BILL ANALYSIS

Senate Research Center

S.B. 1188
By: Nelson
Health & Human Services
7/18/2005
Enrolled

AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

S.B. 1188 directs the Health and Human Services Commission to make a number of reforms intended to streamline the administration of, maximize funding for, improve recipient outcomes in, and increase the cost effectiveness of the Medicaid program.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 6 (Section 533.005 and Section 533.0072, Government Code), of this bill.

Rulemaking authority previously granted to Health and Human Services Commission or an agency operating part of the medical assistance program, as appropriate, is transferred to the executive commissioner of the Health and Human Services Commission in SECTION 7 (Section 32.027, Human Resources Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 11 (Section 531.02175, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 15 (Section 531.02131, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 19 (Section 533.009, Government Code) of this bill.

Rulemaking authority previously granted to Health and Human Services Commission or an agency operating part of the medical assistance program, as appropriate, is transferred to the executive commissioner of the Health and Human Services Commission in SECTION 19 (Section 32.059, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 20 (Chapter 533.061, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

[While the statutory reference in this bill is to the Texas Department of Human Services, the following amendments affect the Health and Human Services Commission, as the successor agency to the Texas Department of Human Services.]

SECTION 1. COMMUNITY COLLABORATION. Amends Subchapter A, Chapter 531, Government Code, by adding Section 531.020, as follows:

> Sec. 531.020. OFFICE OF COMMUNITY COLLABORATION. Requires the executive commissioner of the Health and Human Services Commission (executive commissioner) (HHSC) to establish within HHSC an office of community collaboration. Sets forth certain responsibilities for said office.

SECTION 2. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02113, as follows:

Sec. 531.02113. OPTIMIZATION OF MEDICAID FINANCING. Requires HHSC to ensure that the Medicaid finance system is optimized to perform certain functions.

(b) Amends Section 32.042, Human Resources Code, by amending Subsections (a), (b), (d), and (e), and adding Subsection (b-1), as follows:

(a) Requires an insurer to maintain a file system that contains specific information.

(b) Authorizes HHSC to request that an insurer provide identifying information for each enrollee, beneficiary, subscriber, or policyholder of the insurer to HHSC.

(b-1) Requires an insurer from which HHSC requests information under Subsection (b) to provides that information, except that the insurer is only required to provide HHSC with the information maintained under Subsection (a) by the insurer or made available to the insurer from the plan. Provides that a plan administrator is subject to Subsection (b) and is required to provide information under that subsection to the extent the information is made available to the plan administrator from the insurer or plan. Deletes existing text requiring the insurer to provide the requested information within a specific time period.

(d) Makes a conforming change.

(e) Requires HHSC to enter into an agreement to reimburse an insurer or plan administrator for necessary and reasonable costs incurred in providing information requested under Subsection (b)(1), not to exceed $5,000 for each data match made under that subdivision. Requires HHSC, upon making a data match using information provided under Subsection (b)(2), to reimburse the insurer or plan administrator for reasonable administrative expenses incurred in providing the information. Prohibits the reimbursement for information under Subsection (b)(2) from exceeding $5,000 for initially producing information with respect to a person, or $200 for each subsequent production of information with respect to the person. Makes a conforming change.

(c) Sets forth requirements for HHSC to examine certain program possibilities.

(d) Requires HHSC, upon choosing to increase reimbursement rates for any providers under Subsection (c)(2), to give priority to providers serving medically underserved areas, those who treat a high volume of Medicaid patients, and those who provide care that is an alternative to care in an emergency department.

SECTION 3. COLLECTION AND ANALYSIS OF INFORMATION. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02141, as follows:

Sec. 531.02141. MEDICAID INFORMATION COLLECTION AND ANALYSIS. (a) Requires HHSC to make every effort to improve data analysis and integrate available information associated with the Medicaid program. Requires HHSC to use the decision support system in HHSC's center for strategic decision support for this purpose and to modify or redesign the system to allow for the data collected by the Medicaid program to be used more systematically and effectively for Medicaid program evaluation and policy development. Requires HHSC to develop or redesign the system as necessary to ensure that the system meets certain requirements.

(b) Requires HHSC to 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. Requires, if privacy concerns exist or arise with respect to making the data sets

available on the Internet, the system and HHSC to 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.

(b) Requires HHSC to allow for sufficient opportunities for stakeholder input in the modification or redesign of the decision support system in the HHSC's center for strategic decision support as required by Section 531.02141, Government Code, as added by this section. Authorizes HHSC to provide these opportunities through certain activities.

SECTION 4. ADMINISTRATIVE PROCESSES AND AUDIT REQUIREMENTS. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02411 and 531.02412, as follows:

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. Requires HHSC to make every effort using HHSC's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in the Medicaid program and to use technology and efficient business practices to decrease those burdens. Requires HHSC to make every effort to improve the business practices associated with the administration of the Medicaid program by certain methods HHSC determines are cost-effective.

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. (a) Requires HHSC to make every effort to ensure the integrity of the Medicaid Program. Requires HHSC to take certain steps to ensure that integrity.

(b) Provides that this section does not affect the duty of the Texas Department of Transportation to manage the delivery of transportation services, including the delivery of transportation services for clients of health and human services programs.

(b) Authorizes HHSC, to further encourage the use of medical technology by providers under the Medicaid program, to enter into a certain written agreements and to accept certain program benefits, such as the operation of a pilot program. Requires the program to be operated in a manner that is acceptable to HHSC and to be designed to test the benefits and cost-effectiveness on a sufficiently large scale. Requires the manufacturer to report the results of the program, including an analysis of the program's benefits and cost-effectiveness, to the commission. Requires HHSC to report those results to the 80th Legislature not later than January 15, 2007.

(c) The Health and Human Services Commission shall examine certain options for standardizing and simplifying the interaction between the Medicaid system and providers.

SECTION 5. LONG-TERM CARE SERVICES. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.083 and 531.084, as follows:

Sec. 531.083. MEDICAID LONG-TERM CARE SYSTEM. (a) Requires HHSC to 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. Requires HHSC to take certain steps to make every effort to improve the quality of care for recipients of Medicaid long-term care services.

Sec. 531.084. MEDICAID LONG-TERM CARE COST CONTAINMENT STRATEGIES. (a) Requires HHSC to make every effort to achieve cost efficiencies within the Medicaid long-term care program. Requires HHSC to take certain steps to achieve those efficiencies.

(b) Requires the executive commissioner and the commissioner of the Department of Aging and Disability Services to jointly appoint persons to serve on a work

group to assist HHSC in developing the required fee schedule for reimbursable incurred medical expenses for dental services controlled in long-term care facilities. Requires the work group to consist of providers of long-term care services, including dentists and long-term care advocates.

(c) Requires HHSC to make certain considerations in developing the required fee schedule.

(d) Requires HHSC to annually update the required fee schedule.

(b) Requires HHSC to examine possibilities regarding implementing certain benefit programs.

(c) Requires HHSC to study and determine whether polypharmacy reviews for Medicaid recipients receiving long-term care services could identify inappropriate pharmaceutical usage patterns and lead to controlled costs.

(d) Requires HHSC to make every effort to expedite the approval of dental treatment plans and the approval and payment of reimbursable incurred medical expenses for dental services provided to residents of long-term care facilities prior to developing and adopting the required fee schedule.

SECTION 6. MEDICAID MANAGED CARE. (a) Amends Section 533.005, Government Code, by amending Subsection (a) and adding Subsection (c), as follows:

(a) Requires a contract between a managed care organization and HHSC for the organization to provide health care services to recipients to contain specific procedures, rates, and requirements.

(c) Requires the executive commissioner of HHSC to 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).

(b) Amends Subchapter A Chapter 533, Government Code, by adding Sections 533.0071 and 533.0072, as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. Requires HHSC to make every effort to improve the administration of contracts with managed care organizations. Requires HHSC to take certain steps to improve the administration of the contracts.

Sec. 533.0072. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) Requires HHSC to prepare and maintain a record of each enforcement action initiated by it 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) Sets forth certain requirements for the record.

(c) Requires HHSC to post and maintain the records required by this section on HHSC's website in English and Spanish. Requires the records to be posted in a format that is readily accessible to and understandable by a member of the public. Requires HHSC to update the list of records on the website at least quarterly.

(d) Prohibits HHSC from posting information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) Prohibits a record prepared under this section from including information that is excepted from disclosure under Chapter 552 (Public Information).

(f) Requires the executive commissioner to adopt rules as necessary to implement this section.

(c) Requires HHSC to re-evaluate the case management fee used in the primary care case management program and to make recommendations to the Legislative Budget Board if HHSC finds that a different rate is appropriate.

(d) Requires HHSC to examine certain information regarding the cost-effectiveness and operational efficiency of the primary care case management program.

(e) Requires HHSC to make every effort to improve the delivery of health care services to recipients enrolled in the Medicaid managed care program by evaluating certain actions for a determination of cost-effectiveness and pursuing those actions if they are determined to be cost-effective.

(f) Makes application of Section 533.005, Government Code, as amended by this section, prospective.

(g) Makes application of Section 533.0072, Government Code, as added by this section, prospective.

SECTION 7. SELECTION OF MEDICAL ASSISTANCE PROVIDERS. (a) Amends Section 32.027, Human Resources Code, by amending Subsection (f) and adding Subsection (l), as follows:

(f) Authorizes the executive commissioner, rather than HHSC or an agency operating part of the medical assistance program, as appropriate, by rule to develop a system of selective contracting with health care providers for the provision of nonemergency inpatient hospital services to a recipient of medical assistant under this chapter. Makes a conforming change.

(l) Requires HHSC, subject to appropriations, to assure that a recipient of medical assistance under this chapter may select certain licensed individuals to perform any health care service or procedure covered under the medical assistance program if the selected person is authorized by law to perform the service or procedure. Requires this subsection to be liberally construed.

(b) Repealer: Section 32.027(e) (relating to HHSC providing medical assistance through certain licensed individuals), Human Resources Code, as amended by Chapter 1251, Acts of the 78th Legislature, Regular Session, 2003.

SECTION 8. OPTIMIZATION OF CASE MANAGEMENT SYSTEMS. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding 32.0551, as follows:

Sec. 32.0551. OPTIMIZATION OF CASE MANAGEMENT SYSTEMS. Sets forth certain requirements of HHSC pertaining to case management initiatives across HHSC and health and human services agencies.

(b) Requires HHSC to evaluate the cost-effectiveness of developing intensive case management and targeted interventions for all Medicaid recipients who are aged, blind, or disabled.

(c) Requires HHSC to identify Medicaid programs or protocols in existence on the effective date of this section that are not resulting in their anticipated cost savings or quality outcomes. Requires HHSC to enhance or replace these programs or protocols with targeted strategies that have demonstrated success in improving coordination of care and cost savings within similar Medicaid recipient populations.

(d) Requires HHSC to evaluate the cost-effectiveness of making certain inclusions within Medicaid disease management programs in existence on the effective date of this section. Authorizes HHSC, in evaluating certain information in studying the cost-effectiveness of including other diseases, conditions, and strategies, to review existing data from the provider of disease management services under Section 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003. Authorizes HHSC to also research the experiences of other states, insurance companies, and managed care organizations and review other sources of data determined appropriate. Requires HHSC to expand Medicaid disease management programs and related programs to include the diseases, conditions, and strategies determined under this section will be cost-effective.

(e) Requires HHSC to conduct a study to determine the feasibility of combining certain quality and cost-control measures implemented with respect to the Medicaid program under a certain single federal waiver. Requires HHSC to develop the combined program if HHSC determines that the combination is feasible. Requires HHSC, in conducting the study, to solicit stakeholder input and consider information from any other optimization-related projects currently being operated, including certain specific programs.

SECTION 9. EDUCATION CAMPAIGN. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.071, as follows:

Sec. 32.071. RECIPIENT AND PROVIDER EDUCATION. (a) Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to develop and implement a comprehensive medical assistance education campaign for recipients and providers to ensure that care is provided in such a way as to improve patient outcomes and maximize cost-effectiveness. Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to ensure that educational information developed under this section is demographically relevant and appropriate for each recipient or provider to whom the information is provided.

(b) Requires the comprehensive medical assistance education campaign to include elements designed to encourage recipients to obtain, maintain, and use a medical home and to reduce their use of high-cost emergency department services for conditions that can be treated through primary care or nonemergency physicians or other providers. Requires the campaign to include the dissemination of educational information through newsletters and emergency department staff members and at local health fairs, unless HHSC determines that these methods of dissemination are not effective in increasing recipients' appropriate use of the health care system.

(c) Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to evaluate whether certain risk groups may disproportionately increase their appropriate use of the health care system as a result of targeted elements of an education campaign. Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to develop and implement the appropriate targeted educational elements, if HHSC, or an agency operating part of the medical assistance program, as appropriate, determines that certain risk groups will respond with more appropriate use of the system.

(d) Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to develop a system for reviewing recipient prescription drug use and educating providers with respect to that drug use in a manner that emphasizes reducing inappropriate prescription drug use and the possibility of adverse drug interactions.

(e) Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to coordinate the medical assistance education campaign with certain area health education centers, federally qualified health centers and

other stakeholders who use public funds to educate recipients and providers about the health care system in this state. Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to make every effort to maximize state funds by working through these partners to maximize receipt of additional federal funding for administrative and other costs.

(f) Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to coordinate with certain other entities as appropriate to ensure certain personnel are used in the medical assistance education campaign.

(g) Requires HHSC to ensure that all state agencies that work with recipients, all administrative persons who provide eligibility determination and enrollment services, and all service providers use the same curriculum for recipient and provider education, as appropriate.

(b) Requires HHSC, in developing the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section, to ensure that private entities participating in the Medicaid program, including vendors providing claims administration, eligibility determination, enrollment services, and managed care services, are involved to the extent those entities' participation is useful.

(c) Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to identify all funds being spent on the effective date of this section on education for Medicaid recipients. Requires HHSC to integrate these funds into the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section.

SECTION 10. OFFICE OF MEDICAL TECHNOLOGY. Amends Subchapter A, Chapter 531, Government Code, by adding Section 531.0081, as follows:

Sec. 531.0081. OFFICE OF MEDICAL TECHNOLOGY. (a) Defines "office."

(b) Requires HHSC to establish the office of medical technology (office) within HHSC. Requires the office to explore and evaluate new developments in medical technology and propose implementing the technology in the medical assistance program under Chapter 32 (Medical Assistance Program), Human Resources Code, if appropriate and cost-effective.

(c) Requires office staff to have skills and experience in research regarding health care technology.

SECTION 11. MEDICAID REIMBURSEMENT RATES. (a) Amends Section 531.021, Government Code, by adding Subsections (f) and (g), as follows:

(f) Authorizes the executive commissioner, in adopting rates for medical assistance payments under Subsection (b)(2), to 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. Requires a physician to certify that the nursing services are medically appropriate for the recipient for those services to qualify for reimbursement under this subsection.

(g) Authorizes the executive commissioner, in adopting rates for medical assistance payments under Subsection (b)(2), to adopt cost-effective reimbursement rates for group appointments with medical assistance providers for certain diseases and medical conditions specified by rules of the executive commissioner.

(b) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02175, as follows:

Sec. 531.02175. REIMBURSEMENT FOR ONLINE MEDICAL CONSULTATIONS. (a) Defines "physician."

(b) Authorizes the executive commissioner, by rule, subject to the requirements of this subsection, to require HHSC and each health and human services agency that administers a part of the Medicaid program 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. Authorizes the executive commissioner to require HHSC 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.

(c) Authorizes the executive commissioner to develop and implement a pilot program in one or more sites under which Medicaid reimbursements are paid for medical consultations provided by physicians or other health care professionals using the Internet. Sets forth requirements for the pilot program. Authorizes the executive commissioner to modify or expand the pilot program in certain manners.

(d) Provides that 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.

SECTION 12. HOSPITAL EMERGENCY ROOM USE REDUCTION. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.085, as follows:

Sec. 531.085. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES. Requires HHSC to develop and implement a comprehensive plan to reduce the use of hospital emergency room services by recipients under the medical assistance program. Authorizes the plan to include certain programs and payments.

(b) Authorizes HHSC to develop the health care literacy component of the comprehensive plan to reduce the use of hospital emergency room services to operate in a manner similar to a specific institute.

SECTION 13. PERFORMANCE BONUS PILOT PROGRAM. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.086, as follows:

Sec. 531.086. PERFORMANCE BONUS PILOT PROGRAM. (a) Requires HHSC to develop a proposal for providing higher reimbursement rates to primary care case management providers under the Medicaid program who treat program recipients with chronic health conditions in accordance with evidence-based, nationally accepted best practices and standards of care.

(b) Requires HHSC to define specific parameters of the proposed program.

(c) Requires HHSC, not later than December 1, 2006, to report to the standing committees of the senate and the house of representatives having primary jurisdiction over welfare programs regarding the proposed program under this section. Sets forth requirements for the report.

(d) Provides that this section expires September 1, 2007.

SECTION 14. RETURN OF UNUSED DRUGS. Amends Section 562.1085, Occupations Code, by amending Subsection (a) and adding Subsection (f), as follows:

(a) Deletes existing text requiring unused drugs be sealed in the manufacturer's original packaging.

(f) Provides that the tamper-evident packaging required under Subsection (a)(1) for the return of unused drugs is not required to be the manufacturer's original packaging unless that packaging is required by federal law.

SECTION 15. MEDICAL INFORMATION TELEPHONE HOTLINE. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02131, as follows:

Sec. 531.02131. MEDICAID MEDICAL INFORMATION TELEPHONE HOTLINE PILOT PROGRAM. (a) Defines "net cost-savings."

(b) Requires HHSC to evaluate the cost-effectiveness, in regard to preventing unnecessary emergency room visits and ensuring that Medicaid recipients seek medical treatment in the most medically appropriate and cost-effective setting, of developing a Medicaid medical information telephone hotline pilot program under which physicians are available by telephone to answer medical questions and provide medical information for recipients. Requires HHSC to develop the pilot program, upon determining that the pilot program is likely to result in net cost-savings.

(c) Requires HHSC to select the area in which to implement the pilot program. Sets forth requirements for the selected area.

(d) Requires HHSC to request proposals from private vendors for the operation of a telephone hotline under the pilot program. Prohibits HHSC from awarding a contract to a vendor unless the vendor agrees to certain contractual terms.

(e) Requires HHSC to periodically determine whether the pilot program is resulting in net cost-savings. Requires HHSC to discontinue the pilot program upon determining that the pilot program is not resulting in net cost-savings after a reasonable period.

(f) Provides that notwithstanding any other provision of this section, including Subsection (b), HHSC is not required to develop the pilot program if suitable private vendors are not available to operate the telephone hotline.

(g) Requires the executive commissioner to adopt rules necessary for implementation of this section.

(b) Requires HHSC, not later than December 1, 2005, to determine whether the pilot program described by Section 531.02131, Government Code, as added by this section, is likely to result in net cost-savings. Requires HHSC to take the action required by Subsections (c), (d), and (e) of this section, if the determination indicates that net cost-savings are likely.

(c) Requires HHSC to select the counties in which the pilot program will be implemented, not later than January 1, 2006.

(d) Requires HHSC to request proposals from private vendors for the operation of a medical information telephone hotline, not later than February 1, 2006. Requires HHSC to evaluate the proposals and choose one or more vendors as soon as possible after the receipt of the proposals.

(e) Requires HHSC to report to specific government officials regarding the pilot program, not later than January 1, 2007. Sets forth requirements for the report.

SECTION 16. PRESCRIPTION DRUGS. (a) Amends Section 531.070, Government Code, by amending Subsection (l) and adding Subsection (n), as follows:

(l) Sets forth requirements for the report to be submitted to the legislature and the governor by HHSC.

(n) Requires HHSC, prior to or during supplemental rebate agreement negotiations for drugs being considered for the preferred drug list, to disclose 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 to pharmaceutical manufacturers.

(b) Makes application of Section 531.070(n), Government Code, as applied by this section, prospective to the effective date of this Act.

SECTION 17. PHARMACEUTICAL AND THERAPEUTICS COMMITTEE. Amends Section 531.074, Government Code, by adding Subsection (m), as follows:

(m) Requires HHSC or the HHSC agent to publicly disclose each specific drug recommended for preferred drug list (list) status for each drug class included in the list for the Medicaid vendor drug program. Requires the disclosure to be made in writing after the conclusion of committee deliberations that result in recommendations made to the executive commissioner regarding the placement of drugs on the list.

SECTION 18. FRAUD, ABUSE, OR OVERCHARGES. (a) Amends Section 531.102, Government Code, by adding Subsections (j) and (k), as follows:

(j) Requires the office to prepare a final report on each audit or investigation conducted under this section. Sets forth requirements for the final report.

(k) Provides that a final report on an audit or investigation is subject to required disclosure under Chapter 552 (Public Information). Provides that all information and materials compiled during the audit or investigation remain confidential and not subject to required disclosure in accordance with Section 531.1021(g).

(b) Amends Section 531.1021, Government Code, by amending Subsection (g) and adding Subsection (h), as follows:

(g) Provides that all information and material subpoenaed or complied by the office in connection with an audit are confidential and not subject to disclosure under Chapter 552. Makes conforming changes.

(h) Authorizes a person who receives information under Subsection (g) to 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.

SECTION 19. MEDICAID DISEASE MANAGEMENT PROGRAMS. (a) Amends Section 533.009, Government Code, by adding Subsection (f), as follows:

(f) Requires the executive commissioner, by rule, to prescribe the minimum requirements that a managed care organization, in providing a disease management program to meet to be eligible to receive a contract under this section. Sets forth the minimum requirements for the managed care organization.

(b) Amends Section 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003, by amending Subsection (c) and adding Subsection (c-1), as follows:

(c) Requires the executive commissioner, rather than HHSC, by rule, to prescribe the minimum requirements a provide of a disease management program to meet to be eligible to receive a contract under this section. Sets forth minimum requirements for the provider.

(c-1) Requires a managed care health plan that develops and implements a disease management program under Section 533.009, Government Code, and a provider of a disease management program under this section to coordinate during a transition period beneficiary care for patients that move from one disease management program to another program.

(c) Authorizes the executive commissioner to use a provider of a disease management program under Section 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003, as amended by this section, to provide disease management services upon determining that the use of that provider will be more cost-effective to the Medicaid program than using a provider of a disease management program under Section 533.009, Government Code, as amended by this section. Authorizes a Medicaid recipient currently in a disease management program provided under Section 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003, in a service area that is subject to a Medicaid managed care expansion to remain enrolled in the recipient's current disease management program if the executive commissioner determines that allowing those recipients to remain is cost-effective.

SECTION 20. INTEGRATED CARE MANAGEMENT MODEL. (a) Amends Chapter 533, Government Code, by adding Subchapter D, as follows:

SUBCHAPTER D. INTEGRATED CARE MANAGEMENT MODEL

Sec. 533.061. INTEGRATED CARE MANAGEMENT MODEL. (a) Requires the executive commissioner, by rule, to develop an integrated care management model (model) of Medicaid managed care. Defines "integrated care management model."

(b) Requires the executive commissioner, in developing the model, to ensure that the model utilizes managed care principles and strategies to assure proper utilization of acute care and long-term care services and supports. Sets forth requirements for the components of the model.

(c) Provides that for purposes of this chapter, the integrated care management model is a managed care plan.

Sec. 533.062. CONTRACTING FOR INTEGRATED CARE MANAGEMENT. (a) Authorizes HHSC to contract with one or more administrative services organizations to perform the coordination of care and other services and functions of the model developed under Section 533.061.

(b) Authorizes HHSC to require that each administrative services organization contracting with HHSC under this section assume responsibility for exceeding administrative costs and not meeting performance standards in connection with the provision of acute care and long-term care services and supports under the terms of the contract.

(c) Authorizes HHSC to include a written guarantee of state savings on Medicaid expenditures for recipients receiving services provided under the model developed under Section 533.061 in a contract awarded under this section.

(d) Authorizes HHSC to require that each administrative services organization contracting with HHSC under this section establish pay-for-performance incentives for providers to improve patient outcomes.

(e) Defines "administrative services organization."

Sec. 533.063. STATEWIDE INTEGRATED CARE MANAGEMENT ADVISORY COMMITTEE. Authorizes the executive commissioner to appoint an advisory committee to assist in the development and implementation of the model. Provides that the advisory committee is subject to Chapter 551 (Open Meetings).

(b) Requires HHSC to require each administrative services organization contracting with HHSC to perform services under Section 533.062, Government Code, as added by this section, to coordinate with, use, and otherwise interface with the fee-for-service claims payment contractor operating in this state on August 31, 2005, until the date the claims payment contract expires, subject to renewal of the contract.

(c) Authorizes HHSC to require each administrative services organization contracting with HHSC to perform services under Section 533.062, Government Code, as added by this section, to incorporate disease management into the integrated care management model established under Section 533.061, Government Code, as added by this section, utilizing the Medicaid disease management contractor operating in this state on November 1, 2004, until the date the disease management contract expires, subject to renewal of the contract.

(d) Provides that if any provision of this section conflicts with another statute enacted by the 79th Legislature, Regular Session, 2005, the provision of this section controls.

SECTION 21. DISPENSATION OF PRESCRIPTION DRUGS. (a) Amends Section 481.074, Health and Safety Code, by amending Subsections (o) and (p), as follows:

(o) Authorizes a pharmacist to dispense a Schedule II controlled substance pursuant to facsimile copy of an official prescription completed in a manner required by Section 481.075 and transmitted by the practitioner or the practitioner's agent to the pharmacy if certain requirements are met.

(p) Deletes existing text requiring a hard copy of the prescription to be delivered to the pharmacist within a specific amount of time.

SECTION 22. PROVISION OF CERTAIN PRESCRIPTION DRUGS PROHIBITED. Amends Section 32.024, Human Resources Code, by adding Subsection (bb), as follows:

(bb) Prohibits HHSC from providing an erectile dysfunction medication under the Medicaid vendor drug program to a person required to register as a sex offender under Chapter 62 (Sex Offender Registration Program), Code of Criminal Procedure, to the maximum extent federal law allows HHSC to deny that medication.

SECTION 23. CONTINUOUS ELIGIBILITY. Amends Section 32.0261, Human Resources Code, to requires the rules to provide that the child remains eligible for medical assistance, without additional review by HHSC and regardless of changes in the child's resources or income, until the earlier of the end of the six-month period, rather than first anniversary, of the date on which the child's eligibility was determined or the child's 19th birthday.

SECTION 24. NOTICE OF AVAILABILITY OF CERTAIN BENEFITS. Amends Chapter 159, Occupations Code, by adding Section 159.010, as follows:

Sec. 159.010. NOTICE OF BENEFITS UNDER STATE CHILD HEALTH PLAN. Requires a physician who provides Medicaid health care services to a pregnant woman to inform the woman of the health benefits for which the woman or the woman's child may be eligible under the state child health plan under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code.

SECTION 25. MEDICAID COVERAGE FOR HEALTH INSURANCE PREMIUMS AND LONG-TERM CARE NEEDS. (a) Requires HHSC to explore HHSC's authority under federal law to offer, and the cost and feasibility of offering certain stipends and payment assistance.

(b) Requires HHSC, in exploring the feasibility of the options described by Subsection (a) of this section, to consider whether other state incentives that could encourage persons to purchase health insurance plans or long-term care insurance are feasible. Authorizes the incentives to include offering tax credits to businesses to increase the availability of affordable insurance.

(c) Requires HHSC to make efforts to implement those options to the extent they are authorized by federal law upon determining that any of the options described by Subsection (a) of this section are feasible and cost-effective. Requires HHSC to request any necessary waivers from the Centers for Medicare and Medicaid Services as soon as possible after determining that an option is feasible and cost-effective. Requires HHSC to report to the 80th Legislature and specify the changes that are needed upon determining that legislative changes are necessary to implement an option.

SECTION 26. MAXIMIZATION OF FEDERAL RESOURCES. Requires HHSC to make every effort to maximize the receipt and use of federal health and human services resources for the office of community collaboration established under Section 531.020, Government Code, as added by this Act, and the decision support system in HHSC's center for strategic decision support.

SECTION 27. ABOLITION OF LONG-TERM CARE LEGISLATIVE OVERSIGHT COMMITTEE; INTERIM REPORT ON LONG-TERM CARE. (a) Repealer: Provides that on the effective date of this Act, Subchapter O (Legislative Oversight), Chapter 242, Health and Safety Code, is repealed, and the long-term care legislative oversight committee established under that subchapter is abolished.

(b) Requires all records in the custody of the long-term care legislative oversight committee that are related to a duty, function, or activity of the committee to be transferred on the effective date of this Act to the standing committees of the senate and house of representatives having primary jurisdiction over long-term care services.

SECTION 28. ABOLITION OF HEALTH AND HUMAN SERVICES TRANSITION LEGISLATIVE OVERSIGHT COMMITTEE. Provides that the Health and Human Services Transition Legislative Oversight Committee established under Section 1.22, Chapter 198, Acts of the 78th Legislature, Regular Session, 2003, is abolished on the effective date of this Act.

SECTION 29. ABOLITION OF INTERAGENCY COUNCIL ON PHARMACEUTICALS BULK PURCHASING. Repealer: Provides that on September 1, 2007, the Interagency Council on Pharmaceuticals Bulk Purchasing is abolished, and Chapter 111 (Interagency Council on Pharmaceuticals Bulk Purchasing), Health and Safety Code, and Subsection (e) (requiring HHSC to report to the Interagency Council on Pharmaceuticals Bulk Purchasing), Section 431.116, and Subsection (d) (requiring HHSC to report to the Interagency Council on Pharmaceuticals Bulk Purchasing), Section 431.208, Health and Safety Code, are repealed.

SECTION 30. IMPLEMENTATION; WAIVER. (a) Requires HHSC to make every effort to take each action and implement each reform required by this Act as soon as possible. Requires HHSC to take each action and implement each reform required by this Act not later than September 1, 2007, except as otherwise provided by this subsection and Subsection (d) of this section. Provides that any action of HHSC taken to justify implementing or ignoring the reforms required by this Act must be defensible, but need not be exhaustive.

(b) Requires HHSC, not later than December 1, 2005, to submit a report to the governor and to the presiding officers of the standing committees of the senate and house of representatives having primary jurisdiction over health and human services that specifies the strategies the commission or an appropriate health and human services agency, as defined by Section 531.001, Government Code, will use to examine, study, evaluate, or

otherwise make a determination relating to a reform or take another action required by this Act.

(c) Requires HHSC, except as provided by Subsection (b) of this section, for each provision of this Act that requires or a health and human services agency, as defined by Section 531.001, Government Code, to examine the possibility of making changes to the Medicaid program, to study an aspect of the Medicaid program, to evaluate the cost-effectiveness of a proposed reform, or to otherwise make a determination before implementing a reform, HHSC to submit a report to the governor and to the presiding officers of the standing committees of the senate and house of representatives having primary jurisdiction over health and human services that includes the criteria used and the results obtained by HHSC or a health and human services agency in taking the required action. Requires the report to be delivered not later than September 1, 2007.

(d) Authorizes delay of implementation of any provision of this Act until any necessary federal waivers or authorizations are obtained.

SECTION 31. EFFECTIVE DATE. Effective date: September 1, 2005, except as otherwise provided by this Act.