . . . . 547.0303
(d) . . . . . 547.0308
(d-1) . . . . . 547.0304
(d-2) . . . . . 547.0305
(e) . . . . . 547.0307
(f) . . . . . 547.0306
(g) . . . . . 547.0308
(h) . . . . . 547.0309
Sec. 531.0993(a) . . . . . 547.0352
(b) . . . . . 547.0354
(c) . . . . . 547.0353
(c-1) . . . . . 547.0353
(c-2) . . . . . 547.0360
(d) . . . . . 547.0355
(e) . . . . . 547.0356
(f) . . . . . 547.0357
(f-1) . . . . . 547.0360
(g) . . . . . 547.0358
(h) . . . . . 547.0359
(i) . . . . . 547.0354
(j) . . . . . 547.0360
Sec. 531.09935(a) . . . . . 547.0402
(b) . . . . . 547.0404
(c) . . . . . 547.0405
(d) . . . . . 547.0403
(e) . . . . . 547.0403
(f) . . . . . 547.0406
(g) . . . . . 547.0407
(h) . . . . . 547.0408
Sec. 531.0994 . . . . . 525.0303
Sec. 531.0995 . . . . . 526.0052
Sec. 531.0998 . . . . . 526.0603
Sec. 531.0999(a) . . . . . 547.0003
(b) . . . . . RN 547.0003
(c) . . . . . RN 547.0003
(d) . . . . . RN 547.0003
(e) . . . . . RN 547.0003
(f) . . . . . 547.0003
Sec. 531.101 . . . . . 544.0205
Sec. 531.1011 . . . . . 544.0001
Sec. 531.1011 (part) . . . . . 544.0151
Sec. 531.102(a) . . . . . 544.0103
(a-1) . . . . . 544.0101
(a-2) . . . . . 544.0102
(a-3) . . . . . 544.0102
(a-4) . . . . . 544.0102
(a-5) . . . . . 544.0103
(a-6) . . . . . 544.0103
(a-7) . . . . . 544.0102
(a-8) . . . . . 544.0102
(b) . . . . . 544.0102
(c) . . . . . 544.0102
(d) . . . . . 544.0102
(e) . . . . . 544.0251
(f)(1) . . . . . 544.0252

(2) . . . . . 544.0254
(f-1) . . . . . 544.0257
(g)(1) . . . . . 544.0255
(2) (part) . . . . . 544.0301
(part) . . . . . 544.0302
(3) . . . . . 544.0303
(4) . . . . . 544.0303
(5) . . . . . 544.0303
(6) . . . . . 544.0304
(7) . . . . . 544.0113
(7-a) . . . . . 544.0301
(8) . . . . . 544.0301
(9) . . . . . 544.0301
(h) . . . . . 544.0103
(i) . . . . . 544.0002
(j) . . . . . 544.0110
(k) . . . . . 544.0110
(l) . . . . . 544.0104
(m) . . . . . 544.0105
(m-1) . . . . . 544.0106
(m-2) . . . . . 544.0106
(n) . . . . . 544.0102
(o) . . . . . 544.0003
(p) . . . . . 544.0102
(q) . . . . . 544.0109
(r) . . . . . 544.0108
(s) . . . . . 544.0108
(t) . . . . . 544.0114
(u) . . . . . 544.0114
(v) . . . . . 544.0109
(w) . . . . . 544.0109
(x) . . . . . 544.0052
Sec. 531.1021 . . . . . 544.0259
Sec. 531.1022 . . . . . 544.0107
Sec. 531.1023 . . . . . 544.0111
Sec. 531.1024 . . . . . 544.0112
Sec. 531.1025 . . . . . 544.0109
Sec. 531.103 . . . . . 544.0051
Sec. 531.1031(a)(1) . . . . . 544.0151
(1-a) . . . . . 544.0151
(1-b) . . . . . 544.0151
(1-c) . . . . . RN 544.0151
(2) . . . . . 544.0151
(3) . . . . . 544.0151
(b) . . . . . 544.0152
(c) . . . . . 544.0152
(c-1) . . . . . 544.0152
(d) . . . . . 544.0152
(e) . . . . . 544.0152
(f) . . . . . 544.0152
(g) . . . . . 544.0152
(h) . . . . . 544.0152
Sec. 531.1032(a) . . . . . 544.0153
(b) . . . . . 544.0153
(c) (as added 84th Leg., R.S., Ch. 945) . . . . . 544.0153
(c) (as added 84th Leg., R.S., Ch. 837) . . . . . RN(1) 544.0153
(d) . . . . . 544.0153
(e) . . . . . 544.0153
(f) . . . . . 544.0153
Sec. 531.1033 . . . . . 544.0154
Sec. 531.1034 . . . . . 544.0155
Sec. 531.104 . . . . . 544.0258
Sec. 531.105(a) . . . . . 544.0203
(b) . . . . . 544.0204
Sec. 531.106 . . . . . 544.0451
Sec. 531.1061 . . . . . 544.0452

Sec. 531.1062 . . . . . 544.0501
Sec. 531.108 . . . . . 544.0202
Sec. 531.1081 . . . . . 544.0456
Sec. 531.109 . . . . . 544.0201
Sec. 531.110 . . . . . 544.0455
Sec. 531.111 . . . . . 544.0453
Sec. 531.1112 . . . . . RN Subch. J 544.0456
Sec. 531.112 . . . . . 544.0056
Sec. 531.113(a) (part) . . . . . 544.0351
(part) . . . . . 544.0352
(b) . . . . . 544.0353
(c) . . . . . 544.0352
(d) . . . . . 544.0354
(d-1) . . . . . 544.0354
(e) . . . . . 544.0355
Sec. 531.1131 . . . . . 544.0502
Sec. 531.1132 . . . . . 544.0505
Sec. 531.1135 . . . . . 544.0503
Sec. 531.114(a) (part) . . . . . 544.0401
(part) . . . . . 544.0402
(b) . . . . . 544.0403
(c) . . . . . 544.0404
(d) . . . . . 544.0404
(e) . . . . . 544.0404
(f) . . . . . 544.0405
(g) . . . . . 544.0406
Sec. 531.115 . . . . . 544.0454
Sec. 531.116 . . . . . 545.0201
Sec. 531.117 . . . . . 544.0504
Sec. 531.118(a) . . . . . 544.0054
(b) . . . . . 544.0252
(c) . . . . . 544.0253
(d) . . . . . 544.0256
(e) . . . . . 544.0256
(f) . . . . . 544.0256
Sec. 531.119 . . . . . 544.0305
Sec. 531.120 . . . . . 544.0506
Sec. 531.1201 . . . . . 544.0507
Sec. 531.1202 . . . . . 544.0055
Sec. 531.1203 . . . . . 544.0053
Sec. 531.121 . . . . . 526.0651
Sec. 531.124 . . . . . 526.0652
Sec. 531.125 . . . . . 526.0653
Sec. 531.151 . . . . . 546.0201
Sec. 531.152 . . . . . 546.0202
Sec. 531.1521 . . . . . 546.0208
Sec. 531.153 . . . . . 546.0203
Sec. 531.1531 . . . . . 546.0205
Sec. 531.1532 . . . . . 546.0214
Sec. 531.1533 . . . . . 546.0209
Sec. 531.154 . . . . . 546.0211
Sec. 531.155 . . . . . 546.0212
Sec. 531.156 . . . . . 546.0207
Sec. 531.157 . . . . . 546.0213
Sec. 531.158 . . . . . 546.0206
Sec. 531.159(a) . . . . . 546.0222
(b) . . . . . 546.0215
(c) . . . . . 546.0215
(d) . . . . . 546.0215
(e) . . . . . 546.0216
(f) (part) . . . . . 546.0217
(part) . . . . . RN 546.0217
Sec. 531.1591 . . . . . 546.0218
Sec. 531.160 . . . . . 546.0220
Sec. 531.161 . . . . . 546.0223
Sec. 531.162 . . . . . 546.0225
Sec. 531.163 . . . . . 546.0226
Sec. 531.164 . . . . . 546.0210

Sec. 531.165 . . . . . 546.0221
Sec. 531.166 . . . . . 546.0219
Sec. 531.167 . . . . . 546.0224
Sec. 531.171(a) . . . . . 524.0251
(b) . . . . . 524.0252
Sec. 531.191(a) (part) . . . . . 545.0002
(part) . . . . . 545.0005
(b) (part) . . . . . 545.0002
(part) . . . . . 545.0006
(c) . . . . . 545.0003
(d) . . . . . 545.0004
(e) . . . . . 545.0005
(f) . . . . . 545.0006
Sec. 531.201(a) . . . . . 526.0301
(b) . . . . . 526.0301
(c) . . . . . RN 526.0301
(d) . . . . . 526.0301
Sec. 531.202 . . . . . 526.0302
Sec. 531.203 . . . . . 526.0303
Sec. 531.251(a) . . . . . 547.0051
(b) . . . . . 547.0052
(c) . . . . . 547.0052
Sec. 531.255 . . . . . 547.0053
Sec. 531.257 . . . . . 547.0054
Sec. 531.281 . . . . . 523.0301
Sec. 531.282 . . . . . 523.0302
Sec. 531.283 . . . . . 523.0303
Sec. 531.284 . . . . . 523.0304
Sec. 531.285 . . . . . 523.0305
Sec. 531.287 . . . . . 523.0306
Sec. 531.301(a) . . . . . 549.0451
(b) . . . . . 549.0452
(c) . . . . . 549.0455
Sec. 531.302 . . . . . 549.0453
Sec. 531.303 . . . . . 549.0454
Sec. 531.304 . . . . . 549.0455
Sec. 531.351 . . . . . 549.0401
Sec. 531.352 . . . . . 549.0402
Sec. 531.353 . . . . . 549.0403
Sec. 531.381 . . . . . 526.0701
Sec. 531.382 . . . . . 526.0702
Sec. 531.383 . . . . . 526.0703
Sec. 531.384 . . . . . 526.0704
Sec. 531.385 . . . . . 526.0705
Sec. 531.421 . . . . . 547.0101
Sec. 531.422 . . . . . 547.0102
Sec. 531.423 . . . . . 547.0103
Sec. 531.424 . . . . . 547.0104
Sec. 531.451 . . . . . 526.0102
Sec. 531.452 . . . . . 526.0103
Sec. 531.453 . . . . . 526.0104
Sec. 531.471 . . . . . 547.0151
Sec. 531.472 . . . . . 547.0152
Sec. 531.473 . . . . . 547.0153
Sec. 531.474 . . . . . 547.0154
Sec. 531.475 . . . . . 547.0155
Sec. 531.476 . . . . . 547.0156
Sec. 531.477 . . . . . 547.0157
Sec. 531.501 . . . . . 526.0151
Sec. 531.502 . . . . . 526.0152
Sec. 531.503 . . . . . 526.0153
Sec. 531.504 . . . . . 526.0154
Sec. 531.505 . . . . . 526.0155
Sec. 531.506 . . . . . 526.0156
Sec. 531.507 . . . . . 526.0157
Sec. 531.508 . . . . . 526.0158
Sec. 531.551(a) . . . . . 526.0251
(b) . . . . . 526.0251

(c) . . . . . 526.0252
(d) . . . . . 526.0253
(e) . . . . . 526.0254
(f) . . . . . 526.0255
(g) (part) . . . . . 526.0256
(part) . . . . . 526.0257
(h) . . . . . 526.0258
(i) . . . . . 526.0257
(j) . . . . . 526.0259
(k) . . . . . 526.0259
(l) . . . . . 526.0260
Sec. 531.751(1) . . . . . RN 550.0251
(2) . . . . . 550.0251
Sec. 531.752 . . . . . 550.0252
Sec. 531.753 . . . . . 550.0253
Sec. 531.754 . . . . . 550.0254
Sec. 531.755 . . . . . 550.0255
Sec. 531.8501 . . . . . 546.0701
Sec. 531.851 . . . . . 546.0702
Sec. 531.852 . . . . . 546.0703
Sec. 531.853 . . . . . 546.0704
Sec. 531.854 . . . . . 546.0705
Sec. 531.855 . . . . . 546.0706
Sec. 531.901(1) . . . . . 525.0201
(2) . . . . . 525.0201
(3) . . . . . 525.0201
(4) . . . . . RN(2) 525.0201
Sec. 531.903(a) . . . . . 525.0202
(b) . . . . . 525.0202
(c) . . . . . 525.0203
(d) . . . . . 525.0202
Sec. 531.9051 . . . . . 525.0204
Sec. 531.906 . . . . . 525.0205
Sec. 531.907 . . . . . 525.0206
Sec. 531.908 . . . . . 525.0207
Sec. 531.909 . . . . . 525.0208
Sec. 531.911 . . . . . 525.0209
Sec. 531.912(a) . . . . . 546.0351
(b) . . . . . 546.0352
(c) . . . . . 546.0353
(d) . . . . . 546.0353
(e) . . . . . 546.0352
(f) . . . . . 546.0354
Sec. 531.951 . . . . . 526.0451
Sec. 531.952 . . . . . 526.0454
Sec. 531.953 . . . . . 526.0453
Sec. 531.954 . . . . . 526.0452
Sec. 531.981 . . . . . 526.0551
Sec. 531.982 . . . . . 526.0553
Sec. 531.983 . . . . . 526.0554
Sec. 531.984 . . . . . 526.0557
Sec. 531.985 . . . . . 526.0555
Sec. 531.986 . . . . . 526.0556
Sec. 531.9871 . . . . . 526.0558
Sec. 531.988 . . . . . 526.0552

Ch. 533

Sec. 533.001(1) . . . . . 540.0001; 540A.0001
(2) . . . . . RN(2) 540.0001; RN(2) 540A.0001
(3) . . . . . RN(2) 540.0001
(4) . . . . . 540.0001
(5) . . . . . 540.0001; 540A.0001
(6) . . . . . 540.0001; 540A.0001
(7) . . . . . 540.0001
Sec. 533.002 . . . . . 540.0051
Sec. 533.0025(a) . . . . . (repealed)
(b) . . . . . 540.0701
(c) . . . . . 540.0701
(d) . . . . . 540.0701

(e) . . . . . 540.0701
(f) . . . . . (expired)
(g) . . . . . (expired)
(h) . . . . . 540.0502
(i) . . . . . 540.0753
Sec. 533.00251(a) (part) . . . . . 540.0001
(part) . . . . . 540.0752
(b) . . . . . 540.0751
(c) . . . . . 540.0752
(d) . . . . . (expired)
(e) . . . . . 540.0752
(f) . . . . . 540.0752
(g) . . . . . (expired)
(h) . . . . . 540.0752
Sec. 533.00253(a)(3) . . . . . 540.0001
(2) . . . . . 540.0851
(1) . . . . . 540.0852
(b) . . . . . 540.0851
(c) . . . . . 540.0852
(c-1) . . . . . 540.0852
(c-2) . . . . . 540.0852
(d) . . . . . 540.0853
(e) . . . . . 540.0854
(f) . . . . . (expired)
(g) . . . . . (expired)
(h) . . . . . (expired)
(i) . . . . . (expired)
(j) . . . . . (expired)
(k) . . . . . (expired)
(l) . . . . . (expired)
(m) . . . . . (expired)
(n) . . . . . 540.0855
Sec. 533.00255 . . . . . 540.0703
Sec. 533.002551 . . . . . 540.0212
Sec. 533.002552 . . . . . 540.0704
Sec. 533.002553 . . . . . 540.0705
Sec. 533.002555 . . . . . 540.0702
Sec. 533.00256(a) (part) . . . . . 540.0001
(part) . . . . . 540.0059
(b) . . . . . 540.0059
Sec. 533.00257(a)(1) . . . . . 540A.0001
(2) . . . . . 540A.0001
(2-a) . . . . . 540A.0001
(3) . . . . . RN(5) 540A.0001
(b) . . . . . 540A.0051
(c) . . . . . 540A.0051
(d) . . . . . 540A.0053
(e) . . . . . 540A.0055
(f) . . . . . 540A.0055
(g) . . . . . 540A.0052
(h) . . . . . (expired)
(i) . . . . . (repealed)
(j) . . . . . 540A.0051
(k) (part) . . . . . 540A.0054
(part) . . . . . 540A.0057
(l) . . . . . 540A.0056
(m) . . . . . 540A.0058
(n) . . . . . 540A.0059
Sec. 533.002571(a) . . . . . 540A.0001
(b) . . . . . 540A.0101
(c) . . . . . 540A.0102
(d) (part) . . . . . 540A.0103
(part) . . . . . 540A.0105
(e) . . . . . 540A.0104
(f) . . . . . 540A.0106
(g) . . . . . 540A.0107
(h) . . . . . 540A.0101
Sec. 533.00258(a) . . . . . 540A.0001

(b) . . . . . 540A.0152
(c) . . . . . 540A.0152
(d) . . . . . RN 540A.0152
(e) . . . . . 540A.0152
(f) . . . . . 540A.0152
(g) . . . . . 540A.0154
(h) . . . . . 540A.0153
(i) . . . . . 540A.0155
(j) . . . . . 540A.0156
Sec. 533.002581(a) . . . . . 540A.0001
(b) . . . . . (expired)
(c) . . . . . 540A.0151
(d) . . . . . 540A.0151
(e) . . . . . 540A.0151
(f) . . . . . 540A.0154
(g) . . . . . 540A.0156
(h) . . . . . 540A.0151
Sec. 533.0026 . . . . . .540.0710
Sec. 533.0027 . . . . . .540.0503
Sec. 533.0028 . . . . . .540.0754
Sec. 533.00281. . . . . .540.0755
Sec. 533.00282(a) . . . . . .540.0301
(b) (part) . . . . . .540.0303
(part) . . . . . .540.0305
(c) . . . . . .540.0303
Sec. 533.002821 . . . . . .540.0302
Sec. 533.00283. . . . . .540.0304
Sec. 533.00284. . . . . .540.0306
Sec. 533.002841 . . . . . .540.0307
Sec. 533.0029 . . . . . .540.0712
Sec. 533.003(a) (part) . . . . . .540.0204
(part) . . . . . RN 540.0204
(b). . . . . .540.0205
Sec. 533.0031 . . . . . .540.0451
Sec. 533.0035 . . . . . .540.0203
Sec. 533.004 . . . . . .540.0206
Sec. 533.005(a) (part) . . . . . .540.0251
(a)(1) . . . . . .540.0252
(2) . . . . . .540.0253
(3) . . . . . .540.0268
(4) . . . . . .540.0268
(5) . . . . . .540.0256
(6) . . . . . .540.0256
(7) . . . . . .540.0265
(7-a) . . . . . .540.0265
(8) . . . . . .540.0257
(9) . . . . . .540.0259
(10) . . . . . .540.0255
(11) . . . . . .540.0263
(12) . . . . . .540.0263
(13) . . . . . .540.0269
(14) . . . . . .540.0266
(15) . . . . . .540.0267
(16) . . . . . .540.0270
(17) . . . . . .540.0271
(18) . . . . . .540.0256
(19) . . . . . .540.0267
(20) . . . . . .540.0260
(21) . . . . . .540.0261
(22) . . . . . .540.0262
(23) (part) . . . . . .540.0273
(part) . . . . . .540.0274
(part) . . . . . .540.0275
(part) . . . . . .540.0276
(part) . . . . . .540.0277
(part) . . . . . .540.0278
(part) . . . . . .540.0279
(part) . . . . . .540.0280

(24) . . . . . 540.0254
(25) . . . . . 540.0264
(26) . . . . . 540.0258
(a-1) . . . . . 540.0273
(a-2) . . . . . 540.0279
(a-3) . . . . . 540.0264
(b) . . . . . 540.0263
(c) . . . . . 540.0266
(d) . . . . . 540.0269
(g) . . . . . 540.0551
(h) . . . . . 540.0272
Sec. 533.0051 . . . . . 540.0211
Sec. 533.00511(a) . . . . . 540.0001
(b) . . . . . 540.0504
Sec. 533.00515 . . . . . 540.0707
Sec. 533.0052 . . . . . 540.0801
Sec. 533.00521 . . . . . 540.0804
Sec. 533.00522 . . . . . 540.0802
Sec. 533.0053 . . . . . 540.0803
Sec. 533.00531 . . . . . 540.0806
Sec. 533.0054 . . . . . 540.0803
Sec. 533.0055 . . . . . 540.0655
Sec. 533.0056 . . . . . 540.0805
Sec. 533.006 . . . . . 540.0651
Sec. 533.0061 . . . . . 540.0652
Sec. 533.0062 . . . . . 540.0653
Sec. 533.0063 . . . . . 540.0654
Sec. 533.0064 . . . . . 540.0656
Sec. 533.0065 . . . . . 540.0657
Sec. 533.0066 . . . . . 540.0658
Sec. 533.0067 . . . . . 540.0651
Sec. 533.007(a) . . . . . 540.0207
(b) . . . . . 540.0208
(c) . . . . . 540.0208
(d) . . . . . 540.0208
(e) . . . . . 540.0209
(f) . . . . . 540.0209
(g) (part) . . . . . 540.0602
(part) . . . . . 540.0605
(h) . . . . . 540.0605
(i) . . . . . 540.0603
(j) . . . . . 540.0604
(k) . . . . . 540.0606
(l) . . . . . 540.0601
Sec. 533.0071 . . . . . 540.0201
Sec. 533.0072 . . . . . 540.0210
Sec. 533.0073 . . . . . 540.0452
Sec. 533.0075 . . . . . 540.0501
Sec. 533.00751 . . . . . 540.0052
Sec. 533.0076 . . . . . 540.0505
Sec. 533.0077 . . . . . 540.0053
Sec. 533.008(a) . . . . . 540.0055
(b) . . . . . 540.0055
(c) . . . . . 540.0056
Sec. 533.009 . . . . . 540.0708
Sec. 533.010 . . . . . 540.0709
Sec. 533.011 . . . . . 540.0202
Sec. 533.012 . . . . . 540.0058
Sec. 533.013(a) . . . . . 540.0351
(b) . . . . . 540.0352
(c) . . . . . 540.0351
(d) . . . . . 540.0352
(e) . . . . . 540.0351
Sec. 533.0131 . . . . . 540.0353
Sec. 533.01315 . . . . . 540.0659
Sec. 533.0132 . . . . . 540.0103
Sec. 533.014 . . . . . 540.0102
Sec. 533.015 . . . . . 540.0057

Sec. 533.016 . . . . . 540.0401
Sec. 533.0161 . . . . . 540.0706
Sec. 533.017 . . . . . 540.0402
Sec. 533.018 . . . . . 540.0403
Sec. 533.019 . . . . . 540.0713
Sec. 533.020(a) (part) . . . . . 540.0060
(part) . . . . . 540.0101
(b) . . . . . 540.0060
Sec. 533.038 . . . . . 540.0552
Sec. 533.039 . . . . . 540.0711
Sec. 533.051 . . . . . 540.0151
Sec. 533.052 . . . . . 540.0152
Sec. 533.053 . . . . . 540.0153
Sec. 533.054 . . . . . 540.0154
Sec. 533.055 . . . . . 540.0155
Sec. 533.056 . . . . . 540.0156
Sec. 533.057 . . . . . 540.0157
Sec. 533.058 . . . . . 540.0158
Sec. 533.059 . . . . . 540.0159
Sec. 533.060 . . . . . 540.0160
Sec. 533.083 . . . . . RN EOC 540.0855

Ch. 534

Sec. 534.001 (part) . . . . . 542.0001
(part) . . . . . RN 542.0001
Sec. 534.002 . . . . . 542.0002
Sec. 534.051 . . . . . 542.0051
Sec. 534.052 . . . . . 542.0053
Sec. 534.053 . . . . . 542.0052
Sec. 534.054 . . . . . 542.0054
Sec. 534.101 . . . . . 542.0101
Sec. 534.1015 . . . . . 542.0104
Sec. 534.102 . . . . . 542.0102
Sec. 534.103 . . . . . 542.0105
Sec. 534.1035 . . . . . 542.0107
Sec. 534.104(a) . . . . . 542.0102
(b) . . . . . 542.0113
(c) . . . . . 542.0103
(d) . . . . . 542.0103
(e) . . . . . 542.0103
(f) . . . . . 542.0103
(g) . . . . . 542.0110
(h) . . . . . 542.0102
(i) . . . . . 542.0117
(j) . . . . . 542.0117
(k) . . . . . 542.0116
Sec. 534.1045(a) . . . . . 542.0109
(a-1) . . . . . 542.0109
(b) . . . . . 542.0110
(c) . . . . . 542.0110
(d) . . . . . 542.0110
(e) . . . . . 542.0111
(f) . . . . . 542.0109
Sec. 534.105 . . . . . 542.0106
Sec. 534.106 . . . . . 542.0115
Sec. 534.1065(a) . . . . . 542.0116
(b) . . . . . 542.0114
(c) . . . . . 542.0116
Sec. 534.107(a) . . . . . 542.0108
(b) . . . . . 542.0110
Sec. 534.108 . . . . . 542.0117
Sec. 534.109 . . . . . 542.0112
Sec. 534.110 . . . . . 542.0120
Sec. 534.111 . . . . . 542.0118
Sec. 534.112 . . . . . 542.0119
Sec. 534.151 . . . . . 542.0151
Sec. 534.152(a) . . . . . 542.0152
(b) . . . . . 542.0152
(c) . . . . . 542.0152

(d) . . . . . 542.0152
(e) . . . . . RN(2) 542.0152
(f) . . . . . 542.0152
(g) . . . . . 542.0152
Sec. 534.202(a) . . . . . 542.0201
(b) . . . . . 542.0201
(c) . . . . . 542.0201
(d) . . . . . 542.0201
(e) . . . . . 542.0201
(f) . . . . . 542.0201
(g) . . . . . 542.0202
(h) . . . . . 542.0202
(i) . . . . . 542.0203
Sec. 534.203 . . . . . 542.0204
Sec. 534.251 . . . . . 542.0003
Sec. 534.252 . . . . . 542.0121

Ch. 535

Sec. 535.001 . . . . . 550.0001
Sec. 535.002 . . . . . 550.0002
Sec. 535.003 . . . . . 550.0003
Sec. 535.004 . . . . . 550.0004
Sec. 535.051 . . . . . 550.0052
Sec. 535.052 . . . . . 550.0053
Sec. 535.053(a) . . . . . 550.0054
(a-1) . . . . . 550.0054
(b) . . . . . 550.0054
(c) . . . . . 550.0055
Sec. 535.054 . . . . . 550.0056
Sec. 535.055(a) . . . . . 550.0057
(b) . . . . . 550.0057
(c) . . . . . 550.0058
(c-1) . . . . . 550.0057
(c-2) . . . . . 550.0057
(d) . . . . . 550.0059
(e) . . . . . 550.0057
Sec. 535.101 . . . . . 550.0101
Sec. 535.102 . . . . . 550.0102
Sec. 535.103 . . . . . 550.0103
Sec. 535.104(a) . . . . . 550.0104
(b) . . . . . 550.0104
(c) . . . . . 550.0106
(d) . . . . . 550.0105
(e) (part) . . . . . 550.0107
(part) . . . . . 550.0108
(f) . . . . . 550.0110
Sec. 535.105 . . . . . 550.0106
Sec. 535.106(a) . . . . . 550.0108
(b) . . . . . 550.0109
(c) . . . . . 550.0109

Ch. 536

Sec. 536.001 . . . . . 543A.0001
Sec. 536.003(a) . . . . . 543A.0002
(a-1) . . . . . 543A.0002
(b) . . . . . 543A.0002
(c) . . . . . 543A.0002
(d) . . . . . 543A.0002
(e) . . . . . 543A.0002
(f) . . . . . 543A.0002
(g) . . . . . 543A.0003
Sec. 536.004 . . . . . 543A.0004
Sec. 536.005 . . . . . 543A.0005
Sec. 536.006 . . . . . 543A.0006
Sec. 536.007 . . . . . 543A.0007
Sec. 536.008 . . . . . 543A.0008
Sec. 536.051 . . . . . 543A.0051
Sec. 536.052 . . . . . 543A.0052
Sec. 536.101(1) . . . . . 543A.0101
(2) . . . . . RN 543A.0101

Sec. 536.102 . . . . . 543A.0102
Sec. 536.103 . . . . . 543A.0103
Sec. 536.151 . . . . . 543A.0151
Sec. 536.152 . . . . . 543A.0152
Sec. 536.201 . . . . . RN Subch. E 543A.0204
Sec. 536.202 . . . . . 543A.0201
Sec. 536.203(a) . . . . . 543A.0201
(b) . . . . . 543A.0202
(c) . . . . . 543A.0202
(d) . . . . . 543A.0202
Sec. 536.204 . . . . . 543A.0203
Sec. 536.205 . . . . . 543A.0204
Sec. 536.251 . . . . . 543A.0251
Sec. 536.252 . . . . . 543A.0252
Sec. 536.253 . . . . . 543A.0253
Ch. 537
Sec. 537.002 . . . . . 532.0056
Ch. 538
Sec. 538.002 . . . . . 543.0001
Sec. 538.003 . . . . . 543.0002
Sec. 538.051 . . . . . 543.0051
Sec. 538.052 . . . . . 543.0052
Sec. 538.053 . . . . . 543.0053
Sec. 538.054 . . . . . 543.0054
Sec. 538.055 . . . . . 543.0055
Sec. 538.056 . . . . . 543.0003
Sec. 538.057 . . . . . 543.0056
Ch. 539
Sec. 539.001 . . . . . RN EOC 547A.0009
Sec. 539.002 . . . . . 547A.0001
Sec. 539.003 . . . . . 547A.0002
Sec. 539.004 . . . . . 547A.0003
Sec. 539.005 . . . . . 547A.0004
Sec. 539.0051 . . . . . 547A.0005
Sec. 539.006 . . . . . 547A.0006
Sec. 539.007 . . . . . 547A.0007
Sec. 539.008 . . . . . 547A.0008
Sec. 539.009 . . . . . 547A.0009
Ch. 541
Sec. 541.001 . . . . . 548.0351
Sec. 541.002 . . . . . 548.0352
Sec. 541.003 . . . . . 548.0353
Sec. 541.004 . . . . . 548.0354
Sec. 541.005 . . . . . 548.0355
Sec. 541.006 . . . . . 548.0356
Sec. 541.007 . . . . . 548.0357
Sec. 541.008 . . . . . 548.0358
Sec. 541.009 . . . . . 548.0359