AN ACT

relating to the medical assistance program and other health and human services.

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

SECTION 1. COMMUNITY COLLABORATION. Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.020 to read as follows:

Sec. 531.020. OFFICE OF COMMUNITY COLLABORATION. The executive commissioner shall establish within the commission an office of community collaboration. The office is responsible for:

(1) collaborating with community, state, and federal stakeholders to improve the elements of the health care system that are involved in the delivery of Medicaid services; and

(2) sharing with Medicaid providers, including hospitals, any best practices, resources, or other information regarding improvements to the health care system.

SECTION 2. MEDICAID FINANCING. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02113 to read as follows:

Sec. 531.02113. OPTIMIZATION OF MEDICAID FINANCING. The commission shall ensure that the Medicaid finance system is optimized to:

(1) maximize the state's receipt of federal funds;

(2) create incentives for providers to use preventive

care;

(3) increase and retain providers in the system to maintain an adequate provider network;

(4) more accurately reflect the costs borne by providers; and

(5) encourage the improvement of the quality of care.

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

(a) An insurer shall maintain a file system that contains:

(1) the name, address, including claim submission address, group policy number, employer's mailing address, social security number, and date of birth of each enrollee, beneficiary, subscriber, or policyholder covered by the insurer; and

(2) the name, address, including claim submission address, and date of birth of each dependent of each enrollee, beneficiary, subscriber, or policyholder covered by the insurer.

(b) The state's Medicaid third-party recovery division shall identify state medical assistance recipients who have third-party health coverage or insurance as provided by this subsection. The department may:

(1) [~~shall~~] provide to an insurer Medicaid data tapes that identify medical assistance recipients and request that the insurer identify each enrollee, beneficiary, subscriber, or policyholder of the insurer whose name also appears on the Medicaid data tape; or

(2) request that an insurer provide to the department

identifying information for each enrollee, beneficiary, subscriber, or policyholder of the insurer.

(b-1) An insurer from which the department requests information under Subsection (b) shall provide that information, except that the [~~An insurer shall comply with a request under this subsection not later than the 60th day after the date the request was made. An~~] insurer is only required [~~under this subsection~~] to provide the department with the information maintained under Subsection (a) by the insurer or made available to the insurer from the plan. A plan administrator is subject to Subsection (b) and shall provide information under that [~~this~~] subsection to the extent the information [~~described in this subsection~~] is made available to the plan administrator from the insurer or plan.

(d) An insurer shall provide the information required under Subsection (b)(1) [~~this section~~] only if the department certifies that the identified individuals are applicants for or recipients of services under Medicaid or are legally responsible for an applicant for or recipient of Medicaid services.

(e) The department shall 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. If the department makes a data match using information provided under Subsection (b)(2), the department shall reimburse the insurer or plan administrator for reasonable administrative expenses incurred in providing the information. The reimbursement for information under Subsection (b)(2) may not

exceed $5,000 for initially producing information with respect to a person, or $200 for each subsequent production of information with respect to the person [~~this section~~]. The department may enter into an agreement with an insurer or plan administrator [~~insurers~~] that provides procedures for requesting and providing information under this section. An agreement under this subsection may not be inconsistent with any law relating to the confidentiality or privacy of personal information or medical records. The procedures agreed to under this subsection must state the time and manner the procedures take effect.

(c) The Health and Human Services Commission shall:

(1) examine the possibility of using existing state funds, including existing state funds for the county indigent health care program and the area health education centers in this state, on health-related programs to maximize receipt of additional federal Medicaid funds;

(2) subject to availability of funds, increase Medicaid reimbursement rates for hospitals and physicians to better align those rates with Medicare and private-pay reimbursement rates;

(3) examine the possibility of a program under which intergovernmental transfers are used to support graduate medical education in support of the Medicaid program and, if cost-effective, implement that program;

(4) examine the possibility of a program that includes comprehensive outpatient rehabilitation facilities in the prospective payment systems methodology and, if cost-effective,

implement that program;

(5) examine the possibility of developing Medicaid waivers for intergovernmental transfers from local entities similar to those used in the demonstration projects under Chapter 534, Government Code;

(6) examine the possibility of developing a Medicaid waiver program to allow local governmental entities as well as private employers to buy into the Medicaid or children's health insurance programs and, if cost-effective, implement that program;

(7) examine the possibility of using employer contributions and donations to expand eligibility and funding for the Medicaid and children's health insurance programs and, if cost-effective, implement that option; and

(8) examine the possibility of providing a tax incentive in the form of an ad valorem, franchise, or sales tax credit for employers to enable those employers to pay the state's portion of the premiums for Medicaid or children's health insurance for employees whose family income does not exceed 200 percent of the federal poverty limit and, if cost-effective, implement that option.

(d) If the Health and Human Services Commission chooses to increase reimbursement rates for any providers under Subdivision (2), Subsection (c) of this section, the commission shall 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) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02141 to read as follows:

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

(1) incorporates program enrollment, utilization, and provider data that are currently collected;

(2) allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within the program;

(3) is able to obtain consistent and accurate answers to questions;

(4) allows for analysis of multiple issues within the program to determine whether any programmatic or policy issues overlap or are in conflict;

(5) includes predefined data reports on utilization of high-cost services that allow program management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate;

(6) includes any encounter data with respect to

recipients that a managed care organization that contracts with the commission under Chapter 533 receives from a health care provider under the organization's provider network; and

(7) links Medicaid and non-Medicaid data sets, including data sets related to the Medicaid program, the Temporary Assistance for Needy Families program, the Special Supplemental Nutrition Program for Women, Infants, and Children, vital statistics, and other public health programs.

(b) The commission shall ensure that all Medicaid data sets created or identified by the decision support system are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist or arise with respect to making the data sets available on the Internet, the system and the commission shall make every effort to make the data available through that means either by removing information by which particular individuals may be identified or by aggregating the data in a manner so that individual records cannot be associated with particular individuals.

(b) The Health and Human Services Commission shall allow for sufficient opportunities for stakeholder input in the modification or redesign of the decision support system in the commission's center for strategic decision support as required by Section 531.02141, Government Code, as added by this section. The commission may provide these opportunities through:

(1) existing mechanisms, such as regional advisory committees or public forums; and

(2) meetings involving state and local agencies and

other entities involved in the planning, management, or delivery of health and human services in this state.

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

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in the Medicaid program and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of the Medicaid program by any method the commission determines is cost-effective, including:

(1) expanding the utilization of the electronic claims payment system;

(2) developing an Internet portal system for prior authorization requests;

(3) encouraging Medicaid providers to submit their program participation applications electronically;

(4) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently apply to the program;

(5) working with federal partners to take advantage of every opportunity to maximize additional federal funding for

technology in the Medicaid program; and

(6) encouraging the increased use of medical technology by providers, including increasing their use of:

(A) electronic communications between patients and their physicians or other health care providers;

(B) electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health care practitioner writes a prescription and that support the electronic transmission of a prescription;

(C) ambulatory computerized order entry systems that facilitate physician and other health care practitioner orders at the point of care for medications and laboratory and radiological tests;

(D) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting;

(E) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and

(F) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely.

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. (a) The commission shall make every effort to ensure the integrity of the Medicaid program. To ensure that integrity, the commission shall:

(1) perform risk assessments of every element of the Medicaid program and audit those elements of the program that are

determined to present the greatest risks;

(2) ensure that sufficient oversight is in place for the Medicaid medical transportation program;

(3) ensure that a quality review assessment of the Medicaid medical transportation program occurs; and

(4) evaluate the Medicaid program with respect to use of the metrics developed through the Texas Health Steps performance improvement plan to guide changes and improvements to the program.

(b) 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) To further encourage the use of medical technology by providers under the Medicaid program, the Health and Human Services Commission may enter into a written agreement with a manufacturer, as defined by Section 531.070, Government Code, to accept as a program benefit in lieu of supplemental rebates, as defined by Section 531.070, Government Code, the manufacturer's operation of a pilot program under which the manufacturer supplies those providers with a graphical electronic medical record system and evaluates the benefits and cost-effectiveness of the system. The program must be operated in a manner that is acceptable to the commission and must be designed to test the benefits and cost-effectiveness on a sufficiently large scale. The manufacturer shall report the results of the program, including an analysis of the program's benefits and cost-effectiveness, to the commission. The commission shall report those results to the 80th Legislature not later than

January 15, 2007.

(c) The Health and Human Services Commission shall examine options for standardizing and simplifying the interaction between the Medicaid system and providers regardless of the service delivery system through which a provider provides services and, using existing resources, implement any options that are anticipated to increase the quality of care and contain costs.

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

Sec. 531.083. MEDICAID LONG-TERM CARE SYSTEM. The commission shall ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds. The commission shall also make every effort to improve the quality of care for recipients of Medicaid long-term care services by:

(1) evaluating the need for expanding the provider base for consumer-directed services and, if the commission identifies a demand for that expansion, encouraging area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with the Department of Aging and Disability Services;

(2) ensuring that all recipients who reside in a nursing facility are provided information about end-of-life care options and the importance of planning for end-of-life care; and

(3) developing policies to encourage a recipient who

resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an appropriate continuum of care.

Sec. 531.084. MEDICAID LONG-TERM CARE COST CONTAINMENT STRATEGIES. (a) The commission shall make every effort to achieve cost efficiencies within the Medicaid long-term care program. To achieve those efficiencies, the commission shall:

(1) establish a fee schedule for reimbursable incurred medical expenses for dental services controlled in long-term care facilities;

(2) implement a fee schedule for reimbursable incurred medical expenses for durable medical equipment in nursing facilities and ICF-MR facilities;

(3) implement a durable medical equipment fee schedule action plan;

(4) establish a system for private contractors to secure and coordinate the collection of Medicare funds for recipients who are dually eligible for Medicare and Medicaid;

(5) create additional partnerships with pharmaceutical companies to obtain discounted prescription drugs for Medicaid recipients; and

(6) develop and implement a system for auditing the Medicaid hospice care system that provides services in long-term care facilities to ensure correct billing for pharmaceuticals.

(b) The executive commissioner and the commissioner of aging and disability services shall jointly appoint persons to serve on a work group to assist the commission in developing the fee

schedule required by Subsection (a)(1). The work group must consist of providers of long-term care services, including dentists and long-term care advocates.

(c) In developing the fee schedule required by Subsection (a)(1), the commission shall consider:

(1) the need to ensure access to dental services for residents of long-term care facilities who are unable to travel to a dental office to obtain care;

(2) the most recent Comprehensive Fee Report published by the National Dental Advisory Service;

(3) the difficulty of providing dental services in long-term care facilities;

(4) the complexity of treating medically compromised patients; and

(5) time-related and travel-related costs incurred by dentists providing dental services in long-term care facilities.

(d) The commission shall annually update the fee schedule required by Subsection (a)(1).

(b) The Health and Human Services Commission shall examine:

(1) the possibility of implementing a program to expand Medicaid home health benefits to include speech pathology services, intravenous therapy, and chemotherapy treatments and, if cost-effective, implement that program;

(2) the possibility of implementing a program to provide respite and other support services to individuals providing daily assistance to persons with Alzheimer's disease or dementia to reduce caregiver burnout and, if cost-effective, implement that

program;

(3) the possibility of implementing a program to offer services through state schools to recipients who are living in the community and a program to use funding for community-based services to pay for the services from the state schools and, if cost-effective, implement those programs;

(4) in conjunction with the Department of Aging and Disability Services, the possibility of implementing a program to simplify the administrative procedures for regulating nursing facilities and, if cost-effective, implement that program; and

(5) the possibility of using fee schedules, prior approval processes, and alternative service delivery options to ensure appropriate utilization and payment for Medicaid services and, if cost-effective, implement those schedules, processes, and options.

(c) The Health and Human Services Commission shall 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) Prior to developing and adopting the fee schedule required by Subdivision (1), Subsection (a), Section 531.084, Government Code, as added by this section, the Health and Human Services Commission shall 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.

SECTION 6. MEDICAID MANAGED CARE. (a) Section 533.005,

Government Code, is amended by amending Subsection (a) and adding Subsection (c) to read as follows:

(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 inspector general [~~investigations and enforcement~~];

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission; [~~and~~]

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and

32.0281, Human Resources Code;

(13) a requirement that the organization use advanced practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician; and

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal; and

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider.

(c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (a)(14).

(b) Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.0071 and 533.0072 to read as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, the commission shall:

(1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program;

(2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to enrollees who leave the managed care program;

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A) where possible, decreasing the duplication of administrative reporting requirements for the managed care organizations, such as requirements for the submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address information directly to the commission for correction in the state system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to the preauthorization process, lengths of hospital stays, filing deadlines, levels of care, and case management services; and

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications; and

(5) reserve the right to amend the managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes.

Sec. 533.0072. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and maintain a record of each enforcement action initiated by the

commission that results in a sanction, including a penalty, being imposed against a managed care organization for failure to comply with the terms of a contract to provide health care services to recipients through a managed care plan issued by the organization.

(b) The record must include:

(1) the name and address of the organization;

(2) a description of the contractual obligation the organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed;

(5) the maximum sanction that may be imposed under the contract for the violation; and

(6) the actual sanction imposed against the organization.

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

(d) The commission may not post information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) A record prepared under this section may not include information that is excepted from disclosure under Chapter 552.

(f) The executive commissioner shall adopt rules as necessary to implement this section.

(c) The Health and Human Services Commission shall reevaluate the case management fee used in the primary care case management program and shall make recommendations to the Legislative Budget Board if the commission finds that a different rate is appropriate.

(d) The Health and Human Services Commission shall examine:

(1) the feasibility and cost-effectiveness of establishing a sliding-scale case management fee for the primary care case management program based on primary care provider performance;

(2) the operational efficiency, health outcomes, case management, and cost-effectiveness of the primary care case management program and adopt any necessary changes to maximize health outcomes and cost-effectiveness; and

(3) the mechanism used to encourage hospital participation in the primary care case management program and adopt alternative policies if current policies are determined to be ineffective.

(e) The Health and Human Services Commission shall make every effort to improve the delivery of health care services to recipients enrolled in the Medicaid managed care program by evaluating the following actions for a determination of cost-effectiveness and pursuing those actions if they are determined to be cost-effective:

(1) adding a Medicaid managed care contract requirement that requires each managed care plan to work with the commission and health care providers to improve the immunization

rate of Medicaid clients and the reporting of immunization information for inclusion in ImmTrac;

(2) to the extent permitted by federal law, allowing managed care organizations access to the previous claims history of a new enrollee that is maintained by a claims administrator if the new managed care organization enrollee was formerly a recipient under the Medicaid fee for service or primary care case management system;

(3) encouraging managed care organizations to operate nurse triage telephone lines and to more effectively notify enrollees that the lines exist and inform enrollees regarding how to access those lines;

(4) creating more rigorous contract standards for managed care organizations to ensure that children have clinically appropriate alternatives to emergency room services outside of regular office hours;

(5) developing more effective mechanisms to identify and control the utilization of program services by enrollees who are found to have abused the services; and

(6) studying the impact on the program of enrollees who have a history of high or abusive use of program services and incorporating the most effective methods of curtailing that activity while assuring that those enrollees receive adequate health services.

(f) Section 533.005, Government Code, as amended by this section, applies only 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 between the commission and an organization 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.

(g) Section 533.0072, Government Code, as added by this section, applies only to a sanction imposed on or after the effective date of this section.

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

(f) The executive commissioner of the Health and Human Services Commission [~~department~~] by rule may [~~shall~~] develop a system of selective contracting with health care providers for the provision of nonemergency inpatient hospital services to a recipient of medical assistance under this chapter. In implementing this subsection, the executive commissioner [~~department~~] shall:

(1) seek input from consumer representatives and from representatives of hospitals licensed under Chapter 241, Health and Safety Code, and from organizations representing those hospitals; and

(2) ensure that providers selected under the system meet the needs of a recipient of medical assistance under this chapter.

(l) Subject to appropriations, the department shall assure

that a recipient of medical assistance under this chapter may select a licensed psychologist, a licensed marriage and family therapist, as defined by Section 502.002, Occupations Code, a licensed professional counselor, as defined by Section 503.002, Occupations Code, or a licensed master social worker, as defined by Section 505.002, Occupations Code, 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. This subsection shall be liberally construed.

(b) Subsection (e), Section 32.027, Human Resources Code, as amended by Chapter 1251, Acts of the 78th Legislature, Regular Session, 2003, is repealed.

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

Sec. 32.0551. OPTIMIZATION OF CASE MANAGEMENT SYSTEMS. The Health and Human Services Commission shall:

(1) create and coordinate staffing and other administrative efficiencies for case management initiatives across the commission and health and human services agencies, as defined by Section 531.001, Government Code; and

(2) optimize federal funding revenue sources and maximize the use of state funding resources for case management initiatives across the commission and health and human services agencies.

(b) The Health and Human Services Commission shall evaluate the cost-effectiveness of developing intensive case management and

targeted interventions for all Medicaid recipients who are aged, blind, or disabled.

(c) The Health and Human Services Commission shall 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. The commission shall 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) The Health and Human Services Commission shall evaluate the cost-effectiveness of including within Medicaid disease management programs in existence on the effective date of this section additional diseases, such as chronic kidney disease or end-stage renal disease, additional chronic medical conditions, such as severe pain that requires management, and other strategies, such as home health services for children with chronic conditions that are not included in the existing disease management programs and the use of schools and school nurses to manage chronic medical conditions of children. In evaluating the cost-effectiveness of including other diseases, conditions, and strategies, the commission may 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. The commission may also research the experiences of other states, insurance companies, and managed care organizations and review other sources of data the commission determines is appropriate. The commission shall expand Medicaid disease

management programs and related programs to include the diseases, conditions, and strategies that the commission determines under this subsection will be cost-effective.

(e) The Health and Human Services Commission shall conduct a study to determine the feasibility of combining the utilization management, case management, care coordination, high-cost targeting, provider incentives, and other quality and cost-control measures implemented with respect to the Medicaid program under a single federal waiver, which may be a waiver under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) or a waiver under Section 1115(a) of that Act (42 U.S.C. Section 1315(a)). If the commission determines that the combination is feasible, the commission shall develop the combined program and seek the appropriate approval from the Centers for Medicare and Medicaid Services. In conducting the study, the commission shall solicit stakeholder input and consider information from any other optimization-related projects currently being operated, including the Consolidated Waiver Project authorized by 531.0219, Government Code, former projects including the Mental Retardation Local Authority program, and related information from projects in other states.

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

Sec. 32.071. RECIPIENT AND PROVIDER EDUCATION. (a) The department shall 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. The department shall 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) The comprehensive medical assistance education campaign must 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. The campaign must include the dissemination of educational information through newsletters and emergency department staff members and at local health fairs, unless the department determines that these methods of dissemination are not effective in increasing recipients' appropriate use of the health care system.

(c) The department shall 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. If the department determines that certain risk groups will respond with more appropriate use of the system, the department shall develop and implement the appropriate targeted educational elements.

(d) The department shall 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) The department shall coordinate the medical assistance education campaign with area health education centers, federally qualified health centers, as defined by 42 U.S.C. Section 1396d(l)(2)(B), and other stakeholders who use public funds to educate recipients and providers about the health care system in this state. The department shall 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) The department shall coordinate with other state and local agencies to ensure that community-based health workers, health educators, state eligibility determination employees who work in hospitals and other provider locations, and promoters are used in the medical assistance education campaign, as appropriate.

(g) The department shall 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) In developing the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section, the Health and Human Services Commission shall 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) The Health and Human Services Commission shall identify all funds being spent on the effective date of this section on education for Medicaid recipients. The commission shall 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. Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.0081 to read as follows:

Sec. 531.0081. OFFICE OF MEDICAL TECHNOLOGY. (a) In this section, "office" means the office of medical technology.

(b) The commission shall establish the office of medical technology within the commission. The office shall explore and evaluate new developments in medical technology and propose implementing the technology in the medical assistance program under Chapter 32, Human Resources Code, if appropriate and cost-effective.

(c) Office staff must have skills and experience in research regarding health care technology.

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

(f) In adopting rates for medical assistance payments under Subsection (b)(2), the executive commissioner may adopt reimbursement rates for appropriate nursing services provided to recipients with certain health conditions if those services are determined to provide a cost-effective alternative to

hospitalization. A physician must certify that the nursing services are medically appropriate for the recipient for those services to qualify for reimbursement under this subsection.

(g) In adopting rates for medical assistance payments under Subsection (b)(2), the executive commissioner may 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) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02175 to read as follows:

Sec. 531.02175. REIMBURSEMENT FOR ONLINE MEDICAL CONSULTATIONS. (a) In this section, "physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(b) Subject to the requirements of this subsection, the executive commissioner by rule may require the commission and each health and human services agency that administers a part of 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. The executive commissioner may require the commission or a health and human services agency to provide the reimbursement described by this subsection only if the Centers for Medicare and Medicaid Services develop an appropriate Current Procedural Terminology code for medical services provided using the Internet.

(c) The executive commissioner may develop and implement a

pilot program in one or more sites chosen by the executive commissioner under which Medicaid reimbursements are paid for medical consultations provided by physicians or other health care professionals using the Internet. The pilot program must be designed to test whether an Internet medical consultation is a cost-effective alternative to an in-person consultation under the Medicaid program. The executive commissioner may modify the pilot program as necessary throughout its implementation to maximize the potential cost-effectiveness of Internet medical consultations. If the executive commissioner determines from the pilot program that Internet medical consultations are cost-effective, the executive commissioner may expand the pilot program to additional sites or may implement Medicaid reimbursements for Internet medical consultations statewide.

(d) The executive commissioner is not required to implement the pilot program authorized under Subsection (c) as a prerequisite to providing Medicaid reimbursement authorized by Subsection (b) on a statewide basis.

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

Sec. 531.085. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES. The commission shall develop and implement a comprehensive plan to reduce the use of hospital emergency room services by recipients under the medical assistance program. The plan may include:

(1) a pilot program designed to facilitate program

participants in accessing an appropriate level of health care, which may include as components:

(A) providing program participants access to bilingual health services providers; and

(B) giving program participants information on how to access primary care physicians, advanced practice nurses, and local health clinics;

(2) a pilot program under which health care providers, other than hospitals, are given financial incentives for treating recipients outside of normal business hours to divert those recipients from hospital emergency rooms;

(3) payment of a nominal referral fee to hospital emergency rooms that perform an initial medical evaluation of a recipient and subsequently refer the recipient, if medically stable, to an appropriate level of health care, such as care provided by a primary care physician, advanced practice nurse, or local clinic;

(4) a program under which the commission or a managed care organization that enters into a contract with the commission under Chapter 533 contacts, by telephone or mail, a recipient who accesses a hospital emergency room three times during a six-month period and provides the recipient with information on ways the recipient may secure a medical home to avoid unnecessary treatment at hospital emergency rooms;

(5) a health care literacy program under which the commission develops partnerships with other state agencies and private entities to:

(A) assist the commission in developing materials that:

(i) contain basic health care information for parents of young children who are recipients under the medical assistance program and who are participating in public or private child-care or prekindergarten programs, including federal Head Start programs; and

(ii) are written in a language understandable to those parents and specifically tailored to be applicable to the needs of those parents;

(B) distribute the materials developed under Paragraph (A) to those parents; and

(C) otherwise teach those parents about the health care needs of their children and ways to address those needs; and

(6) other initiatives developed and implemented in other states that have shown success in reducing the incidence of unnecessary treatment in hospital emergency rooms.

(b) The Health and Human Services Commission may develop the health care literacy component of the comprehensive plan to reduce the use of hospital emergency room services required by Subdivision (5), Section 531.085, Government Code, as added by this section, so that the health care literacy component operates in a manner similar to the manner in which the Johnson & Johnson/UCLA Health Care Institute operates its health care training program that is designed to teach parents to better address the health care needs of their children.

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

Sec. 531.086. PERFORMANCE BONUS PILOT PROGRAM. (a) The commission shall 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) The commission shall define the parameters of the proposed program, including:

(1) the types of chronic health conditions the program would target;

(2) the best practices and standards of care that must be followed for a provider to obtain a higher reimbursement rate under the proposed program; and

(3) the types of providers to whom the higher reimbursement rate would be offered under the proposed program.

(c) Not later than December 1, 2006, the Health and Human Services Commission shall 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. The report must include:

(1) the anticipated effect of the higher reimbursement rates to be offered under the program on the quality of care provided and the health outcomes for program recipients;

(2) a determination of whether the program would be

cost-effective; and

(3) a recommendation regarding implementation of the program.

(d) This section expires September 1, 2007.

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

(a) A pharmacist who practices in or serves as a consultant for a health care facility in this state may return to a pharmacy certain unused drugs, other than a controlled substance as defined by Chapter 481, Health and Safety Code, purchased from the pharmacy as provided by board rule. The unused drugs must:

(1) be approved by the federal Food and Drug Administration and be:

(A) sealed in [~~the manufacturer's original~~] unopened tamper-evident packaging and either individually packaged or packaged in unit-dose packaging;

(B) oral or parenteral medication in sealed single-dose containers approved by the federal Food and Drug Administration;

(C) topical or inhalant drugs in sealed units-of-use containers approved by the federal Food and Drug Administration; or

(D) parenteral medications in sealed multiple-dose containers approved by the federal Food and Drug Administration from which doses have not been withdrawn; and

(2) not be the subject of a mandatory recall by a state

or federal agency or a voluntary recall by a drug seller or manufacturer.

(f) 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) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02131 to read as follows:

Sec. 531.02131. MEDICAID MEDICAL INFORMATION TELEPHONE HOTLINE PILOT PROGRAM. (a) In this section, "net cost-savings" means the total projected cost of Medicaid benefits for an area served under the pilot program minus the actual cost of Medicaid benefits for the area.

(b) The commission shall 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. If the commission determines that the pilot program is likely to result in net cost-savings, the commission shall develop the pilot program.

(c) The commission shall select the area in which to implement the pilot program. The selected area must include:

(1) at least two counties; and

(2) not more than 100,000 Medicaid recipients, with approximately 50 percent of the recipients enrolled in a managed care program in which the recipients receive services from a health maintenance organization.

(d) The commission shall request proposals from private vendors for the operation of a telephone hotline under the pilot program. The commission may not award a contract to a vendor unless the vendor agrees to contractual terms:

(1) requiring the vendor to answer medical questions and provide medical information by telephone to recipients using only physicians;

(2) providing that the value of the contract is contingent on achievement of net cost-savings in the area served by the vendor; and

(3) permitting the commission to terminate the contract after a reasonable period if the vendor's services do not result in net cost-savings in the area served by the vendor.

(e) The commission shall periodically determine whether the pilot program is resulting in net cost-savings. The commission shall discontinue the pilot program if the commission determines that the pilot program is not resulting in net cost-savings after a reasonable period.

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

(g) The executive commissioner shall adopt rules necessary

for implementation of this section.

(b) Not later than December 1, 2005, the Health and Human Services Commission shall 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. If the determination indicates that net cost-savings are likely, the commission shall take the action required by Subsections (c), (d), and (e) of this section.

(c) Not later than January 1, 2006, the Health and Human Services Commission shall select the counties in which the pilot program will be implemented.

(d) Not later than February 1, 2006, the Health and Human Services Commission shall request proposals from private vendors for the operation of a medical information telephone hotline. The commission shall evaluate the proposals and choose one or more vendors as soon as possible after the receipt of the proposals.

(e) Not later than January 1, 2007, the Health and Human Services Commission shall report to the governor, the lieutenant governor, and the speaker of the house of representatives regarding the pilot program. The report must include:

(1) a description of the status of the pilot program, including whether the commission was unable to contract with a suitable vendor;

(2) if the pilot program has been implemented:

(A) an evaluation of the effects of the pilot program on emergency room visits by program participants; and

(B) a description of cost savings in the area

included in the pilot program; and

(3) recommendations regarding expanding or revising the pilot program.

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

(l) Each year the commission shall provide a written report to the legislature and the governor. The report shall cover:

(1) the cost of administering the preferred drug lists adopted under Section 531.072;

(2) an analysis of the utilization trends for medical services provided by the state and any correlation to the preferred drug lists;

(3) an analysis of the effect on health outcomes and results for recipients; [~~and~~]

(4) statistical information related to the number of approvals granted or denied; and

(5) an analysis of the effect during the preceding year of the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. No. 108-173) on the preferred drug list adopted under Section 531.072 and the prior authorization requirements under Section 531.073 applicable under the Medicaid vendor drug program.

(n) Prior to or during supplemental rebate agreement negotiations for drugs being considered for the preferred drug list, the commission shall disclose to pharmaceutical manufacturers any clinical edits or clinical protocols that may be

imposed on drugs within a particular drug category that are placed on the preferred list during the contract period. Clinical edits will not be imposed for a preferred drug during the contract period unless the above disclosure is made.

(b) Subsection (n), Section 531.070, Government Code, as added by this section, applies only to a supplemental rebate agreement that is entered into or renewed on or after the effective date of this Act. A supplemental rebate agreement that is entered into or renewed before the effective date of this Act is governed by the law in effect on the date the agreement was entered into or renewed, and the former law is continued in effect for that purpose.

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

(m) The commission or the commission's agent shall publicly disclose each specific drug recommended for preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The disclosure must 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 preferred drug list.

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

(j) The office shall prepare a final report on each audit or investigation conducted under this section. The final report must include:

(1) a summary of the activities performed by the office in conducting the audit or investigation;

(2) a statement regarding whether the audit or investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(k) A final report on an audit or investigation is subject to required disclosure under Chapter 552. 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) Section 531.1021, Government Code, is amended by amending Subsection (g) and adding Subsection (h) to read as follows:

(g) All information and materials subpoenaed or compiled by the office in connection with an audit or investigation are confidential and not subject to disclosure under Chapter 552, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the office or its employees or agents involved in the audit or investigation conducted by the office, except that this information may be disclosed to the office of the attorney general, the state auditor's office, and law enforcement agencies.

(h) A person who receives information under Subsection (g) may disclose the information only in accordance with Subsection (g) and in a manner that is consistent with the authorized purpose for which the person first received the information.

SECTION 19. MEDICAID DISEASE MANAGEMENT PROGRAMS.

(a) Section 533.009, Government Code, is amended by adding Subsection (f) to read as follows:

(f) The executive commissioner, by rule, shall prescribe the minimum requirements that a managed care organization, in providing a disease management program, must meet to be eligible to receive a contract under this section. The managed care organization must, at a minimum, be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease management services under Section 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003; and

(2) show evidence of ability to manage complex diseases in the Medicaid population.

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

(c) The executive commissioner of the Health and Human Services Commission [~~department~~], by rule, shall prescribe the minimum requirements a provider of a disease management program must meet to be eligible to receive a contract under this section. The provider must, at a minimum, be required to:

(1) use disease management approaches that are based on evidence-supported models, [~~minimum~~] standards of care in the medical community, and clinical outcomes; and

(2) ensure that a recipient's primary care physician and other appropriate specialty physicians, or registered nurses, advanced practice nurses, or physician assistants specified and directed or supervised in accordance with applicable law by the recipient's primary care physician or other appropriate specialty physicians, become directly involved in the disease management program through which the recipient receives services.

(c-1) 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 shall coordinate during a transition period beneficiary care for patients that move from one disease management program to another program.

(c) The executive commissioner of the Health and Human Services Commission may 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 if the executive commissioner determines 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. 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 may 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) Chapter 533, Government Code, is amended by adding Subchapter D to read as follows:

SUBCHAPTER D. INTEGRATED CARE MANAGEMENT MODEL

Sec. 533.061. INTEGRATED CARE MANAGEMENT MODEL. (a) The executive commissioner, by rule, shall develop an integrated care management model of Medicaid managed care. The "integrated care management model" is a noncapitated primary care case management model of Medicaid managed care with enhanced components to:

(1) improve patient health and social outcomes;

(2) improve access to care;

(3) constrain health care costs; and

(4) integrate the spectrum of acute care and long-term care services and supports.

(b) In developing the integrated care management model, the executive commissioner shall ensure that the integrated care management model utilizes managed care principles and strategies to assure proper utilization of acute care and long-term care services and supports. The components of the model must include:

(1) the assignment of recipients to a medical home;

(2) utilization management to assure appropriate access and utilization of services, including prescription drugs;

(3) health risk or functional needs assessment;

(4) a method for reporting to medical homes and other appropriate health care providers on the utilization by recipients

of health care services and the associated cost of utilization of those services;

(5) mechanisms to reduce inappropriate emergency department utilization by recipients, including the provision of after-hours primary care;

(6) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating, and monitoring recipients with complex, chronic, or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;

(7) implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system;

(8) strategies to prevent or delay institutionalization of recipients through the effective utilization of home and community-based support services; and

(9) any other components the executive commissioner determines will improve a recipient's health outcome and are cost-effective.

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

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

(b) The commission may require that each administrative

services organization contracting with the commission 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) The commission may include in a contract awarded under this section a written guarantee of state savings on Medicaid expenditures for recipients receiving services provided under the integrated care management model developed under Section 533.061.

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

(e) In this section, "administrative services organization" means an entity that performs administrative and management functions, such as the development of a physician and provider network, care coordination, service coordination, utilization review and management, quality management, and patient and provider education, for a noncapitated system of health care services, medical services, or long-term care services and supports.

Sec. 533.063. STATEWIDE INTEGRATED CARE MANAGEMENT ADVISORY COMMITTEE. (a) The executive commissioner may appoint an advisory committee to assist the executive commissioner in the development and implementation of the integrated care management model.

(b) The advisory committee is subject to Chapter 551.

(b) The Health and Human Services Commission shall require

each administrative services organization contracting with the commission 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) The commission may require each administrative services organization contracting with the commission 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) 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) Subsections (o) and (p), Section 481.074, Health and Safety Code, are amended to read as follows:

(o) A pharmacist may dispense a Schedule II controlled substance pursuant to a facsimile copy of an official prescription completed in the manner required by Section 481.075 and transmitted by the practitioner or the practitioner's agent to the pharmacy if:

(1) the prescription is written for:

(A) a Schedule II narcotic or nonnarcotic substance for a patient in a long-term care facility (LTCF), and the practitioner notes on the prescription "LTCF patient";

(B) a Schedule II narcotic product to be compounded for the direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous, or intraspinal infusion; or

(C) a Schedule II narcotic substance for a patient with a medical diagnosis documenting a terminal illness or a patient enrolled in a hospice care program certified or paid for by Medicare under Title XVIII, Social Security Act (42 U.S.C. Section 1395 et seq.), as amended, by Medicaid, or by a hospice program that is licensed under Chapter 142, and the practitioner or the practitioner's agent notes on the prescription "terminally ill" or "hospice patient"; and

(2) after transmitting the prescription, the prescribing practitioner or the practitioner's agent:

(A) writes across the face of the official prescription "VOID--sent by fax to (name and telephone number of receiving pharmacy)"; and

(B) files the official prescription in the patient's medical records instead of delivering it to the patient [~~promptly complies with Subsection (p)~~].

(p) [~~Not later than the seventh day after the date a prescribing practitioner transmits the facsimile copy of the official prescription to the pharmacy, the prescribing practitioner shall deliver in person or mail the official written~~

~~prescription to the dispensing pharmacist at the pharmacy where the prescription was dispensed. The envelope of a prescription delivered by mail must be postmarked not later than the seventh day after the date the official prescription was written.~~] On receipt of the prescription, the dispensing pharmacy shall file the facsimile copy of the prescription [~~with the official prescription~~] and shall send information to the director as required by Section 481.075.

(b) This section takes effect immediately if this Act receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this section takes effect September 1, 2005.

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

(bb) The department may not provide an erectile dysfunction medication under the Medicaid vendor drug program to a person required to register as a sex offender under Chapter 62, Code of Criminal Procedure, to the maximum extent federal law allows the department to deny that medication.

SECTION 23. CONTINUOUS ELIGIBILITY. Section 32.0261, Human Resources Code, is amended to read as follows:

Sec. 32.0261. CONTINUOUS ELIGIBILITY. The department shall adopt rules in accordance with 42 U.S.C. Section 1396a(e)(12), as amended, to provide for a period of continuous eligibility for a child under 19 years of age who is determined to be eligible for

medical assistance under this chapter. The rules shall provide that the child remains eligible for medical assistance, without additional review by the department and regardless of changes in the child's resources or income, until the earlier of:

(1) the end of the six-month period following [~~first anniversary of~~] the date on which the child's eligibility was determined; or

(2) the child's 19th birthday.

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

Sec. 159.010. NOTICE OF BENEFITS UNDER STATE CHILD HEALTH PLAN. A physician who provides Medicaid health care services to a pregnant woman shall 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, Health and Safety Code.

SECTION 25. MEDICAID COVERAGE FOR HEALTH INSURANCE PREMIUMS AND LONG-TERM CARE NEEDS. (a) The Health and Human Services Commission shall explore the commission's authority under federal law to offer, and the cost and feasibility of offering:

(1) a stipend paid by the Medicaid program to a person to cover the cost of a private health insurance plan as an alternative to providing traditional Medicaid services for the person;

(2) premium payment assistance through the Medicaid program for long-term care insurance for a person with a health condition that increases the likelihood that the person will need

long-term care in the future; and

(3) a long-term care partnership between the Medicaid program and a person under which the person pays the premiums for long-term care insurance and the Medicaid program provides continued coverage after benefits under that insurance are exhausted.

(b) In exploring the feasibility of the options described by Subsection (a) of this section, the Health and Human Services Commission shall consider whether other state incentives that could encourage persons to purchase health insurance plans or long-term care insurance are feasible. The incentives may include offering tax credits to businesses to increase the availability of affordable insurance.

(c) If the Health and Human Services Commission determines that any of the options described by Subsection (a) of this section are feasible and cost-effective, the commission shall make efforts to implement those options to the extent they are authorized by federal law. The commission shall 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. If the commission determines that legislative changes are necessary to implement an option, the commission shall report to the 80th Legislature and specify the changes that are needed.

SECTION 26. MAXIMIZATION OF FEDERAL RESOURCES. The Health and Human Services Commission shall 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 the commission's center for strategic decision support.

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

(b) 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 shall 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. 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. On September 1, 2007, the Interagency Council on Pharmaceuticals Bulk Purchasing is abolished, and Chapter 111, Health and Safety Code, and Subsection (e), Section 431.116, and Subsection (d), Section 431.208, Health

and Safety Code, are repealed.

SECTION 30. IMPLEMENTATION; WAIVER. (a) The Health and Human Services Commission shall make every effort to take each action and implement each reform required by this Act as soon as possible. Except as otherwise provided by this Act, the commission shall take each action and implement each reform required by this Act not later than September 1, 2007. Any action of the commission taken to justify implementing or ignoring the reforms required by this Act must be defensible, but need not be exhaustive.

(b) Not later than December 1, 2005, the Health and Human Services Commission shall 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) Except as provided by Subsection (b) of this section, for each provision of this Act that requires the Health and Human Services Commission 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, the Health and Human Services Commission shall 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 the commission or health and human services agency in taking the required action. The report must be delivered not later than September 1, 2007.

(d) If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 31. EFFECTIVE DATE. Except as otherwise provided by this Act, this Act takes effect September 1, 2005.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 1188 passed the Senate on April 26, 2005, by the following vote: Yeas 31, Nays 0; May 27, 2005, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 28, 2005, House granted request of the Senate; May 29, 2005, Senate adopted Conference Committee Report by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 1188 passed the House, with amendments, on May 25, 2005, by the following vote: Yeas 143, Nays 0, two present not voting; May 28, 2005, House granted request of the Senate for appointment of Conference Committee; May 29, 2005, House adopted Conference Committee Report by a non-record vote.

Chief Clerk of the House

Approved:

Date

Governor