By: Coleman H.B. No. 3436

A BILL TO BE ENTITLED

1 AN ACT

2 relating to the restoration and expansion of the medical
3 assistance, children's health insurance, and other health and human
4 services programs; making an appropriation.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

6 ARTICLE 1. LEGISLATIVE FINDINGS; APPROPRIATION

7 SECTION 1.01. FINDINGS. The legislature finds that:

8 (1) the drastic reductions in funding for the medical
9 assistance and children's health insurance programs and the
10 extensive public policy changes made to those programs in the
11 regular session of the 78th Legislature have resulted in
12 devastating effects to the health and well-being of Texas children
13 and their families and to the overall fiscal health of this state;

14 (2) economic research has proven that reductions in
15 state funding for health care services do more harm than good to the
16 Texas economy because each dollar of state revenue that is
17 eliminated from the medical assistance and children's health
18 insurance programs results in:

19 (A) an average loss of $2.30 in federal health
20 care funding for Texas and an average loss of approximately $7 in
21 gross state product, $5 in personal income, and $2 in retail sales;
22 and

23 (B) an increase of $1.60 in the insurance
24 premiums for Texans who have private health insurance, plus a $1.50

1 increase in those Texans' out-of-pocket health care costs;
2 (3) as a result of these shortsighted and
3 counterproductive reductions in health care services made by the
4 78th Legislature, local taxpayers bear the entire cost of health
5 care for persons who are no longer receiving services under the
6 medical assistance or children's health insurance programs, often
7 through vastly more expensive visits to hospital emergency rooms,
8 even though the federal government would have paid 60 to 70 percent
9 of the cost of those services through those programs;
10 (4) children in other states have already received
11 over $800 million in federal funds that were intended to provide
12 health care coverage for Texas children under the children's health
13 insurance program, and this state will lose additional federal
14 funds each year if the state fails to restore state funding and
15 repeal the restrictive eligibility and benefits policies enacted by
16 the 78th Legislature;
17 (5) restoring benefits under the children's health
18 insurance program and expanding that program to cover more
19 uninsured children will result in healthier future generations of
20 Texans and immeasurable long-term savings for this state;
21 (6) providing vision, hearing, and dental health
22 services through the medical assistance and children's health
23 programs will improve school performance and average daily
24 attendance records, which will yield additional federal and state
25 revenue for local school districts;
26 (7) reductions in mental health benefits for children
27 and adults made by the 78th Legislature have been especially

1 devastating to families, have strained the resources of local
2 hospitals, community providers, and law enforcement personnel
3 responding to calls for mental health intervention, and have
4 resulted in reported increases of as much as 79 percent in some
5 localities for rates for hospitalization, which is the most
6 expensive form of treatment;
7 (8) this state must make its economy stronger and its
8 workforce more productive by improving access to health care
9 through prudent and sound fiscal policies that maximize the
10 availability of federal funds for health care services for
11 uninsured Texans; and
12 (9) the investment of state resources to maximize
13 receipt of federal funds as described by Subdivision (8) of this
14 section will:
15 (A) prevent the redistribution to other states of
16 tax dollars that Texans have paid to the federal government;
17 (B) alleviate the inefficient cost-shifting of
18 health care services for uninsured Texans to local governments; and
19 (C) stem the escalation of costs being passed on
20 to Texans who have private health insurance.
21 SECTION 1.02. PURPOSE. As a result of the findings made by
22 the legislature as stated in Section 1.01 of this article, the
23 purposes of this Act are to:
24 (1) restore funding for the medical assistance and
25 children's health insurance programs that was reduced by the 78th
26 Legislature;
27 (2) reverse restrictive policy changes made by that

1 legislature with respect to those programs; and
2 (3) expand enrollment in those programs beyond the
3 enrollment levels that existed before September 1, 2003.
4 SECTION 1.03. For the state fiscal biennium beginning
5 September 1, 2005, the Health and Human Services Commission is
6 appropriated from the general revenue fund the amount needed to
7 provide services under the medical assistance and children's health
8 insurance programs in a manner comparable to the manner in which the
9 services were provided under those programs during the state fiscal
10 biennium ending August 31, 2003.
11 ARTICLE 2. RESTORATION AND EXPANSION OF THE
12 MEDICAL ASSISTANCE PROGRAM
13 SECTION 2.01. Subchapter B, Chapter 531, Government Code,
14 is amended by adding Sections 531.02113-531.02117 and 531.02131 to
15 read as follows:
16 Sec. 531.02114. MEDICAID ELIGIBILITY AND ENROLLMENT. The
17 commission shall ensure that:
18 (1) the Medicaid eligibility policies, processes, and
19 time frames of each state agency operating a part of the Medicaid
20 program, including the policies, processes, and time frames
21 relating to an applicant or recipient whose eligibility status is
22 on hold, are designed to minimize the time that an applicant or
23 recipient is required to wait before the applicant or recipient
24 begins receiving services or is recertified; and
25 (2) the Medicaid eligibility policies, processes, and
26 time frames of any agency contractor are designed to minimize the
27 time that an applicant or recipient is required to wait before

1 receiving services.

2 Sec. 531.02115. TEXAS HEALTH STEPS PROGRAM. The commission
3 shall:

4 (1) take all actions necessary to simplify:

5 (A) provider enrollment in the Texas Health Steps
6 program;

7 (B) reporting requirements relating to the Texas
8 Health Steps program; and

9 (C) billing and coding procedures so that Texas
10 Health Steps program processes are more consistent with commercial
11 standards;

12 (2) in consultation with providers of Texas Health
13 Steps program services, develop mechanisms to promote accurate,
14 reliable, and timely reporting of examinations of children
15 conducted under the program to managed care organizations and other
16 appropriate entities;

17 (3) in consultation with providers of Texas Health
18 Steps program services, develop a mechanism to promote
19 incorporation of Texas Health Steps program services into a child's
20 medical home; and

21 (4) require the external quality monitoring
22 organization to evaluate the Texas Health Steps program using
23 information available from all relevant sources and prepare
24 periodic reports regarding the program for submission by the
25 commission to the legislature.

26 Sec. 531.02116. LIMITS ON MEDICAID COST-SHARING. Before
27 requiring Medicaid recipients to make copayments or comply with

1 other cost-sharing requirements, the executive commissioner by
2 rule shall establish monthly limits on total copayments and other
3 cost-sharing requirements.
4 Sec. 531.02131. COMMUNITY OUTREACH CAMPAIGN. (a) The
5 commission shall conduct a community outreach campaign to provide
6 information relating to the availability of Medicaid coverage for
7 children and adults and to promote enrollment of eligible children
8 and adults in Medicaid.
9 (b) The commission may combine the community outreach
10 campaign under this section with any other state outreach campaign
11 or educational activity relating to health care and available
12 health care coverage.
13 SECTION 2.03. (a) The purpose of this section is to pilot a
14 coordinated approach to addressing the needs of homeless people
15 with chronic illnesses who are recipients of medical assistance
16 under Chapter 32, Human Resources Code, so that homeless people may
17 learn to manage their illnesses and become productive members of
18 society. Current state, federal, and local agencies fund separate
19 programs that address only one aspect of the needs of homeless
20 people, such as housing, job training, and medical care. Homeless
21 people with chronic illnesses will benefit from a coordinated
22 approach that comprehensively addresses the needs of homeless
23 people.
24 (b) Subchapter B, Chapter 531, Government Code, is amended
25 by adding Section 531.084 to read as follows:
26 Sec. 531.084. PILOT CASE MANAGEMENT PROGRAM. (a) The
27 commission, in cooperation with the Texas Interagency Council for

1 the Homeless, shall develop a pilot case management program for
2 homeless people who have chronic illnesses, including diabetes and
3 HIV infection or AIDS, and who are recipients of medical assistance
4 under Chapter 32, Human Resources Code. The council in cooperation
5 with relevant state agencies shall administer the pilot program
6 under the direction of the commission.
7 (b) Using existing resources of the agencies composing the
8 Texas Interagency Council for the Homeless, the staff of the
9 council shall:
10 (1) select a county with a population of more than 2.8
11 million in which to implement the program;
12 (2) identify existing services provided through
13 programs of the agencies composing the council to homeless people
14 with chronic illnesses who are recipients of medical assistance;
15 (3) identify existing federal, state, county, and
16 local sources from which money may be available to fund the pilot
17 program; and
18 (4) create a pilot case management program for not
19 more than 75 homeless people with chronic illnesses who are
20 recipients of medical assistance using existing financial and
21 agency resources.
22 (c) The Texas Interagency Council for the Homeless shall
23 select, through competitive bidding, a nonprofit entity to
24 implement the pilot case management program for the homeless. The
25 pilot program established under this section must:
26 (1) provide case management services and existing
27 health-related education services to participants of the program;

1 and

2 (2) coordinate housing, medical, job training, and

3 other necessary services for the participants of the program.

4 (d) The commission shall identify programs available

5 through health and human services agencies through which homeless

6 people described by Subsection (a) may receive housing, medical,

7 job placement, or other services. The commission shall report to

8 the Texas Interagency Council for the Homeless information

9 regarding the identified programs, including the programs' sources

10 of funding and eligibility requirements.

11 (e) Not later than December 15 of each even-numbered year,

12 the Texas Interagency Council for the Homeless shall submit a

13 report to the governor, the lieutenant governor, and the speaker of

14 the house of representatives regarding the effectiveness of the

15 pilot program established under this section.

16 (f) This section expires September 1, 2009.

17 (c) The Health and Human Services Commission shall develop

18 and the Texas Interagency Council for the Homeless shall implement

19 the pilot program established under this section not later than

20 November 1, 2005.

21 SECTION 2.04. The heading to Chapter 533, Government Code,

22 is amended to read as follows:

23 CHAPTER 533. DEVELOPMENT AND IMPLEMENTATION

24 OF MEDICAID MANAGED CARE PROGRAM

25 SECTION 2.05. Subchapter A, Chapter 533, Government Code,

26 is amended by amending Sections 533.001 and 533.002 and adding

27 Sections 533.0021, 533.0022, 533.0023, and 533.0024 to read as

follows:

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.

(2) "Executive commissioner" [~~"Commissioner"~~] means the executive commissioner of the Health and Human Services Commission [~~health and human services~~].

(3) "Health and human services agencies" has the meaning assigned by Section 531.001.

(4) "Managed care organization" means a person who is authorized or otherwise permitted by law to arrange for or provide a managed care plan. The term includes a health care system established under Chapter 845, Insurance Code.

(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 and a health care system established under Chapter 845, Insurance Code. 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 medical assistance under Chapter 32, Human Resources Code.

(7) "Health care service region" or "region" means a

Medicaid managed care service area as delineated by the commission.

Sec. 533.002. MEDICAID HEALTH CARE DELIVERY SYSTEM. The commission may develop a health care delivery system that restructures the delivery of health care services provided under the state Medicaid program.

Sec. 533.0021. DESIGN AND DEVELOPMENT OF HEALTH CARE DELIVERY SYSTEM. In developing the health care delivery system under this chapter, the commission shall:

(1) design the system in a manner that:

(A) improves the health of the people of this state by:

(i) emphasizing prevention;

(ii) promoting continuity of care; and

(iii) providing a medical home for recipients;

(B) ensures that each recipient receives high-quality, comprehensive health care services in the recipient's local community; and

(C) ensures that the community is given an opportunity to provide input and participate in the implementation of the system in the health care service region by holding public hearings in the community at which the commission takes public comment from all persons interested in the implementation of the system;

(2) to the extent that it is cost-effective to this state and local governments:

(A) maximize the financing of the state Medicaid

1 program by obtaining federal matching funds for all resources or
2 other money available for matching;
3 (B) expand Medicaid eligibility to include
4 persons who were eligible to receive indigent health care services
5 through the use of those resources or other money available for
6 matching before expansion of eligibility; and
7 (C) develop a sliding scale copayment schedule
8 for recipients based on income and other factors determined by the
9 commissioner; and
10 (3) develop and prepare the waiver or other documents
11 necessary to obtain federal authorization for the system.
12 Sec. 533.0022. PURPOSE. The commission shall implement the
13 Medicaid managed care program as part of the health care delivery
14 system developed under this chapter [Chapter 532] by contracting
15 with managed care organizations in a manner that, to the extent
16 possible:
17 (1) accomplishes the goals described by Section
18 533.0021 [improves the health of Texans by:
19 [(A) emphasizing prevention;
20 [(B) promoting continuity of care; and
21 [(C) providing a medical home for recipients;
22 [(2) ensures that each recipient receives high
23 quality, comprehensive health care services in the recipient's
24 local community];
25 (2) [(3)] encourages the training of and access to
26 primary care physicians and providers;
27 (3) [(4)] maximizes cooperation with existing public

1 health entities, including local departments of health and
2 community mental health and mental retardation centers established
3 under Chapter 534, Health and Safety Code;
4 (4) [(5)] provides incentives to managed care
5 organizations to improve the quality of health care services for
6 recipients by providing value-added services; [and]
7 (5) [(6)] reduces administrative and other
8 nonfinancial barriers for recipients in obtaining health care
9 services; and
10 (6) controls the costs associated with the state
11 Medicaid program.
12 Sec. 533.0023. RULES FOR HEALTH CARE DELIVERY SYSTEM.
13 (a) The commissioner of insurance shall adopt rules as necessary
14 or appropriate to carry out the functions of the Texas Department of
15 Insurance under this chapter.
16 (b) The executive commissioner shall adopt rules and obtain
17 public input in accordance with Chapter 2001 before making
18 substantive changes to policies or programs under the Medicaid
19 managed care program.
20 Sec. 533.0024. RESOLUTION OF IMPLEMENTATION ISSUES. The
21 commission shall conduct a meeting at least quarterly with managed
22 care organizations that contract with the commission under this
23 chapter and health care providers to identify and resolve
24 implementation issues with respect to the Medicaid managed care
25 program.
26 SECTION 2.06. Subchapter A, Chapter 533, Government Code,
27 is amended by adding Section 533.0035 to read as follows:

Sec. 533.0035. LIMITATION ON NUMBER OF CONTRACTS AWARDED. The commission shall:

(1) evaluate the number of managed care organizations with which the commission contracts to provide health care services in each health care service region, focusing particularly on the market share of those managed care organizations; and

(2) limit the number of contracts awarded to managed care organizations under this chapter in a manner that promotes the successful implementation of the delivery of health care services through the state Medicaid managed care program.

SECTION 2.07. (a) Section 533.005, Government Code, is amended to read as follows:

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;

(2) capitation and provider payment rates that ensure the cost-effective provision of quality health care;

(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;

(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;

(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 not later than the 45th day after the date a claim for payment is received with documentation reasonably necessary for the managed care organization to process the claim, or within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(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;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(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 <u>inspector</u>

general [~~investigations and enforcement~~];

(11) a process by which the commission is required to:

(A) provide in writing to the managed care organization the projected fiscal impact on the state and managed care organizations that contract with the commission under this chapter of proposed Medicaid managed care program, benefit, or contract changes; and

(B) negotiate in good faith regarding appropriate operational and financial changes to the contract with the managed care organization before implementing those changes;

(12) a requirement that the managed care organization providing services to recipients under a Medicaid STAR + Plus pilot program:

(A) have an appropriate number of clinically trained case managers within the Medicaid STAR + Plus pilot program service delivery area to manage medically complex patients; and

(B) implement disease management programs that address the medical conditions of the Medicaid STAR + Plus pilot program population, including persons with HIV infection, AIDS, or sickle cell anemia;

(13) a requirement that the renewal date of the contract coincide with the beginning of the state fiscal year; and

(14) a requirement that the managed care organization reimburse health care providers for an appropriate emergency medical screening that is within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, and that is provided to

1 determine whether:

2 (A) an emergency medical or psychiatric

3 condition exists; and

4 (B) additional medical examination and treatment

5 is required to stabilize the emergency medical or psychiatric

6 condition

7 (b) The changes in law made by Section 533.005, Government

8 Code, as amended by this section, apply to a contract between the

9 Health and Human Services Commission and a managed care

10 organization under Chapter 533, Government Code, that is entered

11 into or renewed on or after the effective date of this section. A

12 contract that is entered into or renewed before the effective date

13 of this section is governed by the law in effect on the date the

14 contract was entered into or renewed, and the former law is

15 continued in effect for that purpose.

16 SECTION 2.08. (a) Subchapter A, Chapter 533, Government

17 Code, is amended by adding Sections 533.0051, 533.0077, 533.0091,

18 and 533.019 through 533.0202 to read as follows:

19 Sec. 533.0051. CONTRACT RENEWAL. Before renewing a

20 contract with a managed care organization under this chapter, the

21 commission shall consider:

22 (1) the managed care organization's:

23 (A) overall contract compliance;

24 (B) implementation of simplified administrative

25 processes for health care providers and recipients;

26 (C) compliance with statutory requirements to

27 promptly reimburse health care providers for covered services

1 provided under the Medicaid managed care program;
2 (D) compliance with the requirements under
3 Chapter 1301, Insurance Code, and Section 843.312, Insurance Code,
4 to identify advanced practice nurses and physician assistants as
5 providers in the managed care organization's provider network;
6 (E) financial performance; and
7 (F) participation in the state child health plan
8 under Chapter 62, Health and Safety Code; and
9 (2) the level of satisfaction of recipients and health
10 care providers with the managed care organization.
11 Sec. 533.0091. UNIFORM STANDARDS FOR IDENTIFYING
12 RECIPIENTS WITH DISABILITIES OR CHRONIC CONDITIONS. (a) The
13 commission shall collaborate with managed care organizations that
14 contract with the commission under this chapter to develop a
15 uniform screening tool to be used by the managed care organizations
16 to identify adult recipients with disabilities or chronic health
17 conditions and assist those recipients in accessing health care
18 services.
19 (b) The executive commissioner, in cooperation with the
20 Department of State Health Services, by rule shall adopt criteria
21 by which to classify a child with certain health conditions as a
22 child with special health care needs. In adopting the criteria, the
23 commission must include children who have:
24 (1) severe disabilities;
25 (2) severe mental or emotional disorders;
26 (3) medically complex or fragile health conditions; or
27 (4) rare or chronic health conditions that are likely

1 to last at least one year and result in limitations on the child's
2 functioning and activities when compared to other children of the
3 same age who do not have those conditions.
4 (c) The commission, in cooperation with the Department of
5 State Health Services, shall:
6 (1) monitor and assess health care services provided
7 under the state Medicaid managed care program and the medical
8 assistance program under Chapter 32, Human Resources Code, to
9 children with special health care needs as determined by the
10 criteria adopted under Subsection (b);
11 (2) adopt specific quality of care standards
12 applicable to health care services provided under the state
13 Medicaid managed care program to children described by Subdivision
14 (1); and
15 (3) undertake initiatives to develop, test, and
16 implement optimum methods for the delivery of appropriate,
17 comprehensive, and cost-effective health care services under the
18 state Medicaid managed care program to children described by
19 Subdivision (1), including initiatives to:
20 (A) coordinate health care services with
21 educational programs and other social and community services; and
22 (B) promote family involvement and support.
23 Sec. 533.019. PREAUTHORIZATION FOR CERTAIN SERVICES NOT
24 REQUIRED. The commission, in consultation with physicians,
25 hospitals, and managed care organizations contracting with the
26 commission under this chapter, shall develop:
27 (1) a process by which the managed care organizations

eliminate preauthorization processes for covered services that are considered to be routine services; and

(2) a process by which to notify health care providers of covered services under the Medicaid managed care program for which preauthorization is not required.

Sec. 533.020. UTILIZATION REVIEW UNDER PRIMARY CARE CASE MANAGEMENT NETWORK. To the extent allowed by federal law, the commission shall require a managed care organization that contracts with the commission under this chapter and that provides health care services to recipients through a primary care case management network to conduct utilization review of those services in accordance with Article 21.58A, Insurance Code.

Sec. 533.0201. NOTICE OF DETERMINATIONS MADE BY UTILIZATION REVIEW AGENTS. (a) In this section, "utilization review agent" has the meaning assigned by Section 2, Article 21.58A, Insurance Code.

(b) A utilization review agent shall notify a recipient or a person acting on behalf of the recipient and the recipient's health care provider of a utilization review determination in accordance with this section and Section 5(a), Article 21.58A, Insurance Code, with respect to services provided under the state Medicaid managed care program.

(c) If the utilization review agent makes an adverse determination, the notice required by this section must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description or the source of the screening criteria used as guidelines in making the determination; and

(4) a description of the procedure for the complaint and appeal process, including a description provided to the recipient of:

(A) the recipient's right to a Medicaid fair hearing at any time; and

(B) the procedures for appealing an adverse determination at a Medicaid fair hearing.

(d) The utilization review agent must provide notice of an adverse determination:

(1) to the recipient and the recipient's health care provider of record by telephone or electronic transmission not later than the next business day after the date the determination is made if the recipient is hospitalized when the determination is made, to be followed not later than the third business day after the date the determination is made by a written notice of the determination;

(2) to the recipient and the recipient's health care provider of record by written notice not later than the third business day after the date the determination is made if the recipient is not hospitalized when the determination is made; or

(3) to the recipient's treating physician or health care provider within the time appropriate to the circumstances that relate to the delivery of the services and the condition of the patient, but not later than one hour after the recipient's treating physician or provider requests poststabilization care following

emergency treatment.

(e) The executive commissioner shall adopt rules to implement this section.

Sec. 533.0202. IMPLEMENTATION OF CERTAIN MANAGED CARE PLANS IN CERTAIN COUNTIES. (a) Notwithstanding any other law, before implementing a Medicaid managed care plan that uses capitation as a method of payment in a county with a population of less than 100,000, the commission must determine that implementation is economically efficient.

(b) Notwithstanding Subsection (a), the commission may continue implementation of a Medicaid managed care plan described by Subsection (a) in a county with a population of less than 100,000 if implementation of the plan in the county was in progress on January 1, 2005.

(b) The changes in law made by Section 533.0201, Government Code, as added by this section, apply to a contract between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this section. A contract that is entered into or renewed before the effective date of this section is governed by the law in effect on the date the contract was entered into or renewed, and the former law is continued in effect for that purpose.

SECTION 2.09. (a) Section 31.0032(d), Human Resources Code, is amended to read as follows:

(d) This section does not prohibit the Texas Workforce Commission, the Health and Human Services Commission, or any health

1 and human services agency, as defined by Section 531.001,
2 Government Code, from providing medical assistance, child care, or
3 any other related social or support services for an individual who
4 is eligible for financial assistance but to whom that assistance is
5 not paid because of the individual's failure to cooperate.

6 (b) The changes in law made to Section 31.0032, Human
7 Resources Code, by this section apply to a person receiving
8 financial assistance under Chapter 31, Human Resources Code, on or
9 after the effective date of this Act, regardless of the date on
10 which eligibility for financial assistance was determined.

11 SECTION 2.10. Section 32.024, Human Resources Code, is
12 amended by reenacting and amending Subsection (i), as amended by
13 Chapters 198 and 1251, Acts of the 78th Legislature, Regular
14 Session, 2003, and Subsection (w), and adding Subsections (bb),
15 (cc), and (dd) to read as follows:

16 (i) The department shall [~~in its adoption of rules may~~]
17 establish a medically needy program that serves pregnant women,
18 children, and caretakers who have high medical expenses[~~, subject~~
19 ~~to availability of appropriated funds~~].

20 (w) The department shall set a personal needs allowance of
21 not less than $60 [~~$45~~] a month for a resident of a convalescent or
22 nursing home or related institution licensed under Chapter 242,
23 Health and Safety Code, personal care facility, ICF-MR facility, or
24 other similar long-term care facility who receives medical
25 assistance. The department may send the personal needs allowance
26 directly to a resident who receives Supplemental Security Income
27 (SSI) (42 U.S.C. Section 1381 et seq.). This subsection does not

apply to a resident who is participating in a medical assistance waiver program administered by the department.

(bb) The department shall ensure that each of the following programs and services under the medical assistance program is provided at or above the level for which the program or service was funded during the state fiscal biennium ending August 31, 2003:

(1) community care programs;

(2) services for pregnant women; and

(3) optional services for adult recipients, including mental health services, podiatric services, eyeglasses, and hearing aids.

(dd) The department shall provide hyperbaric oxygen therapy to the extent permitted by federal law.

SECTION 2.11. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0248 to read as follows:

Sec. 32.0248. ELIGIBILITY OF CERTAIN ALIENS. (a) The department shall provide medical assistance in accordance with 8 U.S.C. Section 1612(b) to a person who:

(1) is a qualified alien, as defined by 8 U.S.C. Sections 1641(b) and (c);

(2) meets the eligibility requirements of the medical assistance program;

(3) entered the United States on or after August 22, 1996; and

(4) has resided in the United States for a period of five years after the date the person entered as a qualified alien.

(b) If authorized by federal law, the department shall

1 provide pregnancy-related medical assistance to the maximum extent
2 permitted by the federal law to a person who is pregnant and is a
3 lawfully present alien as defined by 8 C.F.R. Section 103.12,
4 including a battered alien under 8 U.S.C. Section 1641(c),
5 regardless of the date on which the person entered the United
6 States. The department shall comply with any prerequisite imposed
7 under the federal law for providing medical assistance under this
8 subsection.

9 SECTION 2.12. Subchapter B, Chapter 32, Human Resources
10 Code, is amended by adding Section 32.0252 to read as follows:

11 Sec. 32.0252. CONTRACT TO PROVIDE ELIGIBILITY
12 DETERMINATION SERVICES. (a) To the extent allowed by federal law,
13 and except as otherwise provided by this section, the department
14 may contract for the provision of medical assistance eligibility
15 services with:

16 (1) a hospital district created under the authority of
17 Sections 4-11, Article IX, Texas Constitution;

18 (2) a hospital authority created under the authority
19 of Chapter 262 or 264, Health and Safety Code, that uses resources
20 to provide health care services to indigent persons to some extent;

21 (3) a hospital owned and operated by a municipality or
22 county or by a hospital authority created under Chapter 262 or 264,
23 Health and Safety Code;

24 (4) a medical school operated by this state;

25 (5) a medical school that receives state money under
26 Section 61.093, Education Code, or a chiropractic school that
27 receives state money under the General Appropriations Act;

(6) a teaching hospital operated by The University of Texas System;

(7) a county that is required to provide health care assistance to eligible county residents under Subchapter B, Chapter 61, Health and Safety Code;

(8) a governmental entity that is required to provide money to a public hospital under Section 61.062, Health and Safety Code;

(9) a county with a population of more than 400,000 that provides money to a public hospital and that is not included in the boundaries of a hospital district;

(10) a hospital owned by a municipality and leased to and operated by a nonprofit hospital for a public purpose;

(11) a hospital that receives Medicaid disproportionate share payments;

(12) a community mental health and mental retardation center;

(13) a local mental health or mental retardation authority;

(14) a local health department or public health district;

(15) a school-based health center;

(16) a community health center; and

(17) a federally qualified health center.

(b) The department may contract with an entity described by Subsection (a) for the entity to designate one or more employees of the entity to process medical assistance application forms and

conduct client interviews for eligibility determinations.

(c) Except as provided by Subsection (d), the contract must require each designated employee to submit completed application forms to the appropriate agency as determined by the department to finally determine eligibility and to enroll eligible persons in the program. A designated employee may not make a final determination of eligibility or enroll an eligible person in the program.

(d) Notwithstanding Subsection (c), the executive commissioner of the Health and Human Services Commission may apply for federal authorization to allow a designated employee of an entity described by Subsection (a) to make a final determination of eligibility or enroll an eligible person in the program.

(e) The department may:

(1) monitor the eligibility and application processing program used by an entity with which the department contracts; and

(2) provide on-site supervision of the program for quality control.

(f) The Health and Human Services Commission shall ensure that there are adequate protections to avoid a conflict of interest with an entity described by Subsection (a) that has a contract for eligibility services and also has a contract, either directly or through an affiliated entity, as a managed care organization for the Medicaid program or for the child health plan program under Chapter 62, Health and Safety Code. The commission shall ensure that there are adequate protections for recipients to freely choose a health plan without being inappropriately induced to join an

entity's health plan.

SECTION 2.13. Section 32.027(j), Human Resources Code, as added by Chapter 812, Acts of the 77th Legislature, Regular Session, 2001, is amended to read as follows:

(j) Subject to Section 32.0271, the [The] department shall assure that a recipient of medical assistance under this chapter may select a nurse first assistant, as defined by that section [Section 301.1525, Occupations Code], to perform any health care service or procedure covered under the medical assistance program [if:

[(1) the selected nurse first assistant is authorized by law to perform the service or procedure; and

[(2) the physician requests that the service or procedure be performed by the nurse first assistant].

SECTION 2.14. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0271 to read as follows:

Sec. 32.0271. SELECTION OF NURSE FIRST ASSISTANT. (a) In this section, "nurse first assistant" means a registered nurse who:

(1) is certified in perioperative nursing by an organization recognized by the Board of Nurse Examiners; and

(2) has completed a nurse first assistant educational program approved by an organization recognized by the Board of Nurse Examiners.

(b) As required by Section 32.027(j), as added by Chapter 812, Acts of the 77th Legislature, Regular Session, 2001, the department shall ensure that a recipient of medical assistance may select a nurse first assistant to perform any health care service or

procedure covered under the medical assistance program if:

(1) the selected nurse first assistant is authorized by law to perform the service or procedure; and

(2) the physician requests that the service or procedure be performed by the nurse first assistant.

(c) A managed care organization or a managed care plan, as those terms are defined by Section 533.001, Government Code, may not by contract or any other method require a physician to use the services of a nurse first assistant in providing care to a recipient of medical assistance.

(d) The Board of Nurse Examiners may adopt rules governing nurse first assistants for purposes of this section.

SECTION 2.15. Section 32.028, Human Resources Code, is amended by adding Subsection (n) to read as follows:

(n) The executive commissioner of the Health and Human Services Commission, in adopting reasonable rules and standards governing the allocation of any funds appropriated for rate increases for physician services and outpatient hospital services, shall establish a provider reimbursement methodology that recognizes and rewards high-volume providers, with an emphasis on providers located in areas of this state where medical assistance payments are particularly vital to the health care delivery system.

SECTION 2.16. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0471 to read as follows:

Sec. 32.0471. FAMILY PLANNING COUNSELING SERVICES; PROVIDER QUALIFICATIONS. The department shall require that anyone who provides counseling services related to family planning

services provided under this chapter must be:

(1) a licensed health care provider or a licensed counseling professional; or

(2) under the supervision of a licensed health care professional or a licensed counseling professional.

SECTION 2.17. (a) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Sections 32.071 through 32.074 to read as follows:

Sec. 32.071. DEMONSTRATION PROJECT FOR CERTAIN MEDICATIONS AND RELATED SERVICES. (a) The department shall establish a demonstration project to provide to a person through the medical assistance program psychotropic medications and related laboratory and medical services necessary to conform to a prescribed medical regime for those medications.

(b) A person is eligible to participate in the demonstration project if the person:

(1) has been diagnosed as having a mental impairment, including schizophrenia or bipolar disorder, that is expected to cause the person to become a disabled individual, as defined by Section 1614(a) of the federal Social Security Act (42 U.S.C. Section 1382c);

(2) is at least 19 years of age, but not more than 64 years of age;

(3) has a net family income that is at or below 200 percent of the federal poverty level;

(4) is not covered by a health benefits plan offering adequate coverage, as determined by the department; and

(5) is not otherwise eligible for medical assistance at the time the person's eligibility for participation in the demonstration project is determined.

(c) To the extent allowed by federal law, and except as otherwise provided by this section, the department may contract for the provision of eligibility services for the demonstration project with a local mental health authority.

(d) Notwithstanding any other provision of this section, the department shall provide each participant in the demonstration project with a 12-month period of continuous eligibility for participation in the project.

(e) Participation in the demonstration project does not entitle a participant to other services provided under the medical assistance program.

(f) The department shall establish an appropriate enrollment limit for the demonstration project and may not allow participation in the project to exceed that limit. Once the limit is reached, the department shall establish a waiting list for enrollment in the demonstration project.

(g) To the extent permitted by federal law, the department may require a participant in the demonstration project to make cost-sharing payments for services provided through the project.

(h) To the maximum extent possible, the department shall use existing resources to fund the demonstration project.

(i) Not later than December 1 of each even-numbered year, the department shall submit a biennial report to the legislature regarding the department's progress in establishing and operating

the demonstration project.

(j) Not later than December 1, 2010, the department shall evaluate the cost-effectiveness of the demonstration project, including whether the preventive drug treatments and related services provided under the project offset future long-term care costs for project participants. If the results of the evaluation indicate that the project is cost-effective, the department shall incorporate a request for funding for the continuation of the program in the department's budget request for the next state fiscal biennium.

(k) This section expires September 1, 2016.

Sec. 32.072. DEMONSTRATION PROJECT FOR PERSONS WITH HIV INFECTION OR AIDS. (a) In this section, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

(b) The department shall establish a demonstration project to provide a person with HIV infection or AIDS with the following services and medications through the medical assistance program:

(1) services provided by a physician, physician assistant, advanced practice nurse, or other health care provider specified by the department;

(2) medications not included in the formulary for the HIV medication program operated by the department, but determined to be necessary for treatment of a condition related to HIV infection or AIDS;

(3) vaccinations for hepatitis B and pneumonia;

(4) pap smears, colposcopy, and other diagnostic procedures necessary to monitor gynecologic complications

1 resulting from HIV infection or AIDS in women;
2 (5) hospitalization;
3 (6) laboratory and other diagnostic services,
4 including periodic testing for CD4 T-cell counts, viral load
5 determination, and phenotype or genotype testing if clinically
6 indicated; and
7 (7) other laboratory and radiological testing
8 necessary to monitor potential toxicity of therapy.
9 (c) The department shall establish the demonstration
10 project in at least two counties with a high prevalence of HIV
11 infection and AIDS. The department shall ensure that the
12 demonstration project is financed using funds made available by the
13 counties in which the department establishes the demonstration
14 project. The manner in which a county makes funds available may
15 include an option for the county to be able to certify the amount of
16 funds considered available instead of sending the funds to the
17 state.
18 (d) A person is eligible to participate in the demonstration
19 project if the person:
20 (1) has been diagnosed with HIV infection or AIDS by a
21 physician;
22 (2) is under 65 years of age;
23 (3) has a net family income that is at or below 200
24 percent of the federal poverty level;
25 (4) is a resident of a county included in the project
26 or, subject to guidelines established by the department, is
27 receiving medical care for HIV infection or AIDS through a facility

located in a county included in the project;

(5) is not covered by a health benefits plan offering adequate coverage, as determined by the department; and

(6) is not otherwise eligible for medical assistance at the time the person's eligibility for participation in the demonstration project is determined.

(e) Participation in the demonstration project does not entitle a participant to other services provided under the medical assistance program.

(f) The department shall establish an appropriate enrollment limit for the demonstration project and may not allow participation in the project to exceed that limit. Once the limit is reached, the department:

(1) shall establish a waiting list for enrollment in the demonstration project; and

(2) may allow eligible persons on the waiting list to enroll solely in the HIV medication program operated by the department.

(g) The department shall ensure that a participant in the demonstration project is also enrolled in the HIV medication program operated by the department.

(h) Notwithstanding any other provision of this section, the department shall provide each participant in the project with a six-month period of continuous eligibility for participation in the project.

(i) Not later than December 1 of each even-numbered year, the department shall submit a biennial report to the legislature

1 regarding the department's progress in establishing and operating
2 the demonstration project.
3 (j) Not later than December 1, 2010, the department shall
4 evaluate the cost-effectiveness of the demonstration project,
5 including whether the services and medications provided offset
6 future higher costs for project participants. If the results of the
7 evaluation indicate that the project is cost-effective, the
8 department shall incorporate a request for funding for the
9 expansion of the project into additional counties or throughout the
10 state, as appropriate, in the department's budget request for the
11 next state fiscal biennium.
12 (k) This section expires September 1, 2016.
13 Sec. 32.073. DEMONSTRATION PROJECTS FOR PROVISION OF
14 MEDICAL ASSISTANCE TO CERTAIN LOW-INCOME INDIVIDUALS. (a) The
15 Health and Human Services Commission shall establish demonstration
16 projects to provide medical assistance under this chapter to adult
17 individuals who are not otherwise eligible for medical assistance
18 and whose incomes are at or below 200 percent of the federal poverty
19 level.
20 (b) The Health and Human Services Commission shall select
21 one or more municipalities or counties in which to implement the
22 demonstration projects.
23 (c) The Health and Human Services Commission, in
24 conjunction with local governmental entities that make funds
25 available to the commission in accordance with this section, shall
26 design the components of the demonstration project and shall ensure
27 that:

1 (1) each demonstration project is financed using funds
2 made available by certain local governmental entities, through a
3 certification process, to the commission for matching purposes to
4 maximize federal funds for the medical assistance program; and
5 (2) a participant in a demonstration project is not
6 subject to a limitation imposed on prescription drug benefits under
7 the medical assistance program.
8 (d) The Health and Human Services Commission shall appoint
9 regional advisory committees to assist the commission in
10 establishing and implementing demonstration projects under this
11 section. An advisory committee must include health care providers,
12 employers, and local government officials.
13 Sec. 32.074. DEMONSTRATION PROJECT FOR WOMEN'S HEALTH CARE
14 SERVICES. (a) The department shall establish a five-year
15 demonstration project through the medical assistance program to
16 expand access to preventive health and family planning services for
17 women. A woman eligible under Subsection (b) to participate in the
18 demonstration project may receive preventive health and family
19 planning services, including:
20 (1) medical history;
21 (2) physical examinations;
22 (3) counseling and education on contraceptive methods
23 that includes:
24 (A) promoting abstinence as the preferred choice
25 of behavior related to all sexual activity for unmarried persons;
26 (B) emphasizing abstinence from sexual activity,
27 if used consistently and correctly, is the only method that is 100

1 percent effective in preventing pregnancy, sexually transmitted
2 diseases, infection with human immunodeficiency virus or acquired
3 immune deficiency syndrome, and the emotional trauma associated
4 with adolescent sexual activity; and
5 (C) informing single and divorced adults that
6 abstinence from sexual activity before marriage is the most
7 effective way to prevent pregnancy, sexually transmitted diseases,
8 and infection with human immunodeficiency virus or acquired immune
9 deficiency syndrome;
10 (4) provision of contraceptives;
11 (5) health screenings, including screening for:
12 (A) diabetes;
13 (B) cervical cancer;
14 (C) breast cancer;
15 (D) sexually transmitted diseases;
16 (E) hypertension;
17 (F) cholesterol; and
18 (G) tuberculosis;
19 (6) risk assessment; and
20 (7) referral of medical problems to appropriate
21 providers.
22 (b) A woman is eligible to participate in the demonstration
23 project if the woman:
24 (1) is 18 years of age or older;
25 (2) has a net family income that is at or below 185
26 percent of the federal poverty level; and
27 (3) is not otherwise eligible for the medical

1 assistance program.
2 (c) The department shall develop procedures for determining
3 and certifying presumptive eligibility for a woman eligible under
4 Subsection (b). The department shall integrate these procedures
5 with current procedures to minimize duplication of effort by
6 providers, the department, and other state agencies.
7 (d) The department shall provide for 12 months of continuous
8 eligibility for a woman eligible under Subsection (b).
9 (e) The department shall compile a list of potential funding
10 sources a client can use to help pay for treatment for health
11 problems:
12 (1) identified using services provided to the client
13 under the demonstration project; and
14 (2) for which the client is not eligible to receive
15 treatment under the medical assistance program.
16 (f) Not later than December 1 of each even-numbered year,
17 the department shall submit a report to the legislature that
18 includes a statement of the department's progress in establishing
19 and operating the demonstration project.
20 (g) The department shall ensure that money under the
21 demonstration project established by this section may not be used
22 for an abortion, as that term is defined by Section 245.002, Health
23 and Safety Code.
24 (h) To the extent required by federal budget neutrality
25 requirements, the department may establish an appropriate
26 enrollment limit for the demonstration project.
27 (i) This section expires September 1, 2011.

1 (b) The state agency responsible for implementing the
2 demonstration projects required by Sections 32.071 through 32.074,
3 Human Resources Code, as added by this section, shall request and
4 actively pursue any necessary waivers or authorizations from the
5 Centers for Medicare and Medicaid Services or other appropriate
6 entities to enable the agency to implement the demonstration
7 projects not later than September 1, 2006. The agency may delay
8 implementing a demonstration project until the necessary waivers or
9 authorizations are granted.
10 SECTION 2.18. (a) The executive commissioner of the Health
11 and Human Services Commission shall conduct a study regarding the
12 feasibility of expanding the medical assistance program under
13 Chapter 32, Human Resources Code, to provide medical assistance to
14 disabled children 18 years of age or younger in accordance with 42
15 U.S.C. Section 1396a(e)(3).
16 (b) In conducting the study, the executive commissioner
17 shall evaluate:
18 (1) the number of children who would be eligible for
19 medical assistance under the expanded program and who would be
20 likely to enroll;
21 (2) the effect of other health insurance coverage
22 provided for children who would be eligible under the expanded
23 medical assistance program on the cost of expanding the program;
24 (3) utilization patterns of similar populations of
25 disabled children under similar programs in this state and other
26 states;
27 (4) the cost to the state of inappropriate

1 institutionalization of disabled children resulting from
2 unavailability of health insurance coverage for those children; and
3 (5) options for setting an income eligibility cap for
4 the expanded medical assistance program.
5 (c) Not later than December 1, 2006, the executive
6 commissioner shall submit a report to the legislature regarding the
7 results of the study conducted under this section. The report must
8 include a recommendation regarding expanding the medical
9 assistance program to provide that assistance to disabled children
10 in accordance with 42 U.S.C. Section 1396a(e)(3).
11 SECTION 2.19. The executive commissioner of the Health and
12 Human Services Commission shall examine the reimbursement
13 methodology for air ambulance services purchased under the medical
14 assistance program and may implement any changes necessary to
15 maintain a viable air ambulance system through the state.
16 SECTION 2.20. The following laws are repealed:
17 (1) Sections 531.0392, 531.070(l), 531.072, 531.073,
18 531.074, 531.075, and Government Code; and
19 (2) Sections 31.0032(c), as added by Chapter 198, Acts
20 of the 78th Legislature, Regular Session, 2003, 32.024(z-1), and
21 32.064, Human Resources Code.
22 SECTION 2.21. Except as otherwise provided by this article,
23 this article applies to a person receiving medical assistance on or
24 after the effective date of this article, regardless of the date on
25 which the person began receiving that medical assistance.
26 ARTICLE 3. RESTORATION AND EXPANSION OF THE CHILDREN'S HEALTH
27 INSURANCE PROGRAM

1 SECTION 3.01. Section 62.002(4), Health and Safety Code, is
2 amended to read as follows:
3 (4) "Net [Gross] family income" means the [total]
4 amount of income established for a family after reduction for
5 offsets for expenses such as child care and work-related expenses,
6 in accordance with standards applicable under the Medicaid [without
7 consideration of any reduction for offsets that may be available to
8 the family under any other] program.
9 SECTION 3.02. Subchapter B, Chapter 62, Health and Safety
10 Code, is amended by adding Sections 62.056, 62.057, 62.060, and
11 62.061 to read as follows:
12 Sec. 62.056. COMMUNITY OUTREACH CAMPAIGN; TOLL-FREE
13 HOTLINE. (a) The commission shall conduct a community outreach and
14 education campaign to provide information relating to the
15 availability of health benefits for children under this chapter.
16 The commission shall conduct the campaign in a manner that promotes
17 enrollment in, and minimizes duplication of effort among, all
18 state-administered child health programs.
19 (b) The community outreach campaign must include:
20 (1) outreach efforts that involve school-based health
21 clinics; and
22 (2) a toll-free telephone number through which
23 families may obtain information about health benefits coverage for
24 children.
25 (c) The commission shall contract with community-based
26 organizations or coalitions of community-based organizations to
27 implement the community outreach campaign and shall also promote

1 and encourage voluntary efforts to implement the community outreach
2 campaign. The commission shall procure the contracts through a
3 process designed by the commission to encourage broad participation
4 of organizations, including organizations that target population
5 groups with high levels of uninsured children.
6 Sec. 62.057. REGIONAL ADVISORY COMMITTEES. (a) The
7 commission shall appoint regional advisory committees to provide
8 recommendations on the operation of the child health plan program.
9 (b) The advisory committees, to the extent possible, must be
10 composed of representatives of:
11 (1) hospitals;
12 (2) insurance companies and health maintenance
13 organizations eligible to offer the health benefits coverage under
14 the child health plan;
15 (3) primary care providers;
16 (4) consumer advocates, including advocates for
17 children with special health care needs;
18 (5) parents of children who are enrolled in the child
19 health plan;
20 (6) rural health care providers;
21 (7) specialty health care providers, including
22 pediatric providers;
23 (8) community-based organizations that provide
24 community outreach under Section 62.056; and
25 (9) state agencies.
26 (c) The commission shall establish the regional advisory
27 committees, consistent with Subsection (b), in regions of this

1 state in a manner that ensures geographic representation.

2 (d) In implementing this section, the commission may use
3 other regional advisory structures, augmented to ensure the
4 representation required by Subsection (b), to the extent necessary
5 to avoid duplication of administrative activities.

6 (e) The advisory committees shall meet at least quarterly
7 and are subject to Chapter 551, Government Code.

8 (f) Section 2110.008, Government Code, does not apply to the
9 advisory committees.

10 Sec. 62.060. AMOUNT OF STATE CONTRIBUTION. (a) Not later
11 than November 1 preceding each regular session of the legislature,
12 the executive commissioner of the commission shall certify to the
13 Legislative Budget Board the amount necessary to draw down the
14 maximum amount of federal money available for the child health plan
15 during the following state fiscal biennium, including any federal
16 money unused from a previous biennium that is available for that
17 biennium.

18 (b) Each legislative session the legislature shall
19 appropriate to the commission for the purpose of providing services
20 under the child health plan the amount certified under Subsection
21 (a).

22 Sec. 62.061. EXPENDITURE OF AVAILABLE MONEY. For each
23 state fiscal biennium the commission shall develop a plan to use all
24 federal money available for the state child health plan for that
25 biennium, including money remaining from previous years'
26 allocations of federal money for the plan, by maximizing the number
27 of children provided services under the plan.

SECTION 3.03. Section 62.101(b), Health and Safety Code, is amended to read as follows:

(b) The commission shall establish income eligibility levels consistent with Title XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, and subject to the availability of appropriated money, so that a child who is younger than 19 years of age and whose net [~~gross~~] family income is at or below 200 percent of the federal poverty level is eligible for health benefits coverage under the program. [~~In addition, the commission may establish eligibility standards regarding the amount and types of allowable assets for a family whose gross family income is above 150 percent of the federal poverty level.~~]

SECTION 3.04. Section 62.102, Health and Safety Code, is amended to read as follows:

Sec. 62.102. CONTINUOUS COVERAGE. [~~(a)~~] The commission shall provide that an individual who is determined to be eligible for coverage under the child health plan remains eligible for those benefits until the earlier of:

(1) the end of a period, not to exceed 12 months, following the date of the eligibility determination; or

(2) the individual's 19th birthday.

[~~(b) The period of continuous eligibility may be established at an interval of 6 months beginning immediately upon passage of this Act and ending September 1, 2005, at which time an interval of 12 months of continuous eligibility will be re-established.~~]

SECTION 3.05. Section 62.151(b), Health and Safety Code, is amended to read as follows:

(b) In developing the covered benefits, the commission shall consider the health care needs of healthy children and children with special health care needs. The child health plan must provide at least the covered benefits described by the recommended benefits package described for a state-designed child health plan by the Texas House of Representatives Committee on Public Health "CHIP" Interim Report to the Seventy-Sixth Texas Legislature dated December 1998 and the Senate Interim Committee on Children's Health Insurance Report to the Seventy-Sixth Texas Legislature dated December 1, 1998. The child health plan must include at least the covered benefits provided under the plan on June 1, 2003.

SECTION 3.06. Section 62.153(b), Health and Safety Code, is amended to read as follows:

(b) Cost-sharing [~~Subject to Subsection (d), cost-sharing~~] provisions adopted under this section shall ensure that families with higher levels of income are required to pay progressively higher percentages of the cost of the plan.

SECTION 3.07. Sections 62.154(a) and (d), Health and Safety Code, are amended to read as follows:

(a) To the extent permitted under Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, the child health plan must include a waiting period and[~~. The child health plan~~] may include copayments and other provisions intended to discourage:

(1) employers and other persons from electing to

discontinue offering coverage for children under employee or other group health benefit plans; and

(2) individuals with access to adequate health benefit plan coverage, other than coverage under the child health plan, from electing not to obtain or to discontinue that coverage for a child.

(d) The waiting period required by Subsection (a) must:

(1) extend for a period of 90 days after[:

[(1)] the last date on [first day of the month in] which the applicant was covered under a health benefits plan; and

(2) apply to a child who was covered by a health benefits plan at any time during the 90 days before the date of application for coverage under the child health plan [is enrolled under the child health plan, if the date of enrollment is on or before the 15th day of the month; or

[(2) the first day of the month after which the applicant is enrolled under the child health plan, if the date of enrollment is after the 15th day of the month].

SECTION 3.08. Sections 62.155(c) and (d), Health and Safety Code, are amended to read as follows:

(c) In selecting a health plan provider, the commission:

(1) may give preference to a person who provides similar coverage under the Medicaid program; and

(2) shall provide for a choice of at least two health plan providers in each metropolitan [service] area.

(d) The commissioner may authorize an exception to Subsection (c)(2) if there is only one acceptable applicant to

1 become a health plan provider in the metropolitan [~~service~~] area.
2 SECTION 3.09. The following laws are repealed:
3 (1) Section 62.151(f), Health and Safety Code; and
4 (2) Section 62.153(d), Health and Safety Code.
5 ARTICLE 4. ADDITIONAL CHANGES TO HEALTH AND HUMAN SERVICES
6 PROGRAMS
7 SECTION 4.01. CALL CENTERS. (a) The Health and Human
8 Services Commission may not accept a proposal for the establishment
9 of a call center under Section 531.063, Government Code, as added by
10 Chapter 198, Acts of the 78th Legislature, Regular Session, 2003,
11 or conduct negotiations regarding a proposed contract for a call
12 center under that section on or after the effective date of this
13 article.
14 (b) If the Health and Human Services Commission entered into
15 a contract for the establishment of a call center under Section
16 531.063, Government Code, as added by Chapter 198, Acts of the 78th
17 Legislature, Regular Session, 2003, before the effective date of
18 this article, the commission may not renew the contract. During the
19 term of the contract and except as provided by Sections 32.0252 and
20 32.071, Human Resources Code, as added by this Act, the commission:
21 (1) must continue to directly operate local offices
22 for the purpose of determining an applicant's eligibility for
23 health and human services programs and allow an applicant to access
24 a local office in lieu of accessing a call center for an eligibility
25 determination; and
26 (2) may not terminate the employment of any state
27 employee whose primary job function involves determining the

1 eligibility of an applicant for health and human services programs
2 on the basis that the performance of those functions is no longer
3 needed.
4 (c) Section 531.063, Government Code, as added by Chapter
5 198, Acts of the 78th Legislature, Regular Session, 2003, is
6 repealed.
7 SECTION 4.02. EFFECTIVE DATE OF ARTICLE. This article
8 takes effect immediately if this Act receives a vote of two-thirds
9 of all the members elected to each house, as provided by Section 39,
10 Article III, Texas Constitution. If this Act does not receive the
11 vote necessary for this article to have immediate effect, this
12 article takes effect September 1, 2005.
13 ARTICLE 5. COMPLIANCE WITH FEDERAL REQUIREMENTS; EFFECTIVE DATE
14 SECTION 5.01. FEDERAL WAIVER AS PREREQUISITE TO
15 IMPLEMENTATION. If before implementing any provision of this Act a
16 state agency determines that a waiver or authorization from a
17 federal agency is necessary for implementation of that provision,
18 the agency affected by the provision shall request the waiver or
19 authorization and may delay implementing that provision until the
20 waiver or authorization is granted.
21 SECTION 5.02. EFFECTIVE DATE. Except as otherwise provided
22 by this Act, this Act takes effect September 1, 2005.