BILL ANALYSIS

C.S.S.B. 23
By: Nelson
Appropriations
Committee Report (Substituted)

BACKGROUND AND PURPOSE

C.S.S.B. 23 seeks to make statutory changes to implement various cost-saving and efficiency measures in certain health and human services and health benefits programs. The cost savings and efficiencies are achieved by measures such as carving prescription drugs into Medicaid managed care; transferring children in the State Kids Insurance Program to the Children's Health Insurance Program, allowing the state to leverage federal matching funds while maintaining current services; eliminating the existing electronic fingerprint-imaging requirement for the Supplemental Nutrition Assistance Program and the Temporary Assistance for Needy Families program and requiring the Health and Human Services Commission to implement cost-effective technology to prevent duplicative benefits; removing the Texas health opportunity pool trust fund as a beneficiary of proceeds from the adult entertainment fee; repealing the current prohibition against managed care in South Texas; preventing overutilization of waiver services; and creating an objective client assessment process for acute nursing services, if shown to be cost-effective.

C.S.S.B. 23 seeks to amend current law relating to efficiency, cost-saving, fraud prevention, and funding measures for certain health and human services and health benefits programs, including the Medicaid and child health plan programs.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 3, 6, 9, 10, and 12 of this bill.

ANALYSIS

Section 531.0055, Government Code, as amended by Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, expressly grants to the executive commissioner of the Health and Human Services Commission all rulemaking authority for the operation of and provision of services by the health and human services agencies. Similarly, Sections 1.16-1.29, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, provide for the transfer of a power, duty, function, program, or activity from a health and human services agency abolished by that act to the corresponding legacy agency. To the extent practical, this bill analysis is written to reflect any transfer of rulemaking authority and to update references as necessary to an agency's authority with respect to a particular health and human services program.

Section 1. Sexual Assault Program Fund; Fee Imposed on Certain Sexually Oriented Businesses

C.S.S.B. 23 amends the Business & Commerce Code to require the comptroller of public accounts to deposit the entire amount received from the fee imposed on certain sexually oriented businesses to the credit of the sexual assault program fund, rather than the first $25 million received from the fee per state fiscal biennium, and to make a related conforming change.

C.S.S.B. 23 amends the Government Code to expand the list of entities to which and purposes for which the legislature is authorized to appropriate money deposited to the credit of the sexual assault program fund to include appropriations to the attorney general for grants to health science centers and related nonprofit charitable organizations exempted under the federal Internal Revenue Code of 1986 for research relating to the prevention and mitigation of sexual assault and appropriations to the Department of Family and Protective Services (DFPS) for programs related to sexual assault prevention and intervention and research relating to how DFPS can effectively address the prevention of sexual assault. The bill requires a board, commission, department, office, or other agency in the executive or judicial branch of state government to which money is appropriated from the sexual assault program fund to provide to the Legislative Budget Board, not later than December 1 of each even-numbered year, a report stating, for the preceding fiscal biennium, the amount appropriated to the entity from the fund, the purposes for which the money was used, and any results of a program or research funded. The bill requires the comptroller to collect the fee imposed on certain sexually oriented businesses until a court, in a final judgment upheld on appeal or no longer subject to appeal, finds the provisions of law imposing the fee to be unconstitutional.

C.S.S.B. 23 establishes that its provisions relating to the sexual assault program fund and the fee imposed on certain sexually oriented businesses prevail over any other act of the 82nd Legislature, Regular Session, 2011, regardless of the relative dates of enactment, that purports to amend or repeal Subchapter B, Chapter 102, Business & Commerce Code, or any provision of Chapter 1206 (H.B. 1751), Acts of the 80th Legislature, Regular Session, 2007.

Section 2. Objective Assessment Processes for Certain Medicaid Services

C.S.S.B. 23 amends the Government Code to authorize the Health and Human Services Commission (HHSC) to develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services. The bill sets out the manner in which HHSC is authorized to require that the assessment be conducted and the assessments and documentation that HHSC is authorized to require the process to include. The bill requires HHSC, if developing the objective assessment process, to implement the process within the Medicaid fee-for-service model and the primary care case management Medicaid managed care model and to take necessary actions to implement the process within the STAR and STAR + PLUS Medicaid managed care programs.

C.S.S.B. 23 requires HHSC, if implementing the objective assessment process, to consider whether implementing such a process for assessing the needs of a Medicaid recipient for therapy services that is comparable to the process required for acute nursing services would be feasible and beneficial and authorizes HHSC, on making such a determination, to implement the process within the Medicaid fee-for-service model, the primary care case management Medicaid managed care model, and the STAR and STAR + PLUS Medicaid managed care programs. The bill defines "acute nursing services" and "therapy services."

Section 3. Medicaid Managed Care Program

C.S.S.B. 23 amends the Government Code to require each managed care organization that operates within the South Texas service delivery area to maintain a medical director within the service delivery area whose duties include overseeing and managing the managed care organization medical necessity determination process. The bill authorizes the medical director to be a managed care organization employee or be under contract with the managed care organization; requires the medical director to be available for peer-to-peer discussions about managed care organization medical necessity determinations and other managed care organization clinical policies; and prohibits the medical director from being affiliated with any hospital, clinic, or other health care related institution or business that operates within the service delivery area. The bill removes a prohibition against HHSC providing medical assistance using a

health maintenance organization in Cameron County, Hidalgo County, or Maverick County.

C.S.S.B. 23 requires HHSC to ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same managed care plan. The bill requires the external quality review organization to periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to enrollees in the STAR + PLUS Medicaid managed care program who are eligible to receive health care benefits under both Medicaid and Medicare programs. The bill requires HHSC, to the extent possible, to work to ensure that managed care organizations promote the development of patient-centered medical homes for recipients and provide payment incentives for providers that meet the requirements of a patient-centered medical home and defines "patient-centered medical home." The bill requires HHSC, not later than December 1, 2013, to submit a report to the legislature regarding HHSC's work to ensure that Medicaid managed care organizations promote the development of patient-centered medical homes for Medicaid recipients.

C.S.S.B. 23 requires HHSC, in awarding contracts to managed care organizations, to give extra consideration in each health care service region to an organization that is locally owned, managed, and operated, if one exists, or that is not owned or operated by and does not have a contract, agreement, or other arrangement with a hospital district in the region. The bill expands the components required in a contract between a managed care organization and HHSC for the organization to provide health care services to recipients to include the following:

- a requirement that the organization provide certain information for fraud control and otherwise comply and cooperate with the office of the attorney general, in addition to HHSC's office of inspector general;
- a requirement that a medical director who is authorized to make medical necessity determinations is available in the region where the organization provides health care services;
- a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;
- a requirement that the managed care organization develop and submit to HHSC, before beginning to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to specified types of care;
- a requirement that the managed care organization demonstrate to HHSC, before beginning to provide health care services to recipients, that the organization's provider network is capable of serving recipients in ways specified by the bill;
- a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that meets certain specified criteria;
- a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients that meets certain specified criteria; and
- a requirement that the managed care organization and any entity with which the organization contracts for the performance of services under a managed care plan disclose, at no cost, to HHSC and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan.

C.S.S.B. 23 requires HHSC, to the extent possible, to work to ensure that managed care organizations provide payment incentives to health care providers in the organizations' networks whose performance in promoting recipients' use of preventive services exceeds minimum established standards. The bill includes the provision of a single portal through which providers

in any managed care organization's provider network may submit claims among the ways in which HHSC is required, in improving the administration of contracts with managed care organizations, to decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks.

C.S.S.B. 23 prohibits a recipient enrolled in a Medicaid managed care plan, with certain exceptions and to the extent permitted by federal law, from, at any time, disenrolling from that plan and enrolling in another managed care plan, rather than authorizing HHSC to prohibit a recipient from disenrolling in a Medicaid managed care plan and enrolling in another managed care plan during the 12-month period after the date the recipient initially enrolls in a plan. The bill requires HHSC to allow a recipient who is enrolled in a managed care plan to disenroll from that plan once for any reason after the 91st day after the date of a recipient's initial enrollment in a managed care plan, in addition to at any time for cause in accordance with federal law.

C.S.S.B. 23 specifies that the information a managed care organization contracting with HHSC to implement a Medicaid managed care program is required to submit to HHSC for purposes of fraud control be submitted at no cost and requires such an organization to provide the same information at no cost to the office of the attorney general on request. The bill includes among such required information a description and breakdown of all funds paid by the managed care organization, in addition to all funds paid to the organization, and specifies that a managed care organization includes, for purposes of the description of funds, a pharmacy benefit manager.

C.S.S.B. 23 amends the Human Resources Code to require the executive commissioner of HHSC to adopt rules governing sanctions and penalties that apply to a provider who is enrolled as a network pharmacy provider of a managed care organization contracting with HHSC under the Medicaid managed care program or its subcontractor and who submits an improper claim for reimbursement under the program.

Section 4. Abolishing State Kids Insurance Program

C.S.S.B. 23 abolishes the State Kids Insurance Program operated by the Employees Retirement System of Texas (ERS) on the bill's effective date and requires HHSC to establish a process in cooperation with ERS to facilitate the enrollment of eligible children in the child health plan program for certain low-income children on or before the date those children are scheduled to stop receiving dependent child coverage under the State Kids Insurance Program and to modify any applicable administrative procedures to ensure that affected children maintain continuous health benefits coverage while transitioning from enrollment in the State Kids Insurance Program to enrollment in the child health plan program.

C.S.S.B. 23 amends the Health and Safety Code to specify that a child who is the dependent of an employee of a Texas agency and who meets the eligibility requirements for the child health plan program may be eligible for health benefits coverage under applicable federal law or regulations.

C.S.S.B. 23 repeals provisions of law relating to coverage for certain dependent children of employees and the amount of state contribution for certain dependent children to conform to the abolishment of the State Kids Insurance Program.

Section 5. Prevention of Criminal or Fraudulent Conduct by Certain Facilities, Providers, and Recipients

C.S.S.B. 23 amends the Human Resources Code to require HHSC to use appropriate technology to confirm the identity of applicants for benefits under the Temporary Assistance for Needy Families program and the Supplemental Nutrition Assistance Program (SNAP) and to prevent duplicate participation in either program by a person.

C.S.S.B. 23 amends the Government Code to authorize HHSC, absent an allegation of fraud, waste, or abuse, to conduct an annual review of claims for reimbursement under Medicaid only after HHSC has completed the prior year's annual review of claims.

C.S.S.B. 23 repeals provisions of law relating to the electronic fingerprint-imaging or photo-imaging program for adult and teen parent applicants for and recipients of financial assistance under the Temporary Assistance for Needy Families program or food stamp benefits.

Section 6. Provisions Relating to Convalescent and Nursing Homes

C.S.S.B. 23 amends the Health and Safety Code to extend the period at which a license for a convalescent or nursing home or a related institution is renewable from every two years to every three years following an inspection, if required, payment of the license fee, and Department of Aging and Disability Services (DADS) approval of the report required to be filed by the licensee for license renewal at the same interval as the renewal period. The bill requires the executive commissioner of HHSC, as soon as practicable after the bill's effective date but not later than December 1, 2012, by rule to adopt a system under which an appropriate number of licenses issued by DADS expire on staggered dates occurring in each three-year period. The bill requires DADS, if the expiration date of a license changes as a result of the system, to prorate the licensing fee relating to that license as appropriate. The bill postpones from September 1, 2012, to September 1, 2014, the date on which an institution required to comply with certain automated external defibrillator requirements and extends the expiration date of the provision relating to the requirements from January 1, 2013, to January 1, 2015.

Section 7. Streamlining of and Utilization Management in Medicaid Long-Term Care Waiver Programs

C.S.S.B. 23 redesignates Section 161.077, Human Resources Code, as added by Chapter 759 (S.B. 705), Acts of the 81st Legislature, Regular Session, 2009, as Section 161.081, Human Resources Code, and amends that provision to include among the initiatives the implementation of which DADS is authorized to consider in streamlining the administration of and delivery of services through Section 1915(c) waiver programs, if feasible, concurrently conducting program certification and billing audit and review processes and other related audit and review processes, streamlining other billing and auditing requirements, eliminating duplicative responsibilities with respect to the coordination and oversight of individual care plans for persons receiving waiver services, and streamlining cost reports and other cost reporting processes. The bill specifies that the requirement for DADS to ensure certain actions do not conflict with any HHSC requirements relating to long-term care Medicaid programs applies to actions taken with regard to the consideration of certain streamlining initiatives. The bill requires DADS and HHSC to jointly explore the development of uniform licensing and contracting standards that would apply to all contracts for the delivery of Section 1915(c) waiver program services, promote competition among providers of those program services, and integrate with other DADS and HHSC efforts to streamline and unify the administration and delivery of the program services.

C.S.S.B. 23 amends the Human Resources Code to require DADS to perform a utilization review of services in all Section 1915(c) waiver programs and requires the utilization review to include reviewing program recipients' levels of care and any plans of care for those recipients that exceed service level thresholds established in the applicable waiver program guidelines. The bill provides for the meaning of "Section 1915(c) waiver program" by reference to the Government Code.

Section 8. Provisions Relating to Assisted Living Facilities

C.S.S.B. 23 amends the Health and Safety Code to exempt from the Assisted Living Facility Licensing Act a facility that provides personal care services only to persons enrolled in a program that is funded in whole or in part by the Department of State Health Services (DSHS)

and that is monitored by DSHS, or by its designated local mental health authority in accordance with standards set by DSHS. The bill extends the period during which DADS is authorized to inspect an assisted living facility, in addition to the inspection required for the issuance or renewal of a license and at other reasonable times as necessary to assure compliance with the Assisted Living Facility Licensing Act, from annually to once during an 18-month period.

Section 9. Telemonitoring

C.S.S.B. 23 amends the Government Code to require HHSC to determine whether the Medicaid Enhanced Care program's diabetes self-management training telemonitoring pilot program was cost neutral and, in doing so, to at a minimum compare certain specified factors. The bill requires the executive commissioner, not later than January 1, 2012, on HHSC determination that the pilot program was cost neutral, to adopt rules for providing telemonitoring services through the Medicaid Texas Health Management Program for select diabetes patients in a manner comparable to that program. The bill requires HHSC, on a determination that the pilot program was not cost neutral, to develop and implement within the Medicaid Texas Health Management Program for select diabetes patients a new diabetes telemonitoring pilot program based on evidence-based best practices, provided that HHSC determines implementing the new pilot program would be cost neutral. The bill requires HHSC, in making such a determination, to consider certain appropriate factors.

C.S.S.B. 23 requires HHSC to develop and implement a pilot program within the Medicaid Texas Health Management Program to evaluate the cost neutrality of providing telemonitoring services to persons who are diagnosed with health conditions other than diabetes, if HHSC determines implementing the pilot program would be cost neutral. The bill requires HHSC, in making such a determination, to consider certain appropriate factors. The bill requires HHSC to annually identify telemonitoring strategies implemented within Medicaid that have demonstrated cost neutrality or resulted in improved performance on key health measures and disseminate information about the identified strategies to encourage the adoption of effective telemonitoring strategies. The bill requires HHSC, not later than September 1, 2012, to determine whether implementing a new diabetes telemonitoring pilot program and a telemonitoring pilot program for health conditions other than diabetes would be cost neutral and to report such determination to the governor and the Legislative Budget Board. The bill defines "telemonitoring."

Section 10. Physician Incentive Programs

C.S.S.B. 23 amends the Government Code to require HHSC to conduct a study to evaluate physician incentive programs that attempt to reduce hospital emergency room use for non-emergent conditions by Medicaid recipients. The bill requires each physician incentive program evaluated in the study to be administered by a health maintenance organization participating in the STAR or STAR + PLUS Medicaid managed care program and to provide incentives to primary care providers who attempt to reduce emergency room use for non-emergent conditions by recipients. The bill requires the study to evaluate the cost-effectiveness of each component included in a physician incentive program and any change in statute required to implement each component within the Medicaid fee-for-service or primary care case management model. The bill requires the executive commissioner, not later than August 31, 2012, to submit to the governor and the Legislative Budget Board a report summarizing the findings of the study and sets these provisions to expire September 1, 2013.

C.S.S.B. 23 requires the executive commissioner by rule to establish a physician incentive program designed to reduce the use of hospital emergency room services for non-emergent conditions by Medicaid recipients and authorizes the executive commissioner, in establishing the program, to include only the program components identified as cost-effective in the HHSC's study evaluating physician incentive programs. The bill requires the executive commissioner, if the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, to implement controls to ensure that the after-hours services

billed are actually being provided outside of normal business hours.

Section 11. Billing Coordination and Information Collection

C.S.S.B. 23 amends the Government Code to authorize HHSC, if cost-effective, to contract to expand all or part of the acute care Medicaid billing coordination system to process claims for services provided through other benefits programs administered by HHSC or a health and human services agency; to expand any other billing coordination tools and resources used to process claims for health care services provided through Medicaid to process claims for services provided through other benefits programs administered by HHSC or a health and human services agency; and to expand the scope of persons about whom information is collected by health insurers to include recipients of services provided through other benefits programs administered by HHSC or a health and human services agency. The bill requires each health and human services agency to provide HHSC with any information necessary to allow HHSC or HHSC's designee to perform the billing coordination and information collection activities so authorized.

Section 12. Texas Health Opportunity Pool Trust Fund

C.S.S.B. 23 amends the Government Code to authorize the executive commissioner to include in the federal waiver to the state Medicaid plan, in order to defray costs associated with providing uncompensated health care, federal money appropriated under the disproportionate share hospitals or upper payment limit supplemental payment program or both, rather than authorizing the executive commissioner to include money provided under both programs. The bill removes language specifying that all such money is authorized to be included in the federal waiver. The bill expands the federal money authorized to be included in the waiver to include certain gifts, grants, or donations; local funds received by Texas through intergovernmental transfers; and, if approved in the waiver, federal money obtained through the use of certified public expenditures.

C.S.S.B. 23 requires the comptroller of public accounts to deposit in the Texas health opportunity pool trust fund federal money provided to Texas under the disproportionate share hospitals or the hospital upper payment limit supplemental payment program, rather than requiring the comptroller to deposit money provided under both programs, other than money provided under those programs to state-owned and operated hospitals. The bill authorizes HHSC and the comptroller to receive intergovernmental transfers for purposes consistent with state law governing the fund and with the terms of the federal waiver to the state Medicaid plan. The bill prohibits money from the fund from being used to finance the construction, improvement, or renovation of a building or land unless the construction, improvement, or renovation is approved by HHSC, according to rules adopted by the executive commissioner for that purpose.

C.S.S.B. 23 repeals a provision requiring the executive commissioner to seek the advice of the Legislative Budget Board before finalizing the terms and conditions of the waiver.

Section 13. Report on Medicaid Long-Term Care Services

C.S.S.B. 23 requires HHSC, in cooperation with DADS, to prepare a written report regarding individuals who receive long-term care services in nursing facilities under Medicaid. The bill requires the report to be based on existing data and information and use that data and information to identify the reasons Medicaid recipients of long-term care services are placed in nursing facilities as opposed to being provided long-term care services in home or community-based settings; the types of Medicaid services recipients residing in nursing facilities typically receive and where and from whom those services are typically provided; the community-based services and supports available under a Medicaid program or under a Medicaid waiver granted in accordance with federal law for which recipients residing in nursing facilities may be eligible; and ways to expedite recipients' access to community-based services and supports for which interest lists or other waiting lists exist.

C.S.S.B. 23 requires HHSC, not later than September 1, 2012, to submit the report, together with HHSC recommendations, to the governor, the Legislative Budget Board, the Senate Committee on Finance, the Senate Committee on Health and Human Services, the House Appropriations Committee, and the House Human Services Committee. The bill requires the recommendations to address options for expediting access to community-based services and supports by recipients. The bill defines "long-term care services" and "medical assistance program" by reference to the Human Resources Code and "nursing facility" by reference to the Health and Safety Code.

Section 14. Federal Authorization

C.S.S.B. 23 requires a state agency that is affected by any provision of the bill to request a federal waiver or authorization if the agency determines that a waiver or authorization is necessary for the implementation of that provision and authorizes the agency to delay implementation until the federal waiver or authorization is obtained. The bill makes conforming and nonsubstantive changes.

Repealed Provisions

C.S.S.B. 23 repeals the following provisions:

- Section 102.055, Business & Commerce Code
- Sections 1551.159 and 1551.312, Insurance Code
- Section 31.0325, Human Resources Code
- Section 531.502(g), Government Code

EFFECTIVE DATE

September 1, 2011.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.S.B. 23 contains a provision not included in the original expanding the list of entities to which and purposes for which the legislature is authorized to appropriate money deposited to the credit of the sexual assault program fund. The substitute contains a provision not included in the original requiring an entity to which money is appropriated from the sexual assault program fund to provide a report to the Legislative Budget Board.

C.S.S.B. 23 omits provisions included in the original relating to the provision and coordination of certain attendant care services under a Medicaid program, risk management criteria for certain waiver programs, a Medicaid service options public education initiative, and interest list reporting.

C.S.S.B. 23 differs from the original by authorizing the Health and Human Services Commission (HHSC) to develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services, whereas the original requires HHSC to develop the objective assessment process. The substitute differs from the original by setting out the manner in which HHSC is authorized to require that the assessment be conducted and the assessments and documentation that HHSC is authorized to require the process to include, whereas the original sets out substantially the same provisions as requirements of HHSC. The substitute contains a specification not included in the original making the requirement that such assessment be conducted by a state employee or contractor who is not the person who will deliver any necessary services to the recipient and is not affiliated with the person who will deliver those services contingent on the assessment being cost-effective and in the best interests of the recipient.

C.S.S.B. 23 omits provisions included in the original requiring the executive commissioner of HHSC to adopt rules providing for a process by which a provider of acute nursing services or a provider of therapy services who disagrees with the results of an objective assessment conducted by HHSC may request and obtain a review of those results and requiring that process to be included as part of the objective assessment process.

C.S.S.B. 23 omits provisions included in the original relating to an electronic visit verification system to electronically verify and document basic information relating to the delivery of Medicaid acute nursing services.

C.S.S.B. 23 differs from the original, with regard to the component required to be contained in the contract between a managed care organization and HHSC for the provision of health care services requiring the organization to develop, implement, and maintain an outpatient pharmacy benefit plan, by specifying that the plan reimburses only enrolled pharmacy providers for pharmacy products on the vendor drug program formulary, whereas the original specifies that the plan exclusively employs the vendor drug program formulary or a more cost-effective alternative approved by the commissioner; by specifying that the plan adheres to the applicable preferred drug list adopted by HHSC, whereas the original specifies that the plan complies with the preferred drug list prior authorization policies and procedures adopted by HHSC or a more cost-effective alternative approved by the commissioner; and by specifying that, for purposes of the plan, the managed care organization is prohibited from negotiating or collecting rebates associated with pharmacy products on the vendor drug program formulary or receiving confidential drug rebate or pricing information, whereas the original specifies that the plan includes rebates negotiated by the organization with a manufacturer or labeler, except that an organization is prohibited from negotiating or obtaining a rebate with respect to a product for which HHSC has negotiated or obtained a supplemental rebate. The substitute contains provisions not included in the original with regard to the outpatient pharmacy benefit plan prohibiting the managed care organization, under the plan, from prohibiting, limiting, or interfering with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments or other conditions; requiring the plan to establish uniform administrative, financial, and professional terms for all participating pharmacies and pharmacists; and prohibiting an organization, under the plan, from preventing a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with all such terms.

C.S.S.B. 23 differs from the original with regard to the components required to be contained in a contract between a managed care organization and HHSC for the organization to provide health care services to recipients by omitting requirements included in the original that the organization ensure that organization employees who hold management positions are located in the region where the organization provides health care services and that the organization develop and establish a process for responding to provider appeals in the region and by containing requirements not included in the original requiring the organization to provide certain information for fraud control and otherwise comply and cooperate with the office of the attorney general, in addition to HHSC's office of inspector general, and that the managed care organization and any entity with which the organization contracts for the performance of services under a managed care plan disclose, at no cost, to HHSC and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan.

C.S.S.B. 23 omits provisions included in the original relating to Medicaid managed care prescription drug coverage and the establishment of certain drug protocols. The substitute differs from the original by specifying that the requirement that the executive commissioner of HHSC adopt rules governing sanctions and penalties that apply to a provider who is enrolled as a network pharmacy provider of a managed care organization or its subcontractor applies to such an organization contracting with HHSC under the Medicaid managed care program, whereas the original does not include that specification.

C.S.S.B. 23 contains provisions not included in the original prohibiting a recipient enrolled in a Medicaid managed care plan from, at any time, disenrolling from that plan and enrolling in another managed care plan and requiring HHSC to allow a recipient who is enrolled in a managed care plan to disenroll from that plan once for any reason after the 91st day after the date of a recipient's initial enrollment in a managed care plan.

C.S.S.B. 23 contains provisions not included in the original specifying that the information a Medicaid managed care organization contracting with HHSC is required to submit to HHSC for purposes of fraud control is to be submitted at no cost and requiring such an organization to provide the same information at no cost to the office of the attorney general on request. The substitute contains provisions not included in the original including among such required information a description and breakdown of all funds paid by the managed care organization and specifying that a managed care organization includes, for purposes of the description of funds, a pharmacy benefit manager. The substitute contains a related saving provision not included in the original.

C.S.S.B. 23 omits a provision included in the original prohibiting the board of trustees of the Employees Retirement System of Texas (ERS) from providing dependent child coverage under the State Kids Insurance Program after the first annual open enrollment period that begins under the employee group benefits program after the bill's effective date. The substitute requires HHSC to establish a process in cooperation with ERS to facilitate the enrollment of eligible children in the child health plan program for certain low-income children on or before the date those children are scheduled to stop receiving dependent child coverage under the State Kids Insurance Program, whereas the original requires HHSC to establish a process to ensure the automatic enrollment of eligible children in the child health plan program for certain low-income children on or before that date.

C.S.S.B. 23 differs from the original by requiring HHSC to use appropriate technology to confirm the identity of applicants for benefits under the Temporary Assistance for Needy Families program and SNAP and to prevent duplicate participation in either program by a person, whereas the original requires HHSC, in conjunction with other appropriate agencies, to develop and implement a program to prevent welfare fraud by using cost-effective technology to confirm the identity of adult and teen parent applicants for and recipients of assistance under the Temporary Assistance for Needy Families program or SNAP and to prevent the provision of duplicate benefits to a person under either program, as applicable.

C.S.S.B. 23 omits a provision included in the original requiring HHSC to make reasonable efforts to ensure the prevention of criminal or fraudulent conduct by health care facilities and providers and recipients of benefits under programs administered by HHSC.

C.S.S.B. 23 contains a provision not included in the original authorizing HHSC, absent an allegation of fraud, waste, or abuse, to conduct an annual review of claims for reimbursement under Medicaid only after HHSC has completed the prior year's annual review of claims.

C.S.S.B. 23 contains provisions not included in the original relating to convalescent and nursing homes. The substitute omits provisions included in the original requiring the implementation, if cost-effective, of an electronic visit verification system that allows providers to electronically verify and document basic information relating to the delivery of services under Medicaid.

C.S.S.B. 23 omits provisions included in the original relating to the regulation and oversight of certain community-based services agencies, convalescent and nursing homes and related institutions, and adult day-care facilities.

C.S.S.B. 23 contains provisions not included in the original extending the period during which DADS is authorized to inspect an assisted living facility and making a related conforming

change.

C.S.S.B. 23 omits a provision included in the original making a technical correction to a reference relating to a health care delivery system developed under former law. The substitute omits provisions included in the original relating to the executive commissioner's determination of the most effective alignment of managed care service delivery areas for each model of managed care in certain counties.

C.S.S.B. 23 differs from the original by requiring HHSC to ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same managed care plan, whereas the original requires HHSC to ensure that all children who reside in the same household may, at the family's election, be enrolled in the same health plan. The substitute omits a provision contained in the original setting out the conditions under which a managed care organization is considered to be locally owned.

C.S.S.B. 23 contains provisions not included in the original relating to telemonitoring, physician incentive programs, billing coordination and information collection, and the Texas health opportunity pool trust fund.

C.S.S.B. 23 differs from the original by repealing Section 31.0325, Human Resources Code, whereas the original removes language contained within that statutory provision relating to the adoption of rules for an exemption of electronic imaging requirements for certain persons.

C.S.S.B. 23 contains provisions not included in the original repealing Section 531.502(g), Government Code.

C.S.S.B. 23 differs from the original in nonsubstantive ways and by making conforming and clarifying changes and technical corrections not included in the original.