By: Nelson, et al. S.B. No. 10

A BILL TO BE ENTITLED

AN ACT

relating to the operation and financing of the medical assistance program and other programs to provide health care benefits and services to persons in this state; providing penalties.

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02192 to read as follows:

Sec. 531.02192. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES. (a) In this section:

(1) "Federally qualified health center" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(B).

(2) "Federally qualified health center services" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(A).

(3) "Rural health clinic" and "rural health clinic services" have the meanings assigned by 42 U.S.C. Section 1396d(l)(1).

(b) Notwithstanding any provision of this chapter, Chapter 32, Human Resources Code, or any other law, the commission may not provide Medicaid services to a recipient through a delivery model or by enrolling the recipient in a program, including a delivery model or program implemented under a waiver obtained under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), unless under the delivery model or program:

(1) the recipient has access to federally qualified

health center services or rural health clinic services; and

(2) 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. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02414 to read as follows:

Sec. 531.02414. BILLING COORDINATION SYSTEM. (a) The commission shall, on or before March 1, 2008, contract for the implementation of a billing coordination system 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 issuer the system determines is the primary payor.

(b) The executive commissioner shall 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 services provided under the Medicaid program.

(c) An entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state must allow the contractor under Subsection (a) access to databases to allow the contractor to carry out the purposes of this subchapter subject to the contractor's contract with the commission and rules adopted under this subchapter 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 subchapter.

(d) After June 1, 2008, no public funds shall be expended on entities not in compliance with this subchapter unless a memorandum of understanding is entered into between the entity and the executive commissioner.

(e) Information obtained under this subchapter is confidential. The agent may use the information only for the purposes authorized under this subchapter. A person commits an offense if the person knowingly uses information obtained under this subchapter for any purpose not authorized under this subchapter. An offense under this subsection is a Class B misdemeanor.

SECTION 3. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.094, 531.0941, 531.097, and 531.0971 to read as follows:

Sec. 531.094. PILOT PROGRAM AND OTHER PROGRAMS TO PROMOTE HEALTHY LIFESTYLES. (a) The commission shall develop and implement a pilot program in one region of this state under which Medicaid recipients are provided positive incentives to lead healthy lifestyles, including through participating in certain health-related programs or engaging in certain health-conscious behaviors, thereby resulting in better health outcomes for those recipients.

(b) Except as provided by Subsection (c), in implementing the pilot program, the commission may provide:

(1) expanded health care benefits or value-added services for Medicaid recipients who participate in certain

programs, such as specified weight loss or smoking cessation programs;

(2) individual health rewards accounts that allow Medicaid recipients who follow certain disease management protocols to receive credits in the accounts that may be exchanged for health-related items specified by the commission that are not covered by Medicaid; and

(3) any other positive incentive the commission determines would promote healthy lifestyles and improve health outcomes for Medicaid recipients.

(c) The commission shall consider similar incentive programs implemented in other states to determine the most cost-effective measures to implement in the pilot program under this section.

(d) Not later than December 1, 2010, the commission shall submit a report to the legislature that:

(1) describes the operation of the pilot program;

(2) analyzes the effect of the incentives provided under the pilot program on the health of program participants; and

(3) makes recommendations regarding the continuation or expansion of the pilot program.

(e) In addition to developing and implementing the pilot program under this section, the commission may, if feasible and cost-effective, 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 program. The

commission shall provide incentives under the program for managed care organizations contracting with the commission under Chapter 533 and Medicaid providers to encourage those organizations and providers to support the delivery and documentation of timely and complete health care screenings under the early and periodic screening, diagnosis, and treatment program.

(f) This section expires September 1, 2011.

Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a) If the commission determines that it is cost-effective and feasible, the commission shall develop and implement a Medicaid health savings account pilot program that is consistent with federal law to:

(1) encourage health care cost awareness and sensitivity by adult recipients; and

(2) promote appropriate utilization of Medicaid services by adult recipients.

(b) If the commission implements a pilot program under this section, the commission may only include adult recipients as participants in the program.

(c) If the commission implements a Medicaid health savings account pilot program under this section, the commission shall ensure that:

(1) participation in the pilot program is voluntary; and

(2) a recipient who participates in the pilot program may, at the recipient's option, discontinue participation in the program and resume receiving benefits and services under the

traditional Medicaid delivery model.

Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to develop and, subject to Subsection (c), implement tailored benefit packages designed to:

(1) provide Medicaid benefits that are customized to meet the health care needs of recipients within defined categories of the Medicaid population through a defined system of care;

(2) improve health outcomes for those recipients;

(3) improve those recipients' access to services;

(4) achieve cost containment and efficiency; and

(5) reduce the administrative complexity of delivering Medicaid benefits.

(b) The commission:

(1) shall develop a tailored benefit package that is customized to meet the health care needs of Medicaid recipients who are children with special health care needs, subject to approval of the waiver described by Subsection (a); and

(2) may develop tailored benefit packages that are customized to meet the health care needs of other categories of Medicaid recipients.

(c) If the commission develops tailored benefit packages under Subsection (b)(2), the commission shall submit a report to the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program that

specifies, in detail, the categories of Medicaid recipients to which each of those packages will apply and the services available under each package. The commission may not implement a package developed under Subsection (b)(2) before September 1, 2009.

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

(e) Each tailored benefit package developed under this section must include:

(1) a basic set of benefits that are provided under all tailored benefit packages; and

(2) to the extent applicable to the category of Medicaid recipients to which the package applies:

(A) a set of benefits customized to meet the health care needs of recipients in that category; and

(B) services to integrate the management of a recipient's acute and long-term care needs, to the extent feasible.

(f) In addition to the benefits required by Subsection (e), a tailored benefit package developed under this section that applies to Medicaid recipients who are children must provide at least the services required by federal law under the early and periodic screening, diagnosis, and treatment program.

(g) A tailored benefit package developed under this section

may include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventive health or wellness service.

(g-1) A tailored benefit package implemented under this section may not reduce the scope of benefits that were available under the Medicaid state plan immediately before September 1, 2007, to the category of Medicaid recipients to which the package applies.

(h) In developing the tailored benefit packages, the commission shall consider similar benefit packages established in other states as a guide.

(i) The executive commissioner, by rule, shall define each category of recipients to which a tailored benefit package applies and a mechanism for appropriately placing recipients in specific categories. Recipient categories must include children with special health care needs and may include:

(1) persons with disabilities or special health needs;

(2) elderly persons;

(3) children without special health care needs; and

(4) working-age parents and caretaker relatives.

(j) This section does not apply to a tailored benefit package or similar package of benefits implemented before September 1, 2007.

Sec. 531.0971. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) The commission shall identify state or federal non-Medicaid programs that provide health care services to persons whose health care needs could be met by providing customized

benefits through a system of care that is used under a Medicaid tailored benefit package implemented under Section 531.097.

(b) If the commission determines that it is feasible and to the extent permitted by federal and state law, the commission shall:

(1) provide the health care services for persons identified under Subsection (a) through the applicable Medicaid tailored benefit package; and

(2) if appropriate or necessary to provide the services as required by Subdivision (1), develop and implement a system of blended funding methodologies to provide the services in that manner.

(b) Not later than September 1, 2008, the Health and Human Services Commission shall implement the pilot program under Section 531.094, Government Code, as added by this section.

SECTION 4. (a) Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1112 to read as follows:

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

(b) The commission shall implement any methods the commission and the commission's office of inspector general

determine are effective at strengthening fraud detection and deterrence.

(b) Not later than December 1, 2008, the Health and Human Services Commission shall submit to the legislature a report detailing the findings of the study required by Section 531.1112, Government Code, as added by this section. The report must include a description of any method described by Subsection (b), Section 531.1112, Government Code, as added by this section, that the commission has implemented or intends to implement.

SECTION 5. (a) Chapter 531, Government Code, is amended by adding Subchapter N to read as follows:

SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL

Sec. 531.501. DIRECTION TO OBTAIN FEDERAL WAIVER FOR POOLED FUNDS. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan to allow the commission to more efficiently and effectively use federal money paid to this state under various programs to defray costs associated with providing uncompensated health care in this state by:

(1) depositing that federal money and, to the extent necessary, state money, into a pooled fund established in the state treasury outside the general revenue fund; and

(2) using the money for purposes consistent with this subchapter.

(b) The federal money the executive commissioner may seek approval to pool includes:

(1) money provided under the disproportionate share

hospitals and upper payment limit supplemental payment programs, other than money provided under the disproportionate share hospitals supplemental payment program to state-owned and operated hospitals;

(2) money provided by the federal government in lieu of some or all of the payments under those programs;

(3) any combination of funds authorized to be pooled by Subdivisions (1) and (2); and

(4) any other money available for that purpose, including federal money and money identified under Subsection (c).

(c) The commission shall seek to optimize federal funding by:

(1) identifying health care related state and local funds and program expenditures that, before September 1, 2007, are not being matched with federal money; and

(2) exploring the feasibility of:

(A) certifying or otherwise using those funds and expenditures as state expenditures for which this state may receive federal matching money; and

(B) pooling federal matching money received as provided by Paragraph (A) with other federal money pooled under Subsection (b), 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 as a match for local funds received by this state through intergovernmental transfers.

(d) The terms of a waiver approved under this section must:

(1) include safeguards to ensure that the total amount of federal money in the pooled fund and any federal money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs that is not included in the pooled fund 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 that state fiscal year that are retroactive payments, or the state fiscal years during which the waiver is in effect; and

(2) allow for the development by this state of a methodology for allocating money in the pooled fund to:

(A) offset, in part, the uncompensated health care costs incurred by hospitals;

(B) reduce the number of persons in this state who do not have health benefits coverage; and

(C) maintain and enhance the community public health infrastructure provided by hospitals.

(e) In a waiver under this section, the executive commissioner shall seek to:

(1) obtain maximum flexibility with respect to using the money in the pooled fund for purposes consistent with this subchapter;

(2) 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;

(3) ensure, for the term of the waiver, that the aggregate caps under the upper payment limit 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

(4) to the extent allowed by federal rule, federal regulations, and federal waiver authority, 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.

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

(g) The executive commissioner shall 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. Subject to approval of the waiver authorized by Section 531.501, the Texas health opportunity pool is established in accordance with the terms of that waiver as an account in the state treasury outside the general revenue fund. Money in the pool may 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) Except as otherwise provided by the terms of a waiver authorized by Section 531.501, money in the Texas health opportunity pool may be used:

(1) subject to Section 531.504, to provide reimbursements to health care providers that:

(A) are based on the providers' costs related to providing uncompensated care; and

(B) compensate the providers for at least a portion of those costs;

(2) to reduce the number of persons in this state who do not have health benefits coverage;

(3) to reduce the need for uncompensated health care provided by hospitals in this state; and

(4) for any other purpose specified by this subchapter or the waiver.

(b) On approval of the waiver, the executive commissioner shall:

(1) seek input from a broad base of stakeholder representatives on the development of rules with respect to, and the implementation of, the pool; and

(2) by rule develop a methodology for allocating money in the pool that is consistent with the terms of the waiver.

Sec. 531.504. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Except as otherwise provided by the terms of a waiver authorized by Section 531.501 and subject to Subsections (b) and (c), money in the Texas health opportunity pool may be allocated to

hospitals in this state and political subdivisions of this state to defray the costs of providing uncompensated health care in this state.

(b) To be eligible for money from the pool under this section, a hospital or political subdivision must use a portion of the money to implement strategies that will reduce the need for uncompensated inpatient and outpatient care, including care provided in a hospital emergency room. Strategies that may be implemented by a hospital or political subdivision, as applicable, include:

(1) fostering improved access for patients to primary care systems or other programs that offer those patients medical homes, including the following programs:

(A) three share or multiple share programs;

(B) programs to provide premium subsidies for health benefits coverage; and

(C) other programs to increase access to health benefits coverage; and

(2) creating health care systems efficiencies, such as using electronic medical records systems.

(c) The allocation methodology adopted by the executive commissioner under Section 531.503(b) must specify the percentage of the money from the pool allocated to a hospital or political subdivision that the hospital or political subdivision must use for strategies described by Subsection (b).

Sec. 531.505. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Except as otherwise provided by the terms of a

waiver authorized by Section 531.501, money in the Texas health opportunity pool that is available to reduce the number of persons in this state who do not have health benefits coverage or to reduce the need for uncompensated health care provided by hospitals in this state may be used for purposes relating to increasing access to health benefits coverage for low-income persons, including:

(1) providing premium payment assistance to those persons through a premium payment assistance program developed under this section;

(2) making contributions to health savings accounts for those persons; and

(3) providing other financial assistance to those persons through alternate mechanisms established by hospitals in this state or political subdivisions of this state that meet certain criteria, as specified by the commission.

(b) The commission and the Texas Department of Insurance shall jointly develop a premium payment assistance program designed to assist persons described by Subsection (a) in obtaining and maintaining health benefits coverage. The program may provide assistance in the form of payments for all or part of the premiums for that coverage. In developing the program, the executive commissioner shall adopt rules establishing:

(1) eligibility criteria for the program;

(2) the amount of premium payment assistance that will be provided under the program;

(3) the process by which that assistance will be paid; and

(4) the mechanism for measuring and reporting the number of persons who obtained health insurance or other health benefits coverage as a result of the program.

(c) The commission shall implement the premium payment assistance program developed under Subsection (b), subject to appropriations for that purpose.

Sec. 531.506. INFRASTRUCTURE IMPROVEMENTS. (a) Except as otherwise provided by the terms of a waiver authorized by Section 531.501 and subject to Subsection (c), money in the Texas health opportunity pool may be used for purposes related to developing and implementing initiatives to improve the infrastructure of local provider networks that provide services to Medicaid recipients and low-income uninsured persons in this state.

(b) Infrastructure improvements under this section may include developing and implementing a system for maintaining medical records in an electronic format.

(c) Not more than 10 percent of the total amount of the money in the pool used in a state fiscal year for purposes other than providing reimbursements to hospitals for uncompensated health care may be used for infrastructure improvements described by Subsection (b).

(b) If the executive commissioner of the Health and Human Services Commission obtains federal approval for a waiver under Section 531.501, Government Code, as added by this Act, the executive commissioner shall submit a report to the Legislative Budget Board that outlines the components and terms of that waiver as soon as possible after federal approval is granted.

SECTION 6. (a) Chapter 531, Government Code, is amended by adding Subchapter O to read as follows:

SUBCHAPTER O. UNCOMPENSATED HOSPITAL CARE

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS. (a) The executive commissioner shall adopt rules providing for:

(1) a standard definition of "uncompensated hospital care";

(2) a methodology to be used by hospitals in this state to compute the cost of that care that incorporates the standard set of adjustments described by Section 531.552(g)(4); and

(3) procedures to be used by those hospitals to report the cost of that care to the commission and to analyze that cost.

(b) The rules adopted by the executive commissioner under Subsection (a)(3) may provide for procedures by which the commission may periodically verify the completeness and accuracy of the information reported by hospitals.

(c) The commission shall notify the attorney general of a hospital's failure to report the cost of uncompensated care on or before the date the report was due in accordance with rules adopted under Subsection (a)(3). On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in the amount of $1,000 for each day after the date the report was due that the hospital has not submitted the report, not to exceed $10,000.

(d) If the commission determines through the procedures adopted under Subsection (b) that a hospital submitted a report

with incomplete or inaccurate information, the commission shall notify the hospital of the specific information the hospital must submit and prescribe a date by which the hospital must provide that information. If the hospital fails to submit the specified information on or before the date prescribed by the commission, the commission shall notify the attorney general of that failure. On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in an amount not to exceed $10,000. In determining the amount of the penalty to be imposed, the attorney general shall consider:

(1) the seriousness of the violation;

(2) whether the hospital had previously committed a violation; and

(3) the amount necessary to deter the hospital from committing future violations.

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

(f) The attorney general shall give written notice of the commission's report to the hospital alleged to have failed to comply with a requirement. The notice must include a brief summary of the alleged violation, a statement of the amount of the administrative penalty to be imposed, and a statement of the hospital's right to a hearing on the alleged violation, the amount of the penalty, or both.

(g) Not later than the 20th day after the date the notice is sent under Subsection (f), the hospital must make a written request for a hearing or remit the amount of the administrative penalty to the attorney general. Failure to timely request a hearing or remit the amount of the administrative penalty results in a waiver of the right to a hearing under this section. If the hospital timely requests a hearing, the attorney general shall conduct the hearing in accordance with Chapter 2001, Government Code. If the hearing results in a finding that a violation has occurred, the attorney general shall:

(1) provide to the hospital written notice of:

(A) the findings established at the hearing; and

(B) the amount of the penalty; and

(2) enter an order requiring the hospital to pay the amount of the penalty.

(h) Not later than the 30th day after the date the hospital receives the order entered by the attorney general under Subsection (g), the hospital shall:

(1) pay the amount of the administrative penalty;

(2) remit the amount of the penalty to the attorney general for deposit in an escrow account and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both; or

(3) without paying the amount of the penalty, file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both and file with the court a sworn affidavit stating that the hospital is financially

unable to pay the amount of the penalty.

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

(j) 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, the attorney general shall remit the appropriate amount to the hospital not later than the 30th day after the date the court's judgment becomes final.

(k) If the court sustains the occurrence of the violation:

(1) the court:

(A) shall order the hospital to pay the amount of the administrative penalty; and

(B) may award to the attorney general the attorney's fees and court costs incurred by the attorney general in defending the action; and

(2) the attorney general shall remit the amount of the penalty to the comptroller for deposit in the general revenue fund.

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

Sec. 531.552. WORK GROUP ON UNCOMPENSATED HOSPITAL CARE. (a) In this section, "work group" means the work group on uncompensated hospital care.

(b) The executive commissioner shall establish the work group on uncompensated hospital care to assist the executive

commissioner in developing rules required by Section 531.551 by performing the functions described by Subsection (g).

(c) The executive commissioner shall determine the number of members of the work group. The executive commissioner shall ensure that the work group includes representatives from the office of the attorney general and the hospital industry. A member of the work group serves at the will of the executive commissioner.

(d) The executive commissioner shall designate a member of the work group to serve as presiding officer. The members of the work group shall elect any other necessary officers.

(e) The work group shall meet at the call of the executive commissioner.

(f) A member of the work group may not receive compensation for serving on the work group but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the work group as provided by the General Appropriations Act.

(g) The work group shall study and advise the executive commissioner in:

(1) identifying the number of different reports required to be submitted to the state that address uncompensated hospital care, care for low-income uninsured persons in this state, or both;

(2) standardizing the definitions used to determine uncompensated hospital care for purposes of those reports;

(3) improving the tracking of hospital charges, costs, and adjustments as those charges, costs, and adjustments relate to

identifying uncompensated hospital care and maintaining a hospital's tax-exempt status;

(4) developing and applying a standard set of adjustments to a hospital's initial computation of the cost of uncompensated hospital care that account for all funding streams that:

(A) are not patient-specific; and

(B) are used to offset the hospital's initially computed amount of uncompensated care;

(5) developing a standard and comprehensive center for data analysis and reporting with respect to uncompensated hospital care; and

(6) analyzing the effect of the standardization of the definition of uncompensated hospital care and the computation of its cost, as determined in accordance with the rules adopted by the executive commissioner, on the laws of this state, and analyzing potential legislation to incorporate the changes made by the standardization.

(b) The executive commissioner of the Health and Human Services Commission shall:

(1) establish the work group on uncompensated hospital care required by Section 531.552, Government Code, as added by this section, not later than October 1, 2007; and

(2) adopt the rules required by Section 531.551, Government Code, as added by this section, not later than March 1, 2008.

(c) The executive commissioner of the Health and Human

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

SECTION 7. (a) Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.019 to read as follows:

Sec. 533.019. VALUE-ADDED SERVICES. The commission shall actively encourage managed care organizations that contract with the commission to offer benefits, including health care services or benefits or other types of services, that:

(1) are in addition to the services ordinarily covered by the managed care plan offered by the managed care organization; and

(2) have the potential to improve the health status of enrollees in the plan.

(b) The changes in law made by Section 533.019, Government Code, as added by this Act, apply to a contract between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this section. The commission shall seek to amend contracts entered into with managed care organizations under that chapter before the effective date of this Act to authorize those managed care organizations to offer value-added services to enrollees in accordance with Section 533.019,

Government Code, as added by this section.

SECTION 8. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0214 to read as follows:

Sec. 32.0214. DESIGNATIONS OF PRIMARY CARE PHYSICIAN BY CERTAIN RECIPIENTS. (a) If the department determines that it is cost-effective and feasible and subject to Subsection (b), the department shall require each recipient of medical assistance to designate a primary care physician with whom the recipient will have a continuous, ongoing professional relationship and who will manage and coordinate all aspects of the recipient's health care.

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

SECTION 9. Section 32.0422, Human Resources Code, is amended to read as follows:

Sec. 32.0422. HEALTH INSURANCE PREMIUM PAYMENT REIMBURSEMENT PROGRAM FOR MEDICAL ASSISTANCE RECIPIENTS. (a) In this section:

(1) "Commission" [~~"Department"~~] means the Health and Human Services Commission [~~Texas Department of Health~~].

(2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(3) "Group health benefit plan" means a plan described by Section 1207.001, Insurance Code.

(b) The commission [~~department~~] shall identify individuals,

otherwise entitled to medical assistance, who are eligible to enroll in a group health benefit plan. The commission [~~department~~] must include individuals eligible for or receiving health care services under a Medicaid managed care delivery system.

(b-1) To assist the commission in identifying individuals described by Subsection (b):

(1) the commission shall include on an application for medical assistance and on a form for recertification of a recipient's eligibility for medical assistance:

(A) an inquiry regarding whether the applicant or recipient, as applicable, is eligible to enroll in a group health benefit plan; and

(B) a statement informing the applicant or recipient, as applicable, that reimbursements for required premiums and cost-sharing obligations under the group health benefit plan may be available to the applicant or recipient; and

(2) not later than the 15th day of each month, the office of the attorney general shall provide to the commission the name, address, and social security number of each newly hired employee reported to the state directory of new hires operated under Chapter 234, Family Code, during the previous calendar month.

(c) The commission [~~department~~] shall require an individual requesting medical assistance or a recipient, during the recipient's eligibility recertification review, to provide information as necessary relating to any [~~the availability of a~~] group health benefit plan that is available to the individual or recipient through an employer of the individual or recipient or an

employer of the individual's or recipient's spouse or parent to assist the commission in making the determination required by Subsection (d).

(d) For an individual identified under Subsection (b), the commission [~~department~~] shall determine whether it is cost-effective to enroll the individual in the group health benefit plan under this section.

(e) If the commission [~~department~~] determines that it is cost-effective to enroll the individual in the group health benefit plan, the commission [~~department~~] shall:

(1) require the individual to apply to enroll in the group health benefit plan as a condition for eligibility under the medical assistance program; and

(2) provide written notice to the issuer of the group health benefit plan in accordance with Chapter 1207, Insurance Code.

(e-1) This subsection applies only to an individual who is identified under Subsection (b) as being eligible to enroll in a group health benefit plan offered by the individual's employer. If the commission determines under Subsection (d) that enrolling the individual in the group health benefit plan is not cost-effective, but the individual prefers to enroll in that plan instead of receiving benefits and services under the medical assistance program, the commission, if authorized by a waiver obtained under federal law, shall:

(1) allow the individual to voluntarily opt out of receiving services through the medical assistance program and

enroll in the group health benefit plan;

(2) consider that individual to be a recipient of medical assistance; and

(3) provide written notice to the issuer of the group health benefit plan in accordance with Chapter 1207, Insurance Code.

(f) Except as provided by Subsection (f-1), the commission [~~The department~~] shall provide for payment of:

(1) the employee's share of required premiums for coverage of an individual enrolled in the group health benefit plan; and

(2) any deductible, copayment, coinsurance, or other cost-sharing obligation imposed on the enrolled individual for an item or service otherwise covered under the medical assistance program.

(f-1) For an individual described by Subsection (e-1) who enrolls in a group health benefit plan, the commission shall provide for payment of the employee's share of the required premiums, except that if the employee's share of the required premiums exceeds the total estimated Medicaid costs for the individual, as determined by the executive commissioner, the individual shall pay the difference between the required premiums and those estimated costs. The individual shall also pay all deductibles, copayments, coinsurance, and other cost-sharing obligations imposed on the individual under the group health benefit plan.

(g) A payment made by the commission [~~department~~] under

Subsection (f) or (f-1) is considered to be a payment for medical assistance.

(h) A payment of a premium for an individual who is a member of the family of an individual enrolled in a group health benefit plan under Subsection (e) [~~this section~~] and who is not eligible for medical assistance is considered to be a payment for medical assistance for an eligible individual if:

(1) enrollment of the family members who are eligible for medical assistance is not possible under the plan without also enrolling members who are not eligible; and

(2) the commission [~~department~~] determines it to be cost-effective.

(i) A payment of any deductible, copayment, coinsurance, or other cost-sharing obligation of a family member who is enrolled in a group health benefit plan in accordance with Subsection (h) and who is not eligible for medical assistance:

(1) may not be paid under this chapter; and

(2) is not considered to be a payment for medical assistance for an eligible individual.

(i-1) The commission shall make every effort to expedite payments made under this section, including by ensuring that those payments are made through electronic transfers of money to the recipient's account at a financial institution, if possible. In lieu of reimbursing the individual enrolled in the group health benefit plan for required premium or cost-sharing payments made by the individual, the commission may, if feasible:

(1) make payments under this section for required

premiums directly to the employer providing the group health benefit plan in which an individual is enrolled; or

(2) make payments under this section for required premiums and cost-sharing obligations directly to the group health benefit plan issuer.

(j) The commission [~~department~~] shall treat coverage under the group health benefit plan as a third party liability to the program. Subject to Subsection (j-1), enrollment [~~Enrollment~~] of an individual in a group health benefit plan under this section does not affect the individual's eligibility for medical assistance benefits, except that the state is entitled to payment under Sections 32.033 and 32.038.

(j-1) 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 or another federal waiver program solely based on the individual's enrollment in the group health benefit plan, and the individual may receive those services if the individual is otherwise eligible for the program. The individual is otherwise limited to the health benefits coverage provided under the health benefit plan in which the individual is enrolled, and the individual may not receive any benefits or services under the medical assistance program other than the premium payment as provided by Subsection (f-1) and, if applicable, waiver program services described by this subsection.

(k) The commission [~~department~~] may not require or permit an individual who is enrolled in a group health benefit plan under this

section to participate in the Medicaid managed care program under Chapter 533, Government Code, or a Medicaid managed care demonstration project under Section 32.041.

(l) The commission, in consultation with the Texas Department of Insurance, shall provide training to agents who hold a general life, accident, and health license under Chapter 4054, Insurance Code, regarding the health insurance premium payment reimbursement program and the eligibility requirements for participation in the program. Participation in a training program established under this subsection is voluntary, and a general life, accident, and health agent who successfully completes the training is entitled to receive continuing education credit under Subchapter B, Chapter 4004, Insurance Code, in accordance with rules adopted by the commissioner of insurance.

(m) The commission may pay a referral fee, in an amount determined by the commission, to each general life, accident, and health agent who, after completion of the training program established under Subsection (l), successfully refers an eligible individual to the commission for enrollment in a [~~Texas Department of Human Services shall provide information and otherwise cooperate with the department as necessary to ensure the enrollment of eligible individuals in the~~] group health benefit plan under this section.

(n) The commission shall develop procedures by which an individual described by Subsection (e-1) who enrolls in a group health benefit plan may, at the individual's option, resume receiving benefits and services under the medical assistance

program instead of the group health benefit plan.

(o) The commission shall 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:

(1) the individual must receive counseling informing them that for the period in which the individual is enrolled in the group health benefit plan:

(A) the individual shall be limited to the health benefits coverage provided under the health benefit plan in which the individual is enrolled;

(B) the individual may not receive any benefits or services under the medical assistance program other than the premium payment as provided by Subsection (f-1);

(C) the individual shall pay the difference between the required premiums and the premium payment as provided by Subsection (f-1) and shall also pay all deductibles, copayments, coinsurance, and other cost-sharing obligations imposed on the individual under the group health benefit plan; and

(D) the individual may, at the individual's option, resume receiving benefits and services under the medical assistance program instead of the group health benefit plan; and

(2) the individual must sign and the commission shall retain a copy of a waiver indicating the individual has provided informed consent.

(p) The executive commissioner [~~department~~] shall adopt

rules as necessary to implement this section.

SECTION 10. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0641 to read as follows:

Sec. 32.0641. COST SHARING FOR CERTAIN HIGH-COST MEDICAL SERVICES. If the department determines that it is feasible and cost-effective, and to the extent permitted under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation or under a federal waiver or other authorization, the executive commissioner of the Health and Human Services Commission shall 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:

(1) the hospital from which the recipient seeks service:

(A) performs an appropriate medical screening and determines that the recipient does not have a condition requiring emergency medical services;

(B) informs the recipient:

(i) that the recipient does not have a condition requiring emergency medical services;

(ii) that, if the hospital provides the nonemergency service, the hospital may require payment of a copayment, premium payment, or other cost-sharing payment by the recipient in advance; and

(iii) of the name and address of a

nonemergency Medicaid provider who can provide the appropriate medical service without imposing a cost-sharing payment; and

(C) offers to provide the recipient with a referral to the nonemergency provider to facilitate scheduling of the service; and

(2) after receiving the information and assistance described by Subdivision (1) from the hospital, the recipient chooses to obtain emergency medical services despite having access to medically acceptable, lower-cost medical services.

SECTION 11. (a) The heading to Subtitle C, Title 2, Health and Safety Code, is amended to read as follows:

SUBTITLE C. PROGRAMS PROVIDING [~~INDIGENT~~] HEALTH CARE BENEFITS AND SERVICES

(b) Subtitle C, Title 2, Health and Safety Code, is amended by adding Chapter 76 to read as follows:

CHAPTER 76. MULTIPLE SHARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 76.001. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission.

(2) "Employee" means an individual who is employed by an employer for compensation. The term includes a partner of a partnership.

(3) "Employer" means a person who employs two or more employees.

(4) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(5) "Multiple share program" means an employer-sponsored commercial insurance product or noninsurance health benefit plan funded by a combination of:

(A) employer contributions;

(B) employee cost sharing; and

(C) public or philanthropic funds.

(6) "Partnering entity" means a local entity that partners with the commission to obtain funding for a multiple share program.

(7) "Public share" means the portion of the cost of a multiple share program comprised of public funds.

[Sections 76.002-76.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY OF COMMISSION; METHODS OF FUNDING

Sec. 76.051. MULTIPLE SHARE PROGRAM. A local entity may propose a multiple share program to the commission and may, subject to rules adopted under Section 76.103, act as a partnering entity.

Sec. 76.052. FUNDING. The commission may 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. The commission may cooperate with a partnering entity to finance the public share.

Sec. 76.053. AUTHORITY TO DETERMINE SCOPE. The commission may determine if a multiple share program proposed by a partnering entity should be local, regional, or statewide in scope. The commission shall base this determination on:

(1) appropriate methods to meet the needs of the

uninsured community; and

(2) federal guidance.

Sec. 76.054. METHOD OF FINANCE. If the legislature does not appropriate sufficient money from the general revenue to fund a multiple share program, a partnering entity may use the following types of funding to maximize this state's receipt of available federal matching funds provided through Medicaid and the child health plan:

(1) local funds made available to this state through intergovernmental transfers from local governments; and

(2) certified public expenditures.

[Sections 76.055-76.100 reserved for expansion]

SUBCHAPTER C. COST OF PROGRAM; CONTRIBUTION OF SHARES

Sec. 76.101. CONTRIBUTION OF SHARES. A multiple share program may require that:

(1) each participating employer contribute at least one-third of the cost of coverage; and

(2) this state, a political subdivision of this state, or a nonprofit organization contribute not more than one-third of the cost of coverage.

Sec. 76.102. COST SHARING. Subject to applicable federal law, an employee who participates in a multiple share program may be required to pay:

(1) a share of the premium;

(2) copayments;

(3) coinsurance; and

(4) deductibles.

Sec. 76.103. STANDARDS AND PROCEDURES. The executive commissioner by rule shall:

(1) define the types of local entities that may be partnering entities;

(2) determine eligibility criteria for participating employers and employees;

(3) determine a minimum benefit package for multiple share programs that offer noninsurance health benefit plans;

(4) determine methods for limiting substitution of coverage in multiple share programs of partnering entities;

(5) determine methods for limiting adverse selection in multiple share programs of partnering entities; and

(6) determine how a multiple share program participant may continue program coverage if the participant leaves the employment of a participating employer or becomes ineligible due to income.

(c) Not later than January 1, 2008, the executive commissioner of the Health and Human Services Commission shall adopt rules and procedures necessary to implement the multiple share program created by Chapter 76, Health and Safety Code, as added by this section. In adopting the rules and procedures, the executive commissioner may consult with the Texas Department of Insurance.

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

have immediate effect, this section takes effect September 1, 2007.

SECTION 12. (a) In this section, "committee" means the committee on health and long-term care insurance incentives.

(b) The committee on health and long-term care insurance incentives is established to study and develop recommendations regarding methods by which this state may 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.

(c) The committee on health and long-term care insurance incentives is composed of:

(1) the presiding officers of:

(A) the Senate Committee on Health and Human Services;

(B) the House Committee on Public Health;

(C) the Senate Committee on State Affairs; and

(D) the House Committee on Insurance;

(2) three public members, appointed by the governor, who collectively represent the diversity of businesses in this state, including diversity with respect to:

(A) the geographic regions in which those businesses are located;

(B) the types of industries in which those businesses are engaged; and

(C) the sizes of those businesses, as determined by number of employees; and

(3) the following ex officio members:

(A) the comptroller of public accounts;

(B) the commissioner of insurance; and

(C) the executive commissioner of the Health and Human Services Commission.

(d) The committee shall elect a presiding officer from the committee members and shall meet at the call of the presiding officer.

(e) The committee shall study and develop recommendations regarding incentives this state may provide to employers to encourage those employers to provide health insurance, long-term care insurance, or both, to employees who would otherwise rely on the Medicaid program to meet their health and long-term care needs. In conducting the study, the committee shall:

(1) examine the feasibility and determine the cost of providing incentives through:

(A) the franchise tax under Chapter 171, Tax Code, including allowing exclusions from an employer's total revenue of insurance premiums paid for employees, regardless of whether the employer chooses under Subparagraph (ii), Paragraph (B), Subdivision (1), Subsection (a), Section 171.101, Tax Code, as effective January 1, 2008, to subtract cost of goods sold or compensation for purposes of determining the employer's taxable margin;

(B) deductions from or refunds of other taxes imposed on the employer; and

(C) any other means, as determined by the committee; and

(2) for each incentive the committee examines under Subdivision (1) of this subsection, determine the impact that implementing the incentive would have on reducing the number of individuals in this state who do not have private health or long-term care insurance coverage, including individuals who are Medicaid recipients.

(f) Not later than September 1, 2008, the committee shall submit to the Senate Committee on Health and Human Services, the House Committee on Public Health, the Senate Committee on State Affairs, and the House Committee on Insurance a report regarding the results of the study required by this section. The report must include a detailed description of each incentive the committee examined and determined is feasible and, for each of those incentives, specify:

(1) the anticipated cost associated with providing that incentive;

(2) any statutory changes needed to implement the incentive; and

(3) the impact that implementing the incentive would have on reducing:

(A) the number of individuals in this state who do not have private health or long-term care insurance coverage; and

(B) the number of individuals in this state who are Medicaid recipients.

SECTION 13. (a) The Health and Human Services Commission shall conduct a study regarding the feasibility and

cost-effectiveness of developing and implementing an integrated Medicaid managed care model designed to improve the management of care provided to Medicaid recipients who are aging, blind, or disabled or have chronic health care needs and are not enrolled in a managed care plan offered under a capitated Medicaid managed care model, including recipients who reside in:

(1) rural areas of this state; or

(2) urban or surrounding areas in which the Medicaid Star + Plus program or another capitated Medicaid managed care model is not available.

(b) Not later than September 1, 2008, the Health and Human Services Commission shall submit a report regarding the results of the study to the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program.

SECTION 14. (a) In this section:

(1) "Child health plan program" means the state child health plan program authorized by Chapter 62, Health and Safety Code.

(2) "Medicaid" means the medical assistance program provided under Chapter 32, Human Resources Code.

(b) The Health and Human Services Commission shall conduct a study of the feasibility of providing a health passport for:

(1) children under 19 years of age who are receiving Medicaid and are not provided a health passport under another law of this state; and

(2) children enrolled in the child health plan

program.

(c) The feasibility study must:

(1) examine the cost-effectiveness of the use of a health passport in conjunction with the coordination of health care services under each program;

(2) identify any barriers to the implementation of the health passport developed for each program and recommend strategies for the removal of those barriers;

(3) examine whether the use of a health passport will improve the quality of care for children described in Subsection (b) of this section; and

(4) determine the fiscal impact to this state of the proposed initiative.

(d) Not later than January 1, 2009, the Health and Human Services Commission shall submit to the governor, lieutenant governor, speaker of the house of representatives, and presiding officers of each standing committee of the legislature with jurisdiction over the commission a written report containing the findings of the study and the commission's recommendations.

(e) This section expires September 1, 2009.

SECTION 15. (a) The Health and Human Services Transition Legislative Oversight Committee is created 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) The committee is composed of six members, as follows:

(1) three members of the senate, appointed by the

lieutenant governor not later than October 1, 2007; and

(2) three members of the house of representatives, appointed by the speaker of the house of representatives not later than October 1, 2007.

(c) The executive commissioner of the Health and Human Services Commission serves as an ex officio member of the committee.

(d) A member of the committee serves at the pleasure of the appointing official.

(e) The lieutenant governor and the speaker of the house of representatives shall alternate designating a presiding officer from among their respective appointments. The lieutenant governor shall make the first appointment after the effective date of this Act.

(f) A member of the committee may not receive compensation for serving on the committee but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the committee as provided by the General Appropriations Act.

(g) The committee shall:

(1) facilitate the design and development of any Medicaid waivers needed to affect reform as directed by this Act;

(2) facilitate the establishment of common definitions for uncompensated hospital care and any application of those definitions in the determination of policy that affects reimbursement for that care;

(3) facilitate a smooth transition from existing

Medicaid payment systems and benefit designs to the new model of Medicaid enabled by waiver or policy change by the Health and Human Services Commission;

(4) meet at the call of the presiding officer; and

(5) research, take public testimony, and issue reports on other appropriate issues or specific issues requested by the lieutenant governor or speaker of the house of representatives.

(h) The committee may request reports and other information from the Health and Human Services Commission.

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

(j) Chapter 551, Government Code, applies to the committee.

(k) The committee shall report to the lieutenant governor and speaker of the house of representatives not later than November 15 of each even-numbered year. The report must include:

(1) identification of significant issues which impede the transition to a more effective Medicaid program;

(2) the measures of effectiveness associated with changes to the Medicaid program;

(3) the impact of Medicaid changes on safety net hospitals and other significant traditional providers; and

(4) the impact on the uninsured in Texas.

SECTION 16. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or

authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 17. Except as otherwise provided by this Act, this Act takes effect September 1, 2007.