BILL ANALYSIS

Senate Research Center

S.B. 10
By: Nelson et al.
Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The federal Deficit Reduction Act of 2005 included provisions that give states additional flexibility in the way Medicaid is administered. The Senate Committee on Health and Human Services was charged during the interim with monitoring state and federal Medicaid reform proposals, including their impact on the Medicaid program in Texas, as well as cost-containment measures in other states. The committee made recommendations in its interim report based on those reform measures that were considered most applicable to the Texas Medicaid program.

S.B. 10 enacts the recommendations of the Senate Committee on Health and Human Services with the goal of improving the Texas Medicaid program by focusing on prevention, individual choice, better planning, modernizing services, reducing Texas' rate of uninsured, and helping Texans to live longer, healthier lives.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 2 (Section 531.02413, Government Code), SECTION 4 (Section 531.097, Government Code), SECTION 7 (Sections 531.505 and 531.507, Government Code), SECTION 8 (Section 531.551, Government Code), and SECTION 22 (Section 32.102, Human Resources Code) of this bill.

Rulemaking authority previously granted to the Texas Department of Insurance is transferred to the executive commissioner of the Health and Human Services Commission in SECTION 18 (Section 32.0422, Human Resources Code) of this bill.

Rulemaking authority previously granted to the executive commissioner of the Health and Human Services Commission is modified in SECTION 19 (Section 32.058, Human Resources Code) and SECTION 32 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02192, as follows:

> Sec. 531.02192. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES. (a) Defines "federally qualified health center," "federally qualified health center services," "rural health clinic," and "rural health clinic services."
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> (b) Requires the Health and Human Services Commission (HHSC), notwithstanding any provision of this chapter, Chapter 32 (Medical Assistance Program), Human Resources Code, or any other law, to promote Medicaid recipient access to federally qualified health center services or rural health clinic services and ensure that payment for federally qualified health center services or rural health clinic services is in accordance with 42 U.S.C. Section 1396a(bb).

SECTION 2. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02413, as follows:

Sec. 531.02413. BILLING COORDINATION SYSTEM. (a) Requires HHSC, if cost-effective and feasible, on or before March 1, 2008, to contract through an existing procurement process for the implementation of an acute care Medicaid billing coordination system for the fee-for-service and primary care case management delivery models that will, upon entry in the claims system, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the entity the system determines is the primary payor. Prohibits the system from increasing Medicaid claims payment error rates.

(b) Requires the executive commissioner of HHSC (executive commissioner) to adopt rules for the purpose of enabling the system to identify an entity with primary responsibility for paying a claim and establish reporting requirements for any entity that may have a contractual responsibility to pay for the types of acute care services provided under the Medicaid program, if cost-effective.

(c) Requires an entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state to allow the contractor under Subsection (a) access to databases to allow the contractor to carry out the purposes of this section, subject to the contractor's contract with HHSC and rules adopted under this section, and is subject to an administrative penalty or other sanction as provided by the law applicable to the permit, license, or certificate of authority for a violation by the entity of a rule adopted under this section.

(d) Prohibits any public funds, after September 1, 2008, from being expended on entities not in compliance with this section unless a memorandum of understanding is entered into between the entity and the executive commissioner.

(e) Provides that information obtained under this section is confidential. Authorizes the contractor to use the information only for the purposes authorized under this section. Provides that a person commits an offense if the person knowingly uses information obtained under this section for any purpose not authorized under this section. Provides that an offense under this subsection is a Class B misdemeanor and all other penalties may apply.

SECTION 3. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02414, as follows:

Sec. 531.02414. ADMINISTRATION AND OPERATION OF MEDICAL TRANSPORTATION PROGRAM. (a) Defines "medical transportation program."

(b) Requires HHSC, notwithstanding any other law, to directly supervise the administration and operation of the medical transportation program (program).

(c) Prohibits HHSC, notwithstanding any other law, from delegating HHSC's duty to supervise the program to any other person, including through a contract with the Texas Department of Transportation (TxDOT) for TxDOT to assume any of HHSC's responsibilities relating to the provision of services through that program.

(d) Authorizes HHSC to contract with a public transportation provider, as defined by Section 461.002, Transportation Code, a private transportation provider, or a regional transportation broker for the provision of public transportation services, as defined by Section 461.002, Transportation Code, under the program.

(b) Amends Subchapter A, Chapter 531, Government Code, by adding Section 531.0057, as follows:

Sec. 531.0057. MEDICAL TRANSPORTATION SERVICES. (a) Requires HHSC to provide medical transportation services for clients of eligible health and human services programs.

(b) Authorizes HHSC to contract with any public or private transportation provider or with any regional transportation broker for the provision of public transportation services.

SECTION 4. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.094, 531.0941, 531.097, and 531.0971, as follows:

Sec. 531.094. PILOT PROGRAM AND OTHER PROGRAMS TO PROMOTE HEALTHY LIFESTYLES. (a) Requires the Health and Human Services Commission (HHSC) to develop and implement a pilot program in one region of this state under which Medicaid recipients are provided positive incentives to lead healthy lifestyles, thereby resulting in better health outcomes for those recipients (lifestyle program).

(b) Authorizes HHSC to provide certain positive incentives to Medicaid recipients who participate in certain health-related programs, follow certain disease prevention protocols, or otherwise take actions determined by HHSC to lead to a healthy lifestyle, except as provided by Subsection (c).

(c) Requires HHSC to consider similar incentive programs implemented in other states to determine the most cost-effective measures to implement the lifestyle program.

(d) Requires HHSC to submit a report to the legislature that describes the operation of the lifestyle program, analyzes the effects of the incentives provided by the lifestyle program, and makes recommendations regarding the continuation or expansion of the lifestyle program, not later than December 1, 2010.

(e) Authorizes HHSC, in addition to developing and implementing the pilot program under this section, to develop and implement an additional incentive program to encourage Medicaid recipients who are younger than 21 years of age to make timely health care visits under the early and periodic screening, diagnosis, and treatment (EPSDT) program, if feasible and cost-effective. Requires HHSC to provide incentives under the program for managed care organizations contracting with HHSC under Chapter 553 (Implementation of Medicaid Managed Care Program), Government Code, and Medicaid providers to encourage those organizations and providers to support the delivery and documentation of timely and complete health care screenings under the EPSDT program.

(f) Provides that this section expires September 1, 2011.

Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a) Requires HHSC, if HHSC determines it is cost-effective and feasible, to develop and implement a Medicaid health savings account pilot program that is consistent with federal law to encourage health care cost awareness and sensitivity by adult recipients and to promote appropriate utilization of Medicaid services by adult recipients.

(b) Authorizes HHSC to only include adult recipients in the pilot program under this section if HHSC implements the pilot program.

(c) Requires HHSC, if the pilot program is implemented, to ensure that participation in the pilot program is voluntary and that a recipient who participates in the pilot program may, at the recipient's option and subject

to Subsection (d), discontinue participation in the program and resume receiving benefits and services under the traditional Medicaid delivery model.

(d) Provides that a recipient who chooses to discontinue participation in the pilot program and resume receiving benefits and services under the traditional Medicaid delivery model before completion of the health savings account enrollment period forfeits any funds remaining in the recipient's health savings account.

Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a) Authorizes the executive commissioner of HHSC (executive commissioner) to seek a waiver under Section 1115 (Demonstration Projects) of the federal Social Security Act to develop, and subject to Subsection (c), implement tailored benefit packages (tailored packages) designed to meet certain goals.

(b) Requires HHSC to develop a tailored benefit package (tailored package) that is customized to meet the health care needs of children who are Medicaid recipients and who have special health care needs, subject to the approval of the waiver described in Subsection (a). Authorizes HHSC to develop tailored packages that are customized to met the health care needs of other categories of Medicaid recipients.

(c) Requires HHSC, if HHSC develops a tailored package to meet the health care needs of other categories of Medicaid recipients, to submit a report to certain standing committees in the legislature that specifies, in detail, the categories of Medicaid recipients to which each of those packages will apply and the services available under each package. Prohibits HHSC from implementing such a package before September 1, 2009.

(d) Provides that HHSC, except as otherwise provided by this section and subject to the terms of the waiver authorized by this section, has broad discretion to develop the tailored packages and to determine the categories of Medicaid recipients to which these packages apply in a manner that preserves recipients' access to necessary services and is consistent with federal requirements.

(e) Sets forth the benefits and services each tailored package developed under this section must include.

(f) Requires a tailored package that applies to Medicaid recipients who are children to provide at least the services required by federal law under the EPSDT program in addition to the benefits required by Subsection (e).

(g) Authorizes a tailored package to include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventative health or wellness service.

(g-1) Requires a tailored benefit package developed under this section to increase the state's flexibility with respect to the state's use of Medicaid funding and prohibits the package from reducing the benefits available under the Medicaid state plan to any Medicaid recipient population.

(h) Requires HHSC to consider similar benefit packages established in other states as a guide for developing tailored packages.

(i) Requires the executive commissioner, by rule, to define each category of recipients to which a tailored package applies and a mechanism for appropriately placing recipients in specific categories. Authorizes certain

recipient categories, which are required to include children with special needs, to be included in populations to which a tailored package applies.

(j) Provides that this section does not apply to a tailored benefit package or similar package of benefits if certain conditions are met before September 1, 2007.

Sec. 531.0971. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) Requires HHSC to identify state or federal non-Medicaid programs that provide health care services to persons whose health care needs could not be met by providing customized benefits through a tailored package.

(b) Requires HHSC, if HHSC determines that it is feasible and to the extent permitted by federal and state law, to provide health care services for those persons through the applicable tailored package, and to develop and implement a system of blended funding methodologies to provide those services if it is appropriate or necessary.

(b) Requires HHSC to implement the lifestyle pilot program by September 1, 2008.

SECTION 5. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.0972, as follows:

Sec. 531.0972. PILOT PROGRAM TO PREVENT THE SPREAD OF CERTAIN INFECTIOUS OR COMMUNICABLE DISEASES. Authorizes HHSC to provide guidance to the local health authority of Bexar County in establishing a pilot program funded by the county to prevent the spread of HIV, hepatitis B, hepatitis C, and other infectious and communicable diseases. Authorizes the program to include a disease control program that provides for the anonymous exchange of used hypodermic needles and syringes.

SECTION 6. (a) Amends Subchapter C, Chapter 531, Government Code, by adding Section 531.1112, as follows:

Sec. 531.1112. STUDY CONCERNING INCREASED USE OF TECHNOLOGY TO STRENGTHEN FRAUD DETECTION AND DETERRENCE; IMPLEMENTATION. Requires HHSC and HHSC's office of inspector general (inspector general) to jointly study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in the state Medicaid program (study). Requires the study to include the determination of the feasibility of using technology to verify a person's citizenship and eligibility for coverage.

(b) Requires HHSC to implement any methods HHSC and the inspector general determine are effective at strengthening fraud detection and deterrence.

(b) Requires HHSC to submit a report detailing the findings of the study, including descriptions of methods implemented under Section 531.1112(b), Government Code, that the HHSC has or will implement, not later than December 1, 2008.

SECTION 7. (a) Amends Chapter 531, Government Code, by adding Subchapter N, as follows:

SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND

Sec. 531.501. DEFINITION. Defines "fund."

Sec. 531.502. DIRECTION TO OBTAIN FEDERAL WAIVER. (a) Authorizes the executive commissioner to seek a waiver under Section 1115 (Demonstration Projects) of the federal Social Security Act to the state Medicaid plan to authorize HHSC to more efficiently and effectively use federal money paid to the state

under various programs to defray costs associated with providing uncompensated health care by using that federal money, appropriated state money to the extent necessary, and any other money described by this section for purposes consistent with this subchapter.

(b) Sets forth certain types of federal money that the executive commissioner is authorized to include in the waiver.

(c) Requires HHSC to seek to optimize federal funding by identifying health care related state and local funds and program expenditures that, before September 1, 2007, are not being matched with federal money, and to explore the feasibility of certifying or otherwise using those funds and expenditures as state expenditures for which this state may receive federal matching money or depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 531.504, or substituting that federal matching money for federal money that otherwise would be received under the disproportionate share hospitals and upper payment limit supplemental payment programs (supplemental payment programs) as a match for local funds received by this state through intergovernmental transfers.

(d) Requires the terms of the waiver for pooling funds approved under this section to include safeguards ensuring that the total amount of federal money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs that is deposited as provided by Section 531.504 is, for a particular state fiscal year, at least equal to the greater of the annualized amount provided to this state under those supplemental payment programs during state fiscal year 2007, excluding amounts provided during said year that are retroactive payments, or the state fiscal years during which the waiver is in effect. Sets forth certain provisions that the executive commissioner is required to seek in order to allocate money in the fund.

(e) Requires the executive commissioner to seek to obtain maximum flexibility with respect to the use of money in the fund for purposes consistent with this subchapter; to include an annual adjustment to the aggregate caps under the upper payment limit supplemental payment program to account for inflation, population growth, and other appropriate demographic factors that affect the ability of residents of this state to obtain health benefits coverage; to ensure, for the term of the waiver, that the aggregate caps under said supplemental payment program for each of the three classes of hospitals are not less than the aggregate caps that applied during state fiscal year 2007; and to preserve federal supplemental payment program payments made to hospitals, the state match with respect to which is funded by intergovernmental transfers or certified public expenditures that are used to optimize Medicaid payments to safety net providers for uncompensated care, and preserve allocation methods for those payments, unless the need for payments is revised through measures that reduce the Medicaid shortfall or uncompensated care costs.

(f) Requires the executive commissioner to seek broad-based stakeholder input in the development of the waiver under this section and to provide information to stakeholders regarding the terms and components of the waiver for which the executive commissioner seeks federal approval.

(g) Requires the executive commissioner to seek the advice of the Legislative Budget Board before finalizing the terms and conditions of the negotiated waiver.

Sec. 531.503. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL TRUST FUND. Establishes the Texas health opportunity pool trust fund,

subject to the approval of and the terms of the waiver, as a trust fund outside the state treasury to be held by the comptroller and administered by HHSC as trustee on behalf of residents of this state who do not have private health benefits coverage and health care providers providing uncompensated care to those persons. Authorizes HHSC to make expenditures of money in the fund only for purposes consistent with this subchapter and the terms of the waiver authorized by Section 531.502.

Sec. 531.504. DEPOSITS TO FUND. (a) Requires the comptroller to deposit certain federal and state money to the fund in a specific manner.

(b) Authorizes HHSC and the comptroller to accept gifts, grants, and donations from any source for purposes consistent with this subchapter and the terms of the waiver. Requires the comptroller to deposit a gift, grant, or donation made for those purposes in the fund.

Sec. 531.505. USE OF FUND IN GENERAL; RULES FOR ALLOCATION. (a) Sets forth specific authorized uses of the money in the fund, unless otherwise provided for by the terms of the waiver.

(b) Requires the executive commissioner, on approval of the waiver, to seek input from a broad base of stakeholder representatives on the development of rules with respect to, and the administration of, the fund, and by rule develop a methodology for allocating money in the fund that is consistent with the terms of the waiver.

Sec. 531.506. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Authorizes the allocation of the money in the fund to hospitals and political subdivisions in Texas to defray the costs of providing uncompensated health care in this state, except as otherwise provided by the waiver and subject to Subsections (b) and (c).

(b) Requires a hospital or political subdivision, to be eligible to use pool money, to use a portion of that money to implement strategies that will reduce the need for uncompensated inpatient and outpatient care, including care provided in a hospital emergency room. Sets forth certain authorized strategies.

(c) Requires the allocation methodology to specify the percentage of money in the fund allocated to a political subdivision or hospital that is required to be used for those strategies.

Sec. 531.507. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Authorizes money in the fund that is available to reduce the number of persons in this state lacking health benefits coverage or to reduce the need for uncompensated health care provided by hospitals in this state to be used for purposes relating to increased access to coverage for low-income persons, including the provision of premium payment assistance to those persons through a premium payment assistance program developed under this section, making contributions to health savings accounts for those persons, and providing other financial assistance to those persons through alternate mechanisms established by hospitals or political subdivisions of this state that meet certain HHSC-specified criteria.

(b) Requires HHSC and the Texas Department of Insurance (TDI) to jointly develop a premium payment assistance program (assistance program) to assist persons described in Subsection (a) in obtaining coverage. Authorizes the assistance program to provide assistance in the form of payments for all or part of the premiums for that coverage. Requires the executive commissioner to adopt certain rules in developing the assistance program.

(c) Requires HHSC to implement the assistance program, subject to availability of money in the fund for that purpose.

Sec. 531.508. INFRASTRUCTURE IMPROVEMENTS. Authorizes the use of money in the fund for the purposes related to the development and implementation of initiatives to improve the infrastructure of local provider networks that provide services to Medicaid recipients and low-income uninsured persons in this state, except as otherwise provided by the terms of the waiver and subject to Subsection (c).

(b) Authorizes infrastructure improvements under this section to include the development and implementation of a system for maintaining medical records in an electronic format.

(c) Prohibits more than 10 percent of the total amount of money in the fund used in a state fiscal year, for purposes other than providing reimbursements to hospitals for uncompensated care, from being used for infrastructure improvements described in this section.

(b) Requires the executive commissioner to submit a report to the Legislative Budget Board that outlines the components and terms of the waiver under Section 531.502, Government Code, as added by this section, if federal approval is obtained for said waiver, as soon as possible after the approval is granted.

SECTION 8. (a) Amends Chapter 531, Government Code, by adding Subchapter O, as follows:

SUBCHAPTER O. UNCOMPENSATED HOSPITAL CARE

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS. (a) Requires the executive commissioner to adopt rules providing for a definition of "uncompensated hospital care," for a methodology to be used by hospitals in this state to compute the cost of uncompensated hospital care that incorporates the standard set of adjustments described by Section 531.552(g)(4), and for procedures to be used by those hospitals to report the cost of that care to HHSC and to analyze that cost.

(b) Authorizes the rules to provide for procedures by which HHSC is authorized to periodically verify the completeness and accuracy of the information provided by hospitals.

(c) Requires HHSC to notify the attorney general of a hospital's failure to report the cost of uncompensated care on or before the date the hospital's report on its rendering of uncompensated care was due. Requires the attorney general, on receipt of the notice, to impose an administrative penalty on the hospital of $1,000 for each day, not to exceed $10,000, after the report's due date that the hospital has not submitted the report.

(d) Requires HHSC to notify the hospital of specific information that HHSC determines to be incomplete or inaccurate through the procedure established under Subsection (b) and to submit and prescribe a date by which the hospital is required to provide that information. Requires the attorney general, if the hospital fails to submit the specified information on or before the date prescribed by HHSC and upon notification of such from HHSC, to impose an administrative penalty, the amount of which is to be determined by the attorney general regarding the seriousness of the violation, the hospital's history of prior violations, and the amount necessary to deter the hospital from committing future violations, not to exceed $10,000.

(e) Requires a report by HHSC to the attorney general under Subsection (b) or (c) to state the facts on which HHSC based its determination that the hospital failed to submit a report or failed to completely and accurately report information, as applicable.

(f) Requires the attorney general to give written notice of HHSC's report to the hospital alleged to have failed to comply with a requirement. Requires the notice to contain certain information.

(g) Requires the hospital, not later than the 20th day after the date the notice was sent under Subsection (f), to make a written request for a hearing or to remit the amount of administrative penalty to the attorney general. Provides that failure to timely request a hearing or remit the amount of the administrative penalty results in a waiver of a right to a hearing under this section. Requires the attorney general to conduct a hearing in accordance with Chapter 2001 (Administrative Procedure), Government Code, if the hospital timely requests as such. Requires the attorney general to provide written notice of the findings established in the hearing and the amount of the penalty, and to enter an order requiring the hospital to pay the amount of the penalty, if the hearing results in a finding that a violation has occurred.

(h) Requires the hospital to pay the amount of the administrative penalty, to remit said amount to the attorney general for deposit in an escrow account and to file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both, or to file a petition for judicial review without paying the amount of the penalty to contest the occurrence of the violation, the amount of the penalty, or both, and to file with the court a sworn affidavit stating that the hospital is financially unable to pay the amount of the penalty.

(i) Provides that the attorney general's order is subject to judicial review as a contested case under Chapter 2001 (Administrative Procedure), Government Code.

(j) Requires the attorney general to remit the appropriate amount to the hospital not later than the 30th day after the date the court's judgment becomes final, if the hospital paid the penalty and on review the court does not sustain the occurrence of the violation or finds that the amount of the administrative penalty should be reduced.

(k) Requires the court, if the court sustains the occurrence of the violation, to order the hospital to pay the amount of the administrative penalty, and authorizes the court to award to the attorney general attorney's fees and court costs incurred by the attorney general in defending the action. Requires the attorney general to remit the amount of the penalty to the comptroller of public accounts for deposit in the general revenue fund.

(l) Authorizes the attorney general to enforce the penalty as provided by law for legal judgments if the hospital does not pay the amount of the administrative penalty after the attorney general's order becomes final for all purposes.

Sec. 531.552. WORK GROUP ON UNCOMPENSATED HOSPITAL CARE. (a) Defines "work group."

(b) Requires the executive commissioner to establish the work group on uncompensated hospital care (work group) to assist the executive commissioner in developing the rules require by Section 531.551 by performing the functions described under Subsection (g).

(c) Requires the executive commissioner to determine the number of members of the work group. Requires the executive commissioner to include representatives from the office of the attorney general and the hospital industry on the work group. Provides that a member of the work group (member) serves at the will of the executive commissioner.

(d) Requires the executive commissioner to designate a member to serve as presiding officer. Requires the members to elect any other necessary officers.

(e) Requires the work group to meet at the executive commissioner's call.

(f) Prohibits members from receiving compensation for serving on the work group but entitles members to reimbursement for travel expenses incurred while conducting work group business as provided by the General Appropriations Act.

(g) Sets forth certain topics on which the work group is required to study and advise the executive commissioner.

(b) Requires the executive commissioner to establish the work group not later than October 1, 2007, and to adopt the rules required by Section 531.551, Government Code, as added by this section, not later than January 1, 2009.

(c) Requires the executive commissioner to review the methodology used under the Medicaid disproportionate share hospitals supplemental payment program to compute low-income utilization costs to ensure that methodology, as added by this Act, and adopted by the executive commissioner, is consistent with the adjustments to those costs described by Section 531.552(g)(4), Government Code.

SECTION 9. Amends Chapter 531, Government Code, by adding Subchapter P, as follows:

SUBCHAPTER P. PHYSICIAN-CENTERED NURSING FACILITY MODEL DEMONSTRATION PROJECT

Sec. 531.601. DEFINITIONS. Defines "nursing facility" and "project."

Sec. 531.602. PHYSICIAN-CENTERED NURSING FACILITY MODEL DEMONSTRATION PROJECT. (a) Authorizes HHSC to develop and implement a demonstration project to determine whether paying an enhanced Medicaid reimbursement rate to a nursing facility that provides continuous, on-site oversight of residents by physicians specializing in geriatric medicine results in certain benefits.

(b) Authorizes HHSC, in developing the project, to consider similar physician-centered nursing facility models implemented in other states to determine the most cost-effective measures to implement in the project under this subchapter.

(c) Authorizes HHSC to consider whether the project could involve the Medicare program, subject to federal law and approval.

Sec. 531.603. REPORT. (a) Requires HHSC, if HHSC develops and implements the project, to submit a preliminary status report to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program not later than December 1, 2008. Sets forth certain information required to be included in the report.

(b) Requires HHSC, if HHSC develops and implements the project, to submit a subsequent report to the specific persons listed in Subsection (a) preceding the

regular session of the 82nd Legislature. Sets forth certain recommendations required to be made in the report.

Sec. 531.604. EXPIRATION. Provides that this subchapter expires September 1, 2011.

SECTION 10. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0051, as follows:

Sec. 533.0051. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS. (a) Requires HHSC to establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization and HHSC for the provision of health care services to recipients that is procured and managed under a value-based purchasing model. Requires the performance measures and incentives to be designed to facilitate and increase recipients' access to appropriate health care services.

(b) Requires HHSC, subject to Subsection (c), to include the performance measures and incentives established under Subsection (a) in each contract described by that subsection in addition to all other contract provisions required by this chapter.

(c) Authorizes HHSC to use a graduated approach to including the performance measures and incentives established under Subsection (a) in contracts described by that subsection to ensure incremental and continued improvements over time.

(d) Requires HHSC, subject to Subsection (f), to assess the feasibility and cost-effectiveness of including provisions in a contract described by Subsection (a) that require the health maintenance organization to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in the care of Medicaid recipients. Authorizes pay-for-performance opportunities to include incentives for providers to provide care after normal business hours and to participate in the early and periodic screening, diagnosis, and treatment program and other activities that improve Medicaid recipients' access to care. Requires HHSC, if it is determined that the provisions are feasible and may be cost-effective, to develop and implement a pilot program in at least one health care service region under which HHSC will include the provisions in contracts with health maintenance organizations offering managed care plans in the region.

(e) Requires HHSC to post the financial statistical report on HHSC's web page in a comprehensive and understandable format.

(f) Requires HHSC, to the extent possible, base an assessment of feasibility and cost-effectiveness under Subsection (d) on publicly available, scientifically valid, evidence-based criteria appropriate for assessing the Medicaid population.

(g) Authorizes HHSC, in performing HHSC's duties under Subsection (d) with respect to assessing feasibility and cost-effectiveness, to consult with physicians, including those with expertise in quality improvement and performance measurement, and hospitals.

SECTION 11. (a) Amends Section 533.012(c), Government Code, to delete existing text authorizing the comptroller to review the information in connection with the health care fraud study conducted by the comptroller.

(b) Repealer: Section 403.028 (Health Care Fraud Study), Government Code.

SECTION 12. (a) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.019, as follows:

Sec. 533.019. VALUE-ADDED SERVICES. Requires HHSC to actively encourage managed care organizations that contract with HHSC to offer benefits, including certain other services and benefits, that are in addition to the services ordinarily covered by the managed care plans offered by those organizations, and that have the potential to improve the health status of enrollees in those plans.

(b) Makes application of Section 533.019, as added by this section, to a contract between HHSC and a managed care organization prospective. Requires HHSC to seek to amend contracts entered into with managed care organizations under Chapter 533 (Implementation of Medicaid Managed Care Program) before the effective date of this section to authorize those organizations to offer value-added services to enrollees in accordance with Section 533.019.

SECTION 13. (a) Amends Subtitle C, Title 2, Health and Safety Code, by adding Chapter 75, as follows:

CHAPTER 75. REGIONAL OR LOCAL HEALTH CARE PROGRAMS FOR EMPLOYEES OF SMALL EMPLOYERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 75.001. PURPOSE. Sets forth the purpose of the chapter.

Sec. 75.002. DEFINITIONS. Defines "employee," "governing body," "local health care program," "regional health care program," and "small employer."

[Reserves Sections 75.003-75.050 for expansion.]

SUBCHAPTER B. REGIONAL OR LOCAL HEALTH CARE PROGRAM

Sec. 75.051. ESTABLISHMENT OF PROGRAM; MULTICOUNTY COOPERATION. (a) Authorizes the commissioners court of a county, by order, to establish or participate in a local health care program (local program) under this subchapter.

(b) Authorizes the commissioners courts of two or more counties, by joint order, to establish or participate in a regional health care program (regional program) under this subchapter.

Sec. 75.052. GOVERNANCE OF PROGRAM. (a) Authorizes a regional program to be operated subject to the direct governance of the commissioners courts of the participating counties. Authorizes a local program to be operated subject to the direct governance of the commissioners court of the participating county. Authorizes a regional or local program to be operated by a joint council, tax-exempt nonprofit entity, or by other certain entities.

(b) Requires the commissioner court or courts, as applicable, to require, to the extent possible, that those other certain entities be authorized under federal law to accept donations on a tax-deductible or otherwise tax-advantaged basis for the contributor.

Sec. 75.053. OPERATION OF PROGRAM. Provides that a regional or local program provides health care services or benefits to the employees of participating small employers located within the boundaries of the participating county or counties, as applicable (small employers). Authorizes a regional or local program to provide services or benefits to the dependents of those employees.

Sec. 75.054. PARTICIPATION BY SMALL EMPLOYERS; SHARE OF COST. Authorizes the governing body of a regional or local program (governing body) to establish criteria for participation in a regional or local program by small

employers, the employees of small employers, and their dependents, subject to Section 75.153. Requires the criteria to mandate the payment of a share of the premium or other cost of the regional or local program by the participating employers and employees.

Sec. 75.055. ADDITIONAL FUNDING. (a) Authorizes a governing body to accept and use state money made available through an appropriation from the general revenue fund or certain funding from any source to operate the regional or local program and to provide services and benefits under the program.

(b) Authorizes a governing body to apply for and receive funding from the health opportunity pool trust fund under Subchapter D.

(b-1) Authorizes a governing body to apply for and receive a grant under Subchapter E to support a regional or local program if money is appropriated for that purpose. Provides that this subsection expires September 1, 2009.

(c) Requires a governing body to actively solicit certain funding to fund services and benefits provided under the regional or local program and to reduce the cost of participation in the regional or local program for small employers and their employees.

[Reserves Sections 75.056-75.100 for expansion.]

SUBCHAPTER C. HEALTH CARE SERVICES AND BENEFITS

Sec. 75.101. ALTERNATIVE PROGRAMS AUTHORIZED; PROGRAM OBJECTIVES. Authorizes a governing body to provide health care services or benefits as described by this subchapter or to develop another type of regional or local program that accomplishes the purpose of this chapter. Sets forth certain required goals and actions under which a regional or local program must be developed to the extent practicable for that regional or local program.

Sec. 75.102. HEALTH BENEFIT PLAN COVERAGE. (a) Authorizes a regional or local program to provide benefits to the employees of small employers by purchasing or facilitating the purchase of health benefit plan coverage (coverage) for those employees from a health benefit plan issuer (issuer), including certain health benefit plans.

(b) Authorizes the governing body to form one or more cooperatives under Subchapter B (Coalitions and Cooperatives), Chapter 1501, Insurance Code.

(c) Authorizes an insurer to issue a group accident and health insurance policy, including a group contract issued by a group hospital service corporation, to cover the employees of small employers participating in a regional or local program, notwithstanding Chapter 1251 (Group and Blanket Health Insurance), Insurance Code. Provides that the group policyholder of said policy is the governing body or the governing body's designee.

(d) Authorizes a health maintenance organization (HMO) to issue a health care plan to cover the employees of small employers. Provides that the group contract holder of said plan is the governing body or the governing body's designee.

Sec. 75.103. OTHER HEALTH BENEFIT PLANS OR PROGRAMS. Authorizes the governing body to establish or facilitate the establishment of self-funded health benefit plans or to facilitate the provision of coverage through

health savings accounts or high-deductible health plans to the extent authorized by federal law.

Sec. 75.104. HEALTH CARE SERVICES. (a) Authorizes a regional or local program to contract with health care providers (providers) within the boundaries of the participating county or counties to provide health care services directly to the employees of small employers and the employees' dependents.

(b) Requires a regional or local health care program to allow any individual who receives state premium assistance to buy into the health benefit plan offered by the regional or local health care program.

(c) Authorizes a governing body that operates a regional or local program under this section to require that participating employees and dependents obtain health care services only from providers under contract with the regional or local program. Authorizes the governing body to limit services provided under the regional or local program to services provided within the boundaries of the participating county or counties.

(d) Provides that a governing body that operates a regional or local program under this section is not an insurer or HMO and that the regional or local program is not subject to regulation by the Texas Department of Insurance.

[Reserves Sections 75.105-75.150 for expansion.]

SUBCHAPTER D. TEXAS HEALTH OPPORTUNITY POOL FUNDS

Sec. 75.151. DEFINITION. Defines "health opportunity pool trust fund."

Sec. 75.152. FUNDING AUTHORIZED. Authorizes a regional or local program to apply for funding from the health opportunity pool trust fund (fund) and authorizes the fund to provide funding in accordance with this subchapter, notwithstanding any other law.

Sec. 75.153. ELIGIBILITY FOR FUNDS; STATEWIDE ELIGIBILITY CRITERIA. Requires a regional or local program, to be eligible for funding from money in the fund that is provided subject to a federal waiver, to comply with certain requirements imposed under the waiver obtained under Section 531.502, Government Code, and to provide health care benefits or services under the program to a person receiving premium payment assistance for coverage through a program established under Section 531.507, Government Code, regardless of whether the person is an employee, or dependent of an employee, of a small employer.

[Reserves Sections 75.154-75.200 for expansion.]

SUBCHAPTER E. GRANTS FOR DEMONSTRATION PROJECTS

Sec. 75.201. DEFINITIONS. Defines "commission" and "executive commissioner."

Sec. 75.202. GRANT PROGRAM. (a) Authorizes the executive commissioner to establish a grant program to support the initial establishment and operation of one or more regional or local programs as demonstration projects, subject to the appropriations of money for this purpose.

(b) Requires the executive commissioner to consider the extent to which the regional or local program proposed by the applicant accomplishes the purposes of this chapter and meets the objectives established under Section 75.101 in choosing regional or local programs to receive grants.

(c) Requires HHSC to establish performance objectives for a grant recipient and to monitor the performance of the grant recipient.

Sec. 75.203. REVIEW OF DEMONSTRATION PROJECT; REPORT. Requires HHSC to complete a review of each grant recipient and to submit to certain elected officials a report that includes an evaluation of the success of the regional and local programs in accomplishing the purposes of this subchapter, and HHSC's recommendations for any legislation needed to facilitate or improve the regional or local programs, not later than December 1, 2008.

Sec. 75.204. EXPIRATION. Provides that this subchapter expires September 1, 2009.

(b) Amends the heading to Subtitle C, Title 2, Health and Safety Code, to read as follows:

SUBTITLE C. PROGRAMS PROVIDING HEALTH CARE BENEFITS AND SERVICES

SECTION 14. (a) Amends Section 773.004(a), Health and Safety Code, by deleting existing text providing that this chapter (Emergency Medical Services) does not apply to a ground transfer vehicle and staff used to transport a patient who is under a physician's care between medical facilities or between a medical facility and a private residence, unless it is medically necessary to transport the patient using a stretcher.

(b) Amends Section 773.041, Health and Safety Code, by adding Subsection (a-1), to prohibit a person from transporting a patient by stretcher in a vehicle unless the person holds a license as an emergency medical services provider issued by the Department of State Health Services (DSHS) in accordance with this chapter. Defines "person."

(c) Requires the executive commissioner, not later than May 1, 2008, to adopt the rules necessary to implement the changes in law made by this section to Chapter 773, Health and Safety Code.

SECTION 15. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0214, as follows:

Sec. 32.0214. DESIGNATIONS OF PRIMARY CARE PROVIDER BY CERTAIN RECIPIENTS. (a) Requires HHSC or an agency operating part of the medical assistance program, as appropriate, (department) if it is determined to be cost-effective and feasible and subject to Subsection (b), to require each recipient of medical assistance to designate a primary care provider with whom the recipient will have a continuous, ongoing professional relationship and who will provide and coordinate the recipient's initial and primary care, maintain the continuity of care provided to the recipient, and initiate any referrals to other health care providers.

(b) Requires a recipient who receives medical assistance through Medicaid managed care model or arrangement under Chapter 533, Government Code, that requires the designation of a primary care provider to designate the recipient's primary care provider as required by that model or arrangement.

SECTION 16. Amends Section 32.024, Human Resources Code, by adding Subsection (y-1), as follows:

(y-1) Provides that a woman who receives a breast or cervical cancer screening service under Title XV of the Public Health Service Act (42 U.S.C. Section 300k et seq.) and who otherwise meets the eligibility requirements for medical assistance for treatment of breast or cervical cancer as provided by Subsection (y) is eligible for medical assistance under that subsection, regardless of whether federal Medicaid matching funds are available for that medical assistance. Provides that a screening service of a type that is within the scope of screening services under that title is considered to be provided under

that title regardless of whether the service was provided by a provider who receives or uses funds under that title.

SECTION 17. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.02471, as follows:

Sec. 32.02471. MEDICAL ASSISTANCE FOR CERTAIN FORMER FOSTER CARE ADOLESCENTS ENROLLED IN HIGHER EDUCATION. (a) Defines "independent foster care adolescent."

(b) Requires the department to provide medical assistance to certain persons.

SECTION 18. Amends Section 32.0422, Human Resources Code, as follows:

Sec. 32.0422. HEALTH INSURANCE PREMIUM PAYMENT REIMBURSEMENT PROGRAM FOR MEDICAL ASSISTANCE RECIPIENTS. (a) Defines "commission," and "executive commissioner." Deletes the existing definition for "department."

(b) Requires HHSC, rather than the Texas Department of Insurance (TDI), to identify individuals who are otherwise entitled to medical assistance, who are eligible to enroll in a group health benefit plan. Requires HHSC to include individuals eligible for or receiving health care services under a Medicaid managed care delivery system.

(b-1) Sets forth requirements to assist HHSC in identifying individuals described by Subsection (b):

(1) Requires HHSC to include on an application for medical assistance and on a form for recertification of a recipient's eligibility for medical assistance an inquiry on whether the applicable party is eligible to enroll in a group health benefit plan and a statement informing the applicable party regarding potentially available reimbursements for required premiums and cost-sharing obligations under the group health benefit plan.

(2) Requires the office of the attorney general to provide HHSC with certain information for each newly hired employee reported to the state directory of new hires operated under Chapter 234 (State Case Registry, Disbursement Unit, and Directory of New Hires), Family Code, for the previous calendar month, not later than the 15th day of each month.

(c) Requires HHSC to require an individual requesting medical assistance or a recipient, during the recipient's eligibility recertification review, to provide information as necessary related to any group health benefit plan that is available to the individual or recipient through the employer of either the individual, the recipient, or their respective spouses or parents to assist HHSC in making the determination required by Subsection (d). Makes conforming changes.

(d) Makes a conforming change.

(e) Makes conforming changes.

(e-1) Provides that this subsection applies to individuals identified as being eligible to enroll in a group health benefit plan offered by an employer. Requires HHSC, pending approval from a federal waiver, to allow the individual to voluntarily opt out of receiving services through the medical assistance program and to enroll in the group health benefit plan, to consider that individual a recipient of medical assistance, and to provide written notice to the group health benefit plan issuer (issuer) in accordance with Chapter 1207 (Enrollment of Medical Assistance Recipients and Children Eligible for State Child Health Plan), Insurance Code, if the individual prefers to enroll in that plan rather than

receiving benefits and services under the medical assistance program, regardless of cost-effectiveness.

(f) Requires HHSC to provide for payment of certain costs related to an individual's enrollment in the group health benefits plan, except as provided by Subsection (f-1)

(f-1) Requires HHSC to provide for payment of the employee's share of the required premiums for an individual, described by Subsection (e-1), who is enrolled in a group health benefit plan, until those premiums exceed the total estimated Medicaid costs for the individual, as determined by the executive commissioner, at which point the individual will pay the difference between the required premiums and those estimated costs. Requires the individual, in addition, to pay certain cost-sharing obligations imposed on the individual under the group health benefit plan.

(g) Makes conforming changes.

(h) Makes a conforming change.

(i) Makes no changes to this subsection.

(i-1) Requires HHSC to make every effort to expedite payments made under this section, including payments made though electronic transfer of money to the recipient's account at a financial institution, if possible. Authorizes HHSC to make payments under this section for required premiums directly to the employer providing the group health benefit plan in which the individual is enrolled, or to make those payments directly to the issuer, in lieu of reimbursement to the individual for those premiums or for cost-sharing payments.

(j) Provides that the enrollment of an individual in a group health benefit plan under this section does not affect the individual's eligibility for medical assistance benefits, subject to Subsection (j-1). Makes a conforming change.

(j-1) Provides that an individual described by Subsection (e-1) who enrolls in a group health benefit plan is not ineligible for community-based services provided under a Section 1915(c) waiver program (regarding certain waiver for home and community-based health services) or another federal waiver program solely based on the individual's enrollment in the group health benefit plan, and authorizes the individual to receive those services if the individual is otherwise eligible for the program. Provides that the individual is otherwise limited to the health benefits coverage under the health benefit plan in which the individual is enrolled, and prohibits the individual from receiving any benefits or services under the medical assistance program other than the premium payment as provided by Subsection (f-1), and waiver program services described by this subsection, if applicable.

(k) Makes a conforming change.

(l) Requires HHSC, in consultation with TDI, to provide training to agents who hold a general life, accident, and health license (agents) under Chapter 4054 (Life, Accident and Health Agents), Insurance Code, regarding the premium payment program and the eligibility requirements for participation in that program. Provides that participation in such a training program is voluntary, and entitles the agents who successfully complete the training to receive continuing education credit under Subchapter B (Agent Continuing Education Requirements), Chapter 4004, Insurance Code, in accordance with rules adopted by the commissioner of insurance.

(m) Authorizes HHSC to pay a referral fee, the amount of which is determined by HHSC, to each agent who successfully refers an eligible individual to HHSC for enrollment in a group health benefit plan under this section after completion of

the training program. Deletes existing text requiring the Texas Department of Human Services to provide information and to otherwise cooperate with TDI to ensure the enrollment of eligible individuals in the group health benefit plan.

(n) Requires HHSC to develop procedures to authorize an individual described in Subsection (e-1) who enrolls in a group health benefit plan to resume receiving benefits and services under the medical assistance program instead of the group health benefit plan at the individual's option.

(o) Requires HHSC to develop procedures which ensure that, prior to allowing an individual described by Subsection (e-1) to enroll in a group health benefit plan or allowing the parent or caretaker of an individual described by Subsection (e-1) under the age of 21 to enroll that child in a group health benefit plan, that certain actions are taken and that require the individual to sign and HHSC to retain a copy of a waiver indicating the individual has provided informed consent.

(p) Requires the executive commissioner, rather than TDI, to adopt rules as necessary to implement this section.

SECTION 19. (a) Amends Section 32.058, Human Resources Code, as follows:

Sec. 32.058. LIMITATION ON MEDICAL ASSISTANCE IN CERTAIN ALTERNATIVE COMMUNITY-BASED CARE SETTINGS. (a) Redefines "medical assistance waiver program." Deletes existing text defining "institution."

(b) Prohibits HHSC or an agency operating part of the medical assistance program, as appropriate, (department) from providing services under a medical assistance waiver program if the projected cost of providing those services over a 12-month period exceeds a certain amount. Deletes existing text prohibiting the department from providing services under a medical assistance waiver program to a person receiving medical assistance if the cost of providing those services exceeds a certain amount. Makes conforming changes.

(c) Requires the department to continue to provide services under a program to certain persons if continuation of those services does not affect the department's compliance with the federal average per capita expenditure requirement, rather than cost-effectiveness and efficiency requirements, of the program under 42 U.S.C. Section 1396n(c) (2) (D), and not Section 1396n (b). Makes conforming and nonsubstantive changes.

(d) Authorizes the department to continue to provide services under a program, other than the home and community-based services program, to a person who is ineligible to receive those services under Subsection (b) and to whom Subsection (c) does not apply if certain conditions are met. Makes conforming changes.

(e) Authorizes the department to exempt a person from the cost limit established under Subsection (d)(1) for a medical assistance waiver program if the department determines that certain conditions exist.

(f) Authorizes the department to continue to provide services under the home and community-based services program to a person who is ineligible to receive those services under Subsection (b) and to whom Subsection (c) does not apply if the department makes, with regard to the person's receipt of services under the home and community-based services program, the same determinations required by Subsections (e)(1) and (2) in the same manner provided by Subsection (e) and determines that continuation of those services does not affect the department's compliance with certain requirements.

(g) Authorizes the executive commissioner to adopt rules to implement Subsections (d), (e), and (f), rather than under which the department is authorized to exempt a person from the cost limit established under Subsection (d)(1).

(h) Authorizes but does not require a state agency to implement a provision of this section if a federal agency determines that compliance with a provision in this section would make this state ineligible to receive federal funds to administer a program to which this section applies.

(b) Provides that the changes in law made by this section apply only to a person receiving medical assistance on or after the effective date of this section, regardless of when eligibility for that assistance was determined.

SECTION 20. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0641, as follows:

Sec. 32.0641. COST SHARING FOR CERTAIN HIGH-COST MEDICAL SERVICES. (a) Requires the executive commissioner to adopt cost-sharing provisions that require a recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a copayment, premium payment, or other cost-sharing payment, for the high-cost medical service, if the hospital from which the recipient seeks service provides certain information and assistance and, after said provision, the recipient chooses to obtain emergency medical services despite having access to medically acceptable, lower-cost medical service.

(b) Prohibits the department from seeking a federal waiver or other authorization under Subsection (a) that would prevent a Medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room or waive any provision under Section 1867, Social Security Act (42 U.S.C. Section 1395dd).

(c) Prohibits HHSC, if the executive commissioner adopts a copayment or other cost-sharing payment under Subsection (a), from reducing hospital payments to reflect the potential receipt of a copayment or other payment from a recipient receiving medical services provided through a hospital emergency room.

SECTION 21. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.072, as follows:

Sec. 32.072. DIRECT ACCESS TO EYE HEALTH CARE SERVICES. (a) Entitles a recipient of medical assistance, notwithstanding any other law, to select certain ophthalmologists or therapeutic optometrists and to have direct access to specific nonsurgical services in a certain manner.

(b) Authorizes the department to require a specific ophthalmologist or therapeutic optometrist to forward certain information related to the recipient's eye health care to the recipient's physician, gatekeeper, or health care coordinator.

(c) Prohibits this section from being construed to expand the scope of eye health care services provided under the medical assistance program.

(b) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0026, as follows:

Sec. 533.0026. DIRECT ACCESS TO EYE HEALTH CARE SERVICES UNDER MEDICAID MANAGED CARE MODEL OR ARRANGEMENT. (a) Requires HHSC, notwithstanding any other law, to ensure that a managed care organization that contracts with HHSC under this chapter and any other Medicaid

managed care model or arrangement implemented under this chapter allow a Medicaid recipient who receives services through the plan or other model or arrangement to, in the manner and to the extent required by Section 32.072, Human Resources Code, to select an in-network ophthalmologist or therapeutic optometrist in the managed care network to provide eye health care services, other than surgery and have direct access to the selected in-network ophthalmologist or therapeutic optometrist for the provision of the nonsurgical services.

(b) Provides that this section does not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms and conditions of the managed care plan.

(c) Provides that the changes in law made by Section 533.0026, Government Code, as added by this section, apply to a contract between HHSC 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.

SECTION 22. Amends Chapter 32, Human Resources Code, by adding Subchapter C, as follows:

SUBCHAPTER C. ELECTRONIC COMMUNICATIONS

Sec. 32.101. DEFINITIONS. Defines "electronic health record," "executive commissioner," "health care provider," "health information technology," "operating agency," "participating provider," "physician," and "recipient."

Sec. 32.102. ELECTRONIC COMMUNICATIONS. (a) Authorizes the executive commissioner, to the extent allowed by federal law, to adopt rules allowing HHSC to permit, facilitate, and implement the use of health information technology for the medical assistance program to allow for electronic communication among HHSC, the operating agencies, and participating providers for certain purposes.

(b) Authorizes HHSC, if the executive commissioner determines that a need exists for the use of health information technology in the medical assistance program and that the technology is cost-effective, to acquire and implement the technology or evaluate the feasibility of developing and, if feasible, develop, the technology through the use or expansion of other systems or technologies HHSC uses for other purposes.

(c) Requires HHSC to ensure that health information technology used under this section complies with the applicable requirements of the Health Insurance Portability and Accountability Act. Authorizes HHSC to require the health information technology used under this section to include technology to extract and process claims and other information collected, stored, or accessed by the medical assistance program, program contractors, participating providers, and state agencies operating any part of the medical assistance program for the purpose of providing patient information at the location where the patient is receiving care. Requires HHSC to ensure that a paper record or document is not required to be filed if the record or document is permitted or required to be filed or transmitted electronically by rule of the executive commissioner. Authorizes HHSC to provide for incentives to participating providers to encourage their use of health information technology under this subchapter. Authorizes HHSC to provide recipients with a method to access their own health information. Authorizes HHSC to present recipients with an option to decline having their health information maintained in an electronic format under this subchapter.

(d) Requires the executive commissioner to consult with participating providers and other interested stakeholders in developing any proposed rules under this section and to request advice and information from those stakeholders concerning the proposed rules, including advice regarding the impact of and need for a proposed rule.

SECTION 23. (a) Amends Chapter 32, Human Resources Code, by adding Subchapter D, as follows:

SUBCHAPTER D. ELECTRONIC HEALTH INFORMATION PILOT PROGRAM

Sec. 32.151. DEFINITIONS. Defines "electronic health record," "executive commissioner," "health information technology," "provider," and "recipient."

Sec. 32.152. ELECTRONIC HEALTH INFORMATION PILOT PROGRAM. Requires the executive commissioner, from money appropriated for this purpose, to develop and implement and pilot program for providing health information technology, including electronic health records, for use by primary care providers who provide medical assistance to recipients.

Sec. 32.153. PROVIDER PARTICIPATION. Requires the department, for participation in the pilot program, to select provider who volunteer to participate in the program, are providers of medical assistance, including providers who contract or otherwise agree with a managed care organization to provide medical assistance under this chapter, and demonstrate that at least 40 percent of the providers' practice involves the provision of primary care services to recipients in the medical assistance program.

Sec. 32.154. SECURITY OF PERSONALLY IDENTIFIABLE HEALTH INFORMATION. (a) Requires personally identifiable information of recipients enrolled in the pilot program to be maintained in an electronic format or technology that meets interoperability standards that are recognized by the Certification Commission for Healthcare Information Technology or other federally approved certification standards.

(b) Requires the system used to access a recipient's electronic health record to be secure and maintain the confidentiality of the recipient's personally identifiable health information in accordance with applicable state and federal law.

Sec. 32.155. GIFTS, GRANTS, AND DONATIONS. Authorizes the department to request and accept gifts, grants, and donations from public or private entities for the implementation of the pilot program.

Sec. 32.156. PROTECTED HEALTH INFORMATION. Requires a covered entity, to the extent that this subchapter authorizes the use or disclosure of protected health information by the covered entity, as those terms are defined by the privacy rule of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) contained in 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E, to ensure that the use or disclosure complies with all applicable requirements, standards, or implementation specifications of the privacy rule.

Sec. 32.157. EXPIRATION OF SUBCHAPTER. Provides that this subchapter expires September 1, 2011.

(b) Requires the executive commissioner, not later than December 31, 2008, to submit to the governor, lieutenant governor, speaker of the house of representatives, presiding officer of the House Committee on Public Health, and presiding officer of the Senate Committee on Health and Human Services a report regarding the preliminary results of the pilot program established under Subchapter D, Chapter 32, Human Resources Code, as added by this section, and any recommendations regarding the expansion of the pilot program, including any recommendations for legislation and requests for appropriation necessary for the expansion of the pilot program.

SECTION 24. (a) Amends Section 1207.002(a), Insurance Code, as follows:

(a) Requires a group health benefit plan to permit an eligible individual to enroll in the plan, on receipt of written notice from HHSC, rather than HHSC or a designee of HHSC. Provides that the written notice states that the individual is a child eligible for, rather than enrolled in, the state child health plan under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, and eligible to participate, rather than a participant, in the health insurance premium assistance program under Section 62.059, Health and Safety Code.

(b) Amends Section 1207.003, Insurance Code, as follows:

Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT. (a) Creates this subsection from existing text. Provides that enrollment in a group health benefit plan under Section 1207.002 takes effect on the eligibility enrollment date specified in the written notice from HHSC under Section 1207.002(a) or the first day of the first calendar month that begins at least 30 days after the date written notice or a written request is received by the plan issuer under Section 1207.002(a) or (b), as applicable.

(b) Requires the individual, notwithstanding Subsection (a), to comply with a waiting period required under the state child health plan under Chapter 62, Health and Safety Code, or under the health insurance premium assistance program under Section 62.059, Health and Safety Code, as applicable.

(c) Amends Section 1207.004(b), to require the plan issuer to permit an enrolled individual and any family member of the individual to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides a written request to disenroll from the plan because the individual no longer wishes to participate, rather than provides satisfactory proof to the issuer that the child is no longer a participant, in the health insurance premium assistance program under Section 62.059, Health and Safety Code.

SECTION 25. Amends Subtitle G, Title 8, Insurance Code, by adding Chapter 1508, as follows:

CHAPTER 1508. HEALTHY TEXAS PROGRAM

Sec. 1508.001. STUDY; REPORT. (a) Requires the commissioner of insurance (commissioner) to conduct a study concerning a Healthy Texas Program, under which small employer health plan coverage would be offered through the program to persons who would be eligible for that coverage.

(b) Requires the study to include a market analysis to assist in identification of underserved segments in the voluntary small employer group health benefit plan coverage market in this state.

(c) Authorizes the commissioner, using existing resources, to contract with actuaries and other experts as necessary to conduct the study.

(d) Requires the commissioner, not later than November 1, 2008, to provide a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature addressing the results of the study concerning the Healthy Texas Program. Sets forth certain information and analysis required to be included in the report.

Sec. 1508.002. EXPIRATION. Provides that this chapter expires September 1, 2009.

SECTION 26. (a) Requires the Texas Health Care Policy Council, in coordination with the Institute for Demographic and Socioeconomic Research at The University of Texas at San Antonio, the Regional Center for Health Workforce Studies at the Center for Health Economics and Policy of The University of Texas Health Science Center at San Antonio, and the Texas

Medical Board, to conduct a study increasing the number of medical residency program and medical residents in Texas and the number of physicians practicing medical specialties.

(b) Sets forth specific goals that the study is required to meet.

(c) Requires the Texas Health Care Policy Council, not later than December 1, 2008, to report the results of the study and to make available the raw data of the study to certain individuals and committees.

(d) Authorizes the Texas Health Care Policy Council to accept gifts, grants, and donations of any kind from any source for the purposes of this section.

(e) Provides that this section expires January 1, 2009.

SECTION 27. (a) Defines "committee."

(b) Establishes the committee on health and long-term care insurance incentives (committee) to study and develop recommendations regarding methods to reduce the need for residents of this state to rely on the Medicaid program by providing incentives for employers to provide health insurance, long-term care insurance, or both, to their employees and the number of individuals in the state who are not covered by health insurance or long-term care insurance.

(c) Sets forth the composition of the committee.

(d) Requires the committee to elect a presiding officer and to meet at the call of that presiding officer.

(e) Requires the committee to study and develop recommendations regarding certain matters.

(e-1) Requires the committee to study and develop specific recommendations and to provide information obtained in the study HHSC and TDI.

(f) Requires the committee to submit a report regarding the results of this study to certain legislative committees, not later than September 1, 2008. Requires the report to include certain information.

SECTION 28. (a) Requires HHSC to conduct a study regarding the feasibility and cost-effectiveness of developing and implementing an integrated Medicaid managed care model (model) designed to improve management of care provided to certain Medicaid recipients who have chronic health care needs and are not enrolled in a managed care plan offered under a capitated model and who reside in certain areas.

(b) Requires HHSC to submit a report of this study to certain standing committees in the legislature having primary jurisdiction over the Medicaid program, not later than September 1, 2008.

SECTION 29. (a) Defines "child health plan program" and "Medicaid."

(b) Requires HHSC to conduct a study of the feasibility of providing a health passport for children under 19 years of age who are receiving Medicaid and are not provided a health passport under another law of Texas and children enrolled in the child health plan program.

(c) Sets forth certain goals that the feasibility study is required to meet.

(d) Requires HHSC, not later than January 1, 2009, to submit to the governor, the lieutenant governor, speaker of the house of representatives, and presiding officers of each standing committee of the legislature with jurisdiction over HHSC a written report containing the findings of the study and HHSC's recommendations.

(e) Provides that this section expires September 1, 2009.

SECTION 30. (a) Creates the Medicaid Reform Legislative Oversight Committee (oversight committee) to facilitate the reform efforts in Medicaid, the process of addressing the issues of uncompensated hospital care, and the establishment of programs addressing the uninsured.

(b) Sets forth the composition of the oversight committee.

(c) Provides that a member of the oversight committee serves at the pleasure of the appointing official.

(d) Requires the lieutenant governor to designate a member of the oversight committee as the presiding officer.

(e) Prohibits a member of the oversight committee from receiving compensation for serving on the oversight committee but entitles a member to be reimbursed for travel expenses incurred by the member while conducting the business of the oversight committee as provided by the General Appropriations Act.

(f) Sets forth certain duties required to be performed by the oversight committee.

(g) Sets forth certain duties authorized to be performed by the oversight committee.

(h) Requires the oversight committee to use existing staff of the senate, the house of representatives, and the Texas Legislative Council to assist the oversight committee in performing its duties under this section.

(i) Provides that Chapter 551 (Open Meetings), Government Code, applies to the oversight committee.

(j) Requires the oversight committee to report to the lieutenant governor and speaker of the house of representatives not later than November 15, 2008. Sets forth certain information required to be included in the report.

(k) Provides that this section expires September 1, 2009, and abolishes the oversight committee on that date.

(l) Effective date, this section: upon passage or September 1, 2007.

SECTION 31. (a) Defines "commission" and "department."

(b) Requires HHSC and TDI to jointly study a small employer premium assistance program to provide financial assistance for the purchase of small employer health benefit plans by small employers.

(c) Sets forth certain factors that the study is required to address.

(d) Authorizes TDI and HHSC, in conducting the study, to consider programs and efforts undertaken by other states to provide premium assistance to small employers.

(e) Requires TDI and HHSC, not later than November 1, 2008, too jointly submit a report to the legislature. Requires the report to summarize the results of the study conducted under this section and the recommendations of TDI and HHSC and is authorized to include recommendations for proposed legislation to implement a small employer premium assistance program as described by Subsection (b) of this section.

SECTION 32. (a) Transfers, subject to the appropriation of funds for these purposes and Subsection (c) of this section, all powers, duties, functions, activities, obligations, rights, contracts, records, assets, personal property, personnel, and appropriations or other money of

TxDOT that are essential to the administration of the medical transportation program, as specified in Section 531.0057, Government Code, as added by this Act, to HHSC.

(b) Provides that a reference in law or an administrative rule to TxDOT that relates to the medical transportation program means HHSC.

(c) Requires TxDOT to take all action necessary to provide for the transfer of its contractual obligations to administer the medical transportation program, as specified in Section 531.0057, Government Code, as added by this Act, to HHSC as soon as possible after the effective date of this section but not later than September 1, 2008.

(d) Amends Section 461.012(a), Health and Safety Code, effective September 1, 2008, to delete existing text requiring HHSC to contract with TxDOT for TxDOT to assume all responsibilities of HHSC relating to the provision of transportation services for clients of eligible programs.

(e) Requires HHSC, notwithstanding Section 461.012(a)(19), Health and Safety Code, to implement that section only to the extent necessary until HHSC effects the transfer of the medical transportation program, as specified in Section 531.0057, Government Code, as added by this Act, to HHSC not later than September 1, 2008.

(f) Provides that the following sections remain in effect until September 1, 2008, for the limited purpose of effecting the transfer of the medical transportation program, as specified in Section 531.0057, Government Code, as added by this Act and are then repealed: Section 531.02412(b) (Service Delivery Audit Mechanisms), Government Code; Sections 461.012(g) (Powers and Duties) and 533.012(b) (Cooperation of State Agencies), Health and Safety Code; Sections 22.001(e) (Powers and Duties of Commissioner of Health and Human Services), 40.002(f) (Department of Family and Protective Services; General Duties of Department), 91.021(g) (Responsibility for Visually Handicapped Persons), 101.0256(b) (Coordinated Access to Local Services), and 111.0525(d) (Coordination With State Agencies), Human Resources Code; and Sections 455.0015 (Transportation Needs of Clients of Health and Human Services Agencies) and 461.003 (Rules of Texas Transportation Commission), Transportation Code.

SECTION 33. SEVERABILITY. Provides that if any provision of this Act is held by a court to be invalid, that invalidity does not affect the other provisions of this Act, and to this end the provisions of this Act are severable.

SECTION 34. Authorizes a state agency to delay implementing a provision of this Act until a requested federal waiver or authorization necessary to implement that provision is granted.

SECTION 35. Effective date, except as otherwise provided by this Act: September 1, 2007.