BILL ANALYSIS

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C.S.S.B. 10
By: Nelson et al.
Health & Human Services
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Committee Report (Substituted)

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.

C.S.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 1 (Section 531.097, Government Code), SECTION 3 (Sections 531.503 and 531.505, Government Code), SECTION 4 (Section 531.551, Government Code), SECTION 8 (Section 76.103, Health and Safety Code), and SECTION 9 (Section 76.103, Health and Safety 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 6 (Section 32.0422, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. (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).
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> (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).
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> (c) Requires HHSC to consider similar incentive programs implemented in other states to determine the most cost-effective measures to implement the lifestyle program.
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> (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 such a pilot program.

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.

(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 package or similar packages of benefits implemented 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 2. (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 3. (a) Amends Chapter 531, Government Code, by adding Subchapter N, as follows:

SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL

Sec. 531.501. DIRECTION TO OBTAIN FEDERAL WAIVER FOR POOLED FUNDS. (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 depositing that federal money and state money, to the extent necessary, into a pooled fund established in the state treasury outside the general revenue fund (pooled fund), and to use that money for purposes consistent with this subchapter (waiver for pooling funds).

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

(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 pooling federal matching money received provided by the certifying of said funds and expenditures as state expenditures with other federal money pooled under Subsection (b), or substituting that federal matching money for federal money that otherwise would be received under the 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 money in the pooled fund, and any federal money provided under supplemental payment programs not included in the opportunity fund, is at least equal to 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 the formation of the waiver.

(e) Requires the executive commissioner to seek to obtain in a waiver for pooling funds under this section maximum flexibility with respect to the use of money in the pooled 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 existing resources funded by intergovernmental transfer or certified public expenditure that are used to optimize Medicaid payments to safety net hospitals for uncompensated care, unless the need for the resources is revised through measures that reduce the Medicaid shortfall or uncompensated care costs to the extent allowed by federal rule, federal regulations, and federal waiver authority.

(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. 531.502. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL. Establishes the Texas Health Opportunity Pool (pool), subject to the approval of and the terms of the waiver, as an account in the state treasury outside the general revenue fund. Provides that the money in the pool (pool money) is to be used only for purposes consistent with this subchapter and the terms of the waiver.

Sec. 531.503. USE OF TEXAS HEALTH OPPORTUNITY POOL IN GENERAL; RULES FOR ALLOCATION. (a) Sets forth specific authorized uses of the pool money, 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 implementation of, the pool, and, by rule, to develop a methodology for allocating pool money (allocation methodology) that is consistent with the terms of that waiver.

Sec. 531.504. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Authorizes the allocation of the pool money 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 pool money allocated to a political subdivision or hospital that is required to be used for those strategies.

Sec. 531.505. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Authorizes pool money available to reduce the number of persons in this state lacking health benefits coverage (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 appropriations for that purpose.

Sec. 531.506. INFRASTRUCTURE IMPROVEMENTS. Authorizes the use of pool money 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 pool money 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, if federal approval is obtained for said waiver, as soon as possible after the approval is granted.

SECTION 4. (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 March 1, 2008.

(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 5. (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 Act, 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 to authorize those organizations to offer value-added services to enrollees in accordance with Section 533.019.

SECTION 6. 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," rather than "department," and "executive commissioner." Makes conforming changes.

(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 the individual's 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).

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

SECTION 7. 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. 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.

SECTION 8. (a) 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

(b) Amends Subtitle C, Title 2, Health and Safety Code, by adding Chapter 76, as follows:

CHAPTER 76. MULTIPLE SHARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 76.001. DEFINITIONS. Defines "commission," "employee," "employer," "executive commissioner," "multiple share program," "partnering entity," and "public share."

[Reserves Sections 76.002-76.050 for expansion.]

SUBCHAPTER B. AUTHORITY OF COMMISSION; METHODS OF FUNDING

Sec. 76.051. MULTIPLE SHARE PROGRAM. Authorizes a local entity to propose a multiple share program to HHSC and to act as a partnering entity, subject to rules adopted under Section 76.103, Health and Safety Code.

Sec. 76.052. FUNDING. Authorizes HHSC to seek a waiver from the Centers for Medicare and Medicaid Services, or another appropriate federal agency, to use Medicaid or child health plan program funds to finance the public share of a multiple share program. Authorizes HHSC to cooperate with a partnering entity to finance the public share.

Sec. 76.053. AUTHORITY TO DETERMINE SCOPE. Authorizes HHSC to determine if a multiple share program proposed by a partnering entity should be local, regional or statewide in scope. Requires HHSC to base such a determination on appropriate methods to meet the uninsured community's needs and federal guidance.

Sec. 76.054. METHOD OF FINANCE. Authorizes a partnering entity to use local funds made via intergovernmental transfers from local governments, or certified public expenditures, to maximize this state's receipt of available federal matching funds provided through Medicaid and the child health plan should the legislature appropriate insufficient money towards a multiple share program.

[Reserves Sections 76.055-76.100 for expansion.]

SUBCHAPTER C. COST OF PROGRAM; CONTRIBUTION OF SHARES

Sec. 76.101. CONTRIBUTION OF SHARES. Authorizes a multiple share program to require each participating employer to contribute at least one-third of the cost of coverage, and to prohibit this state, a political subdivision of this state, or a nonprofit organization, from paying more than one-third of the cost of coverage.

Sec. 76.102. COST SHARING. Authorizes a multiple share program, subject to applicable federal law, to require an employee participating in the program to pay certain expenses.

Sec. 76.103. STANDARDS AND PROCEDURES. Sets forth specific standards and procedures to be established by the executive commissioner, by rule.

(c) Requires the executive commissioner to adopt rules and procedures necessary to implement the multiple share program created by this Act. Authorizes the executive commissioner to consult with TDI in adopting these rules and procedures.

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

SECTION 9. (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 this state's residents' dependence on the Medicaid program by providing incentives for employers to provide health insurance, long-term care insurance, or both, to their employees.

(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.

(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 10. 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 11. Requires a state agency to request any necessary waiver or authorization and 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 obtained.

SECTION 12. Effective date, except as otherwise provided by this Act: September 1, 2007.