By: Nelson, et al. (Zerwas) S.B. No. 23

Substitute the following for S.B. No. 23:

By: Zerwas C.S.S.B. No. 23

A BILL TO BE ENTITLED

AN ACT

relating to the administration of and efficiency, cost-saving, fraud prevention, and funding measures for certain health and human services and health benefits programs, including the medical assistance and child health plan programs.

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

SECTION 1. SEXUAL ASSAULT PROGRAM FUND; FEE IMPOSED ON CERTAIN SEXUALLY ORIENTED BUSINESSES. (a) Section 102.054, Business & Commerce Code, is amended to read as follows:

Sec. 102.054. ALLOCATION OF [~~CERTAIN~~] REVENUE FOR SEXUAL ASSAULT PROGRAMS. The comptroller shall deposit the amount [~~first $25 million~~] received from the fee imposed under this subchapter [~~in a state fiscal biennium~~] to the credit of the sexual assault program fund.

(b) Section 420.008, Government Code, is amended by amending Subsection (c) and adding Subsection (d) to read as follows:

(c) The legislature may appropriate money deposited to the credit of the fund only to:

(1) the attorney general, for:

(A) sexual violence awareness and prevention campaigns;

(B) grants to faith-based groups, independent school districts, and community action organizations for programs

for the prevention of sexual assault and programs for victims of human trafficking;

(C) grants for equipment for sexual assault nurse examiner programs, to support the preceptorship of future sexual assault nurse examiners, and for the continuing education of sexual assault nurse examiners;

(D) grants to increase the level of sexual assault services in this state;

(E) grants to support victim assistance coordinators;

(F) grants to support technology in rape crisis centers;

(G) grants to and contracts with a statewide nonprofit organization exempt from federal income taxation under Section 501(c)(3), Internal Revenue Code of 1986, having as a primary purpose ending sexual violence in this state, for programs for the prevention of sexual violence, outreach programs, and technical assistance to and support of youth and rape crisis centers working to prevent sexual violence; [~~and~~]

(H) grants to regional nonprofit providers of civil legal services to provide legal assistance for sexual assault victims; and

(I) grants to health science centers and related nonprofit entities exempt from federal income taxation under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt organization under Section 501(c)(3) of that code, for research relating to the prevention and mitigation of sexual

assault;

(2) the Department of State Health Services, to measure the prevalence of sexual assault in this state and for grants to support programs assisting victims of human trafficking;

(3) the Institute on Domestic Violence and Sexual Assault at The University of Texas at Austin, to conduct research on all aspects of sexual assault and domestic violence;

(4) Texas State University, for training and technical assistance to independent school districts for campus safety;

(5) the office of the governor, for grants to support sexual assault and human trafficking prosecution projects;

(6) the Department of Public Safety, to support sexual assault training for commissioned officers;

(7) the comptroller's judiciary section, for increasing the capacity of the sex offender civil commitment program;

(8) the Texas Department of Criminal Justice:

(A) for pilot projects for monitoring sex offenders on parole; and

(B) for increasing the number of adult incarcerated sex offenders receiving treatment;

(9) the Texas Youth Commission, for increasing the number of incarcerated juvenile sex offenders receiving treatment;

(10) the comptroller, for the administration of the fee imposed on sexually oriented businesses under Section 102.052, Business & Commerce Code; [~~and~~]

(11) the supreme court, to be transferred to the Texas

Equal Access to Justice Foundation, or a similar entity, to provide victim-related legal services to sexual assault victims, including legal assistance with protective orders, relocation-related matters, victim compensation, and actions to secure privacy protections available to victims under law; and

(12) the Department of Family and Protective Services for:

(A) programs related to sexual assault prevention and intervention; and

(B) research relating to how the department can effectively address the prevention of sexual assault.

(d) 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 under this section shall, not later than December 1 of each even-numbered year, provide to the Legislative Budget Board a report stating, for the preceding fiscal biennium:

(1) the amount appropriated to the entity under this section;

(2) the purposes for which the money was used; and

(3) any results of a program or research funded under this section.

(c) The comptroller of public accounts shall collect the fee imposed under Section 102.052, Business & Commerce Code, until a court, in a final judgment upheld on appeal or no longer subject to appeal, finds Section 102.052, Business & Commerce Code, or its predecessor statute, to be unconstitutional.

(d) Section 102.055, Business & Commerce Code, is repealed.

(e) This section prevails 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. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02417 and 531.024171 to read as follows:

Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS. (a) In this section, "acute nursing services" means home health skilled nursing services, home health aide services, and private duty nursing services.

(b) The commission may develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services. The commission may require that:

(1) the assessment be conducted:

(A) if cost-effective and in the best interests of the recipient, 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; and

(B) in a timely manner so as to protect the health and safety of the recipient by avoiding unnecessary delays in service delivery; and

(2) the process include:

(A) an assessment of specified criteria and documentation of the assessment results on a standard form;

(B) an assessment of whether the recipient should be referred for additional assessments regarding the recipient's needs for therapy services, as defined by Section 531.024171, attendant care services, and durable medical equipment; and

(C) completion by the person conducting the assessment of any documents related to obtaining prior authorization for necessary nursing services.

(c) If the commission develops the objective assessment process under Subsection (b), the commission shall:

(1) implement the process within the Medicaid fee-for-service model and the primary care case management Medicaid managed care model; and

(2) take necessary actions, including modifying contracts with managed care organizations under Chapter 533 to the extent allowed by law, to implement the process within the STAR and STAR + PLUS Medicaid managed care programs.

Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) In this section, "therapy services" includes occupational, physical, and speech therapy services.

(b) If the commission implements the objective assessment process for acute nursing services as authorized by Section 531.02417, the commission shall consider whether implementing an objective assessment process for assessing the needs of a Medicaid recipient for therapy services that is comparable to the process

required under Section 531.02417 for acute nursing services would be feasible and beneficial.

(c) If the commission determines that implementing a comparable process with respect to one or more types of therapy services is feasible and would be beneficial, the commission may implement the process within:

(1) the Medicaid fee-for-service model;

(2) the primary care case management Medicaid managed care model; and

(3) the STAR and STAR + PLUS Medicaid managed care programs.

SECTION 3. MEDICAID MANAGED CARE PROGRAM. (a) Section 533.0025(e), Government Code, is amended to read as follows:

(e) Each managed care organization that operates within the South Texas service delivery area must maintain a medical director within the service delivery area whose duties include overseeing and managing the managed care organization medical necessity determination process. The medical director:

(1) may be a managed care organization employee or be under contract with the managed care organization;

(2) must be available for peer-to-peer discussions about managed care organization medical necessity determinations and other managed care organization clinical policies; and

(3) may not be affiliated with any hospital, clinic, or other health care related institution or business that operates within the service delivery area [~~Notwithstanding Subsection (b)(1), the commission may not provide medical assistance using a~~

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

(b) Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.0027, 533.0028, and 533.0029 to read as follows:

Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN RECIPIENTS ARE ENROLLED IN SAME MANAGED CARE PLAN. The commission shall 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.

Sec. 533.0028. EVALUATION OF CERTAIN STAR + PLUS MEDICAID MANAGED CARE PROGRAM SERVICES. The external quality review organization shall 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 the Medicaid and Medicare programs.

Sec. 533.0029. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOMES FOR RECIPIENTS. (a) For purposes of this section, a "patient-centered medical home" means a medical relationship:

(1) between a primary care physician and a child or adult patient in which the physician:

(A) provides comprehensive primary care to the patient; and

(B) facilitates partnerships between the physician, the patient, acute care and other care providers, and,

when appropriate, the patient's family; and

(2) that encompasses the following primary principles:

(A) the patient has an ongoing relationship with the physician, who is trained to be the first contact for the patient and to provide continuous and comprehensive care to the patient;

(B) the physician leads a team of individuals at the practice level who are collectively responsible for the ongoing care of the patient;

(C) the physician is responsible for providing all of the care the patient needs or for coordinating with other qualified providers to provide care to the patient throughout the patient's life, including preventive care, acute care, chronic care, and end-of-life care;

(D) the patient's care is coordinated across health care facilities and the patient's community and is facilitated by registries, information technology, and health information exchange systems to ensure that the patient receives care when and where the patient wants and needs the care and in a culturally and linguistically appropriate manner; and

(E) quality and safe care is provided.

(b) The commission shall, to the extent possible, work to ensure that managed care organizations:

(1) promote the development of patient-centered medical homes for recipients; and

(2) provide payment incentives for providers that meet

the requirements of a patient-centered medical home.

(c) Section 533.003, Government Code, is amended to read as follows:

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. In awarding contracts to managed care organizations, the commission shall:

(1) give preference to organizations that have significant participation in the organization's provider network from each health care provider in the region who has traditionally provided care to Medicaid and charity care patients;

(2) give extra consideration to organizations that agree to assure continuity of care for at least three months beyond the period of Medicaid eligibility for recipients;

(3) consider the need to use different managed care plans to meet the needs of different populations; [~~and~~]

(4) consider the ability of organizations to process Medicaid claims electronically; and

(5) give extra consideration in each health care service region to an organization that:

(A) is locally owned, managed, and operated, if one exists; or

(B) notwithstanding Section 533.004 or any other law, is not owned or operated by and does not have a contract, agreement, or other arrangement with a hospital district in the region.

(d) Section 533.005(a), Government Code, is amended to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan not later than the 45th day after the date a claim for payment is received with

documentation reasonably necessary for the managed care organization to process the claim, or within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

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

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that the organization use advanced

practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network;

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

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

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

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

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

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available in

the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(18) a requirement that the managed care organization develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to:

(A) preventive care;

(B) primary care;

(C) specialty care;

(D) after-hours urgent care; and

(E) chronic care;

(19) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that:

(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types; and

(iii) providers located throughout the region where the organization will provide health care services; and

(C) health care services will be accessible to recipients through the organization's provider network to the same extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(20) 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:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(21) a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that reimburses only enrolled pharmacy providers for pharmacy products on the vendor drug program formulary, also known as the Texas drug code index;

(B) that adheres to the applicable preferred drug

list adopted by the commission under Section 531.072;

(C) that includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere 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;

(G) that establishes uniform administrative, financial, and professional terms for all pharmacies and pharmacists that participate in the plan; and

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the terms established under Paragraph (G); and

(22) a requirement that the managed care organization and any entity with which the managed care organization contracts

for the performance of services under a managed care plan disclose, at no cost, to the commission 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.

(e) Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0066 to read as follows:

Sec. 533.0066. PROVIDER INCENTIVES. The commission shall, to the extent possible, 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.

(f) Section 533.0071, Government Code, is amended to read as follows:

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

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

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

(3) maximize Medicaid payment recovery options by

contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to enrollees who leave the managed care program;

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

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

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

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

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

notifications; and

(E) providing a single portal through which providers in any managed care organization's provider network may submit claims; and

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

(g) Sections 533.0076(a) and (c), Government Code, are amended to read as follows:

(a) Except as provided by Subsections (b) and (c), and to the extent permitted by federal law, [~~the commission may prohibit~~] a recipient enrolled [~~from disenrolling~~] in a managed care plan under this chapter may not disenroll from that plan and enroll [~~enrolling~~] in another managed care plan [~~during the 12-month period after the date the recipient initially enrolls in a plan~~].

(c) The commission shall allow a recipient who is enrolled in a managed care plan under this chapter to disenroll from [~~in~~] that plan:

(1) at any time for cause in accordance with federal law; and

(2) once for any reason after the period described by Subsection (b).

(h) Sections 533.012(a), (b), (c), and (e), Government Code, are amended to read as follows:

(a) Each managed care organization contracting with the

commission under this chapter shall submit the following, at no cost, to the commission and, on request, the office of the attorney general:

(1) a description of any financial or other business relationship between the organization and any subcontractor providing health care services under the contract;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control program used by any subcontractor that delivers health care services; and

(4) a description and breakdown of all funds paid to or by the managed care organization, including a health maintenance organization, primary care case management provider, pharmacy benefit manager, and [~~an~~] exclusive provider organization, necessary for the commission to determine the actual cost of administering the managed care plan.

(b) The information submitted under this section must be submitted in the form required by the commission or the office of the attorney general, as applicable, and be updated as required by the commission or the office of the attorney general, as applicable.

(c) The commission's office of investigations and enforcement or the office of the attorney general, as applicable, shall review the information submitted under this section as appropriate in the investigation of fraud in the Medicaid managed care program.

(e) Information submitted to the commission or the office of the attorney general, as applicable, under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552, Government Code.

(i) The heading to Section 32.046, Human Resources Code, is amended to read as follows:

Sec. 32.046. [~~VENDOR DRUG PROGRAM;~~] SANCTIONS AND PENALTIES RELATED TO THE PROVISION OF PHARMACY PRODUCTS.

(j) Section 32.046(a), Human Resources Code, is amended to read as follows:

(a) The executive commissioner of the Health and Human Services Commission [~~department~~] shall adopt rules governing sanctions and penalties that apply to a provider who participates in the vendor drug program or is enrolled as a network pharmacy provider of a managed care organization contracting with the commission under Chapter 533, Government Code, or its subcontractor and who submits an improper claim for reimbursement under the program.

(k) Not later than December 1, 2013, the Health and Human Services Commission shall submit a report to the legislature regarding the commission's work to ensure that Medicaid managed care organizations promote the development of patient-centered medical homes for recipients of medical assistance as required under Section 533.0029, Government Code, as added by this section.

(l) The Health and Human Services Commission shall, in a contract between the 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 Act, include the provisions required by Section 533.005(a), Government Code, as amended by this section.

(m) Sections 533.0076(a) and (c), Government Code, as amended by this section, apply only to a request for disenrollment from a Medicaid managed care plan under Chapter 533, Government Code, made by a recipient on or after the effective date of this Act. A request made by a recipient before that date is governed by the law in effect on the date the request was made, and the former law is continued in effect for that purpose.

SECTION 4. ABOLISHING STATE KIDS INSURANCE PROGRAM. (a) Section 62.101, Health and Safety Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) A child who is the dependent of an employee of an agency of this state and who meets the requirements of Subsection (a) may be eligible for health benefits coverage in accordance with 42 U.S.C. Section 1397jj(b)(6) and any other applicable law or regulations.

(b) Sections 1551.159 and 1551.312, Insurance Code, are repealed.

(c) The State Kids Insurance Program operated by the Employees Retirement System of Texas is abolished on the effective date of this Act. The Health and Human Services Commission shall:

(1) establish a process in cooperation with the Employees Retirement System of Texas to facilitate the enrollment of eligible children in the child health plan program established under Chapter 62, Health and Safety Code, on or before the date

those children are scheduled to stop receiving dependent child coverage under the State Kids Insurance Program; and

(2) modify any applicable administrative procedures to ensure that children described by this subsection maintain continuous health benefits coverage while transitioning from enrollment in the State Kids Insurance Program to enrollment in the child health plan program.

SECTION 5. PREVENTION OF CRIMINAL OR FRAUDULENT CONDUCT BY CERTAIN FACILITIES, PROVIDERS, AND RECIPIENTS. (a) Subchapter B, Chapter 31, Human Resources Code, is amended by adding Section 31.0326 to read as follows:

Sec. 31.0326. VERIFICATION OF IDENTITY AND PREVENTION OF DUPLICATE PARTICIPATION. The Health and Human Services Commission shall use appropriate technology to:

(1) confirm the identity of applicants for benefits under the financial assistance program; and

(2) prevent duplicate participation in the program by a person.

(b) Chapter 33, Human Resources Code, is amended by adding Section 33.0231 to read as follows:

Sec. 33.0231. VERIFICATION OF IDENTITY AND PREVENTION OF DUPLICATE PARTICIPATION IN SNAP. The department shall use appropriate technology to:

(1) confirm the identity of applicants for benefits under the supplemental nutrition assistance program; and

(2) prevent duplicate participation in the program by a person.

(c) Section 531.109, Government Code, is amended by adding Subsection (d) to read as follows:

(d) Absent an allegation of fraud, waste, or abuse, the commission may conduct an annual review of claims under this section only after the commission has completed the prior year's annual review of claims.

(d) Section 31.0325, Human Resources Code, is repealed.

SECTION 6. PROVISIONS RELATING TO CONVALESCENT AND NURSING HOMES. (a) Section 242.033, Health and Safety Code, is amended by amending Subsection (d) and adding Subsection (g) to read as follows:

(d) Except as provided by Subsection (f), a license is renewable every three [~~two~~] years after:

(1) an inspection, unless an inspection is not required as provided by Section 242.047;

(2) payment of the license fee; and

(3) department approval of the report filed every three [~~two~~] years by the licensee.

(g) The executive commissioner by rule shall adopt a system under which an appropriate number of licenses issued by the department under this chapter expire on staggered dates occurring in each three-year period. If the expiration date of a license changes as a result of this subsection, the department shall prorate the licensing fee relating to that license as appropriate.

(b) Section 242.159(e-1), Health and Safety Code, is amended to read as follows:

(e-1) An institution is not required to comply with

Subsections (a) and (e) until September 1, 2014 [~~2012~~]. This subsection expires January 1, 2015 [~~2013~~].

(c) The executive commissioner of the Health and Human Services Commission shall adopt the rules required under Section 242.033(g), Health and Safety Code, as added by this section, as soon as practicable after the effective date of this Act, but not later than December 1, 2012.

SECTION 7. STREAMLINING OF AND UTILIZATION MANAGEMENT IN MEDICAID LONG-TERM CARE WAIVER PROGRAMS. (a) Section 161.077, Human Resources Code, as added by Chapter 759 (S.B. 705), Acts of the 81st Legislature, Regular Session, 2009, is redesignated as Section 161.081, Human Resources Code, and amended to read as follows:

Sec. 161.081 [~~161.077~~]. LONG-TERM CARE MEDICAID WAIVER PROGRAMS: STREAMLINING AND UNIFORMITY. (a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 531.001, Government Code.

(b) The department, in consultation with the commission, shall streamline the administration of and delivery of services through Section 1915(c) waiver programs. In implementing this subsection, the department, subject to Subsection (c), may consider implementing the following streamlining initiatives:

(1) reducing the number of forms used in administering the programs;

(2) revising program provider manuals and training curricula;

(3) consolidating service authorization systems;

(4) eliminating any physician signature requirements the department considers unnecessary;

(5) standardizing individual service plan processes across the programs; [~~and~~]

(6) if feasible:

(A) concurrently conducting program certification and billing audit and review processes and other related audit and review processes;

(B) streamlining other billing and auditing requirements;

(C) eliminating duplicative responsibilities with respect to the coordination and oversight of individual care plans for persons receiving waiver services; and

(D) streamlining cost reports and other cost reporting processes; and

(7) any other initiatives that will increase efficiencies in the programs.

(c) The department shall ensure that actions taken under Subsection (b) [~~this section~~] do not conflict with any requirements of the commission under Section 531.0218, Government Code.

(d) The department and the commission shall jointly explore the development of uniform licensing and contracting standards that would:

(1) apply to all contracts for the delivery of Section 1915(c) waiver program services;

(2) promote competition among providers of those program services; and

(3) integrate with other department and commission efforts to streamline and unify the administration and delivery of the program services, including those required by this section or Section 531.0218, Government Code.

(b) Subchapter D, Chapter 161, Human Resources Code, is amended by adding Section 161.082 to read as follows:

Sec. 161.082. LONG-TERM CARE MEDICAID WAIVER PROGRAMS: UTILIZATION REVIEW. (a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 531.001, Government Code.

(b) The department shall perform a utilization review of services in all Section 1915(c) waiver programs. The utilization review must 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.

SECTION 8. PROVISIONS RELATING TO ASSISTED LIVING FACILITIES. (a) Section 247.004, Health and Safety Code, is amended to read as follows:

Sec. 247.004. EXEMPTIONS. This chapter does not apply to:

(1) a boarding home facility as defined by Section 254.001, as added by Chapter 1106 (H.B. 216), Acts of the 81st Legislature, Regular Session, 2009;

(2) an establishment conducted by or for the adherents of the Church of Christ, Scientist, for the purpose of providing facilities for the care or treatment of the sick who depend exclusively on prayer or spiritual means for healing without the

use of any drug or material remedy if the establishment complies with local safety, sanitary, and quarantine ordinances and regulations;

(3) a facility conducted by or for the adherents of a qualified religious society classified as a tax-exempt organization under an Internal Revenue Service group exemption ruling for the purpose of providing personal care services without charge solely for the society's professed members or ministers in retirement, if the facility complies with local safety, sanitation, and quarantine ordinances and regulations; or

(4) a facility that provides personal care services only to persons enrolled in a program that:

(A) is funded in whole or in part by the department and that is monitored by the department or its designated local mental retardation authority in accordance with standards set by the department; or

(B) is funded in whole or in part by the Department of State Health Services and that is monitored by that department, or by its designated local mental health authority in accordance with standards set by the department.

(b) Section 247.027(a), Health and Safety Code, is amended to read as follows:

(a) In addition to the inspection required under Section 247.023(a), the department may inspect an assisted living facility once during an 18-month period [~~annually~~] and may inspect a facility at other reasonable times as necessary to assure compliance with this chapter.

(c) Section 247.032(b), Health and Safety Code, is amended to read as follows:

(b) The department shall accept an accreditation survey from an accreditation commission for an assisted living facility instead of an inspection under Section 247.023 or an [~~annual~~] inspection or survey conducted once during each 18-month period under the authority of Section 247.027, but only if:

(1) the accreditation commission's standards meet or exceed the requirements for licensing of the executive commissioner of the Health and Human Services Commission for an assisted living facility;

(2) the accreditation commission maintains an inspection or survey program that, for each assisted living facility, meets the department's applicable minimum standards as confirmed by the executive commissioner of the Health and Human Services Commission;

(3) the accreditation commission conducts an on-site inspection or survey of the facility at least as often as required by Section 247.023 or 247.027 and in accordance with the department's minimum standards;

(4) the assisted living facility submits to the department a copy of its required accreditation reports to the accreditation commission in addition to the application, the fee, and any report required for renewal of a license;

(5) the inspection or survey results are available for public inspection to the same extent that the results of an investigation or survey conducted under Section 247.023 or 247.027

are available for public inspection; and

(6) the department ensures that the accreditation commission has taken reasonable precautions to protect the confidentiality of personally identifiable information concerning the residents of the assisted living facility.

SECTION 9. TELEMONITORING. (a) Section 531.001, Government Code, is amended by adding Subdivision (7) to read as follows:

(7) "Telemonitoring" means the use of telecommunications and information technology to provide access to health assessment, intervention, consultation, supervision, and information across distance. Telemonitoring includes the use of technologies such as telephones, facsimile machines, e-mail systems, text messaging systems, and remote patient monitoring devices to collect and transmit patient data for monitoring and interpretation.

(b) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02176, 531.02177, and 531.02178 to read as follows:

Sec. 531.02176. MEDICAID TELEMONITORING PILOT PROGRAMS FOR DIABETES. (a) The commission shall determine whether the Medicaid Enhanced Care program's diabetes self-management training telemonitoring pilot program was cost neutral.

(b) In determining whether the pilot program described by Subsection (a) was cost neutral, the commission shall, at a minimum, compare:

(1) the health care costs of program participants who

received telemonitoring services with the health care costs of a group of Medicaid recipients who did not receive telemonitoring services;

(2) the health care services used by program participants who received telemonitoring services with the health care services used by a group of Medicaid recipients who did not receive telemonitoring services;

(3) for program participants who received telemonitoring services, the amount spent on health care services before, during, and after the receipt of telemonitoring services; and

(4) for program participants who received telemonitoring services, the health care services used before, during, and after the receipt of telemonitoring services.

(c) If the commission determines that the pilot program described by Subsection (a) was cost neutral, the executive commissioner shall adopt rules for providing telemonitoring services through the Medicaid Texas Health Management Program for select diabetes patients in a manner comparable to that program.

(d) If the commission determines that the pilot program described by Subsection (a) was not cost neutral, the commission shall 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 the commission determines implementing the new diabetes telemonitoring pilot program would be cost neutral.

(e) In determining whether implementing a new diabetes telemonitoring pilot program under Subsection (d) would be cost neutral, the commission shall consider appropriate factors, including the following:

(1) the target population, participant eligibility criteria, and the number of participants to whom telemonitoring services would be provided;

(2) the type of telemonitoring technology to be used;

(3) the estimated cost of the telemonitoring services to be provided;

(4) the estimated cost differential to the state based on changes in participants' use of emergency department services, outpatient services, pharmaceutical and ancillary services, and inpatient services other than inpatient labor and delivery services; and

(5) other indirect costs that may result from the provision of telemonitoring services.

Sec. 531.02177. MEDICAID TELEMONITORING PILOT PROGRAM FOR CERTAIN CONDITIONS. (a) The commission shall 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 the commission determines implementing the pilot program would be cost neutral.

(b) In determining whether implementing a pilot program under Subsection (a) would be cost neutral, the commission shall consider appropriate factors, including the following:

(1) the types of health conditions that could be assessed through the program by reviewing existing research and other evidence on the effectiveness of providing telemonitoring services to persons with those conditions;

(2) the target population, participant eligibility criteria, and the number of participants to whom telemonitoring services would be provided;

(3) the type of telemonitoring technology to be used;

(4) the estimated cost of the telemonitoring services to be provided;

(5) the estimated cost differential to the state based on changes in participants' use of emergency department services, outpatient services, pharmaceutical and ancillary services, and inpatient services other than inpatient labor and delivery services; and

(6) other indirect costs that may result from the provision of telemonitoring services.

Sec. 531.02178. DISSEMINATION OF INFORMATION ABOUT EFFECTIVE TELEMONITORING STRATEGIES. The commission shall annually:

(1) identify telemonitoring strategies implemented within the Medicaid program that have demonstrated cost neutrality or resulted in improved performance on key health measures; and

(2) disseminate information about the identified strategies to encourage the adoption of effective telemonitoring strategies.

(c) Not later than January 1, 2012, the executive

commissioner of the Health and Human Services Commission shall adopt the rules required by Section 531.02176(c), Government Code, as added by this section, if the commission determines that the Medicaid Enhanced Care program's diabetes self-management training telemonitoring pilot program was cost neutral.

(d) Not later than September 1, 2012, the Health and Human Services Commission shall determine whether implementing a new diabetes telemonitoring pilot program would be cost neutral if required by Section 531.02176(d), Government Code, as added by this section, and report that determination to the governor and the Legislative Budget Board.

(e) Not later than September 1, 2012, the Health and Human Services Commission shall determine whether implementing a telemonitoring pilot program for health conditions other than diabetes would be cost neutral as required by Section 531.02177(a), Government Code, as added by this section, and report that determination to the governor and the Legislative Budget Board.

SECTION 10. PHYSICIAN INCENTIVE PROGRAMS. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.086 and 531.0861 to read as follows:

Sec. 531.086. STUDY REGARDING PHYSICIAN INCENTIVE PROGRAMS TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) The commission shall conduct a study to evaluate physician incentive programs that attempt to reduce hospital emergency room use for non-emergent conditions by recipients under the medical assistance program. Each physician incentive program evaluated in the study must:

(1) be administered by a health maintenance organization participating in the STAR or STAR + PLUS Medicaid managed care program; and

(2) provide incentives to primary care providers who attempt to reduce emergency room use for non-emergent conditions by recipients.

(b) The study conducted under Subsection (a) must evaluate:

(1) the cost-effectiveness of each component included in a physician incentive program; and

(2) any change in statute required to implement each component within the Medicaid fee-for-service or primary care case management model.

(c) Not later than August 31, 2012, the executive commissioner shall submit to the governor and the Legislative Budget Board a report summarizing the findings of the study required by this section.

(d) This section expires September 1, 2013.

Sec. 531.0861. PHYSICIAN INCENTIVE PROGRAM TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) The executive commissioner by rule shall establish a physician incentive program designed to reduce the use of hospital emergency room services for non-emergent conditions by recipients under the medical assistance program.

(b) In establishing the physician incentive program under Subsection (a), the executive commissioner may include only the program components identified as cost-effective in the study conducted under Section 531.086.

(c) If the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, the executive commissioner shall 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. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.024131 to read as follows:

Sec. 531.024131. EXPANSION OF BILLING COORDINATION AND INFORMATION COLLECTION ACTIVITIES. (a) If cost-effective, the commission may:

(1) contract to expand all or part of the billing coordination system established under Section 531.02413 to process claims for services provided through other benefits programs administered by the commission or a health and human services agency;

(2) expand any other billing coordination tools and resources used to process claims for health care services provided through the Medicaid program to process claims for services provided through other benefits programs administered by the commission or a health and human services agency; and

(3) expand the scope of persons about whom information is collected under Section 32.042, Human Resources Code, to include recipients of services provided through other benefits programs administered by the commission or a health and human services agency.

(b) Notwithstanding any other state law, each health and

human services agency shall provide the commission with any information necessary to allow the commission or the commission's designee to perform the billing coordination and information collection activities authorized by this section.

SECTION 12. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND. (a) Sections 531.502(b) and (d), Government Code, are amended to read as follows:

(b) The executive commissioner may include the following federal money in the waiver:

(1) [~~all~~] money provided under the disproportionate share hospitals or [~~and~~] upper payment limit supplemental payment program, or both [~~programs~~];

(2) money provided by the federal government in lieu of some or all of the payments under one or both of 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:

(A) federal money and money identified under Subsection (c);

(B) gifts, grants, or donations for that purpose;

(C) local funds received by this state through intergovernmental transfers; and

(D) if approved in the waiver, federal money obtained through the use of certified public expenditures.

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

(1) include safeguards to ensure that the total amount

of federal money provided under the disproportionate share hospitals or [~~and~~] upper payment limit supplemental payment program [~~programs~~] that is deposited as provided by Section 531.504 is, for a particular state fiscal year, at least equal to the greater of the annualized amount provided to this state under those supplemental payment programs during state fiscal year 2007, excluding amounts provided during 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 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.

(b) Section 531.504, Government Code, is amended to read as follows:

Sec. 531.504. DEPOSITS TO FUND. (a) The comptroller shall deposit in the fund:

(1) [~~all~~] federal money provided to this state under the disproportionate share hospitals supplemental payment program or [~~and~~] the hospital upper payment limit supplemental payment program, or both, other than money provided under those programs to state-owned and operated hospitals, and all other non-supplemental payment program federal money provided to this state that is

included in the waiver authorized by Section 531.502; and

(2) state money appropriated to the fund.

(b) The commission and comptroller may accept gifts, grants, and donations from any source, and receive intergovernmental transfers, for purposes consistent with this subchapter and the terms of the waiver. The comptroller shall deposit a gift, grant, or donation made for those purposes in the fund.

(c) Section 531.508, Government Code, is amended by adding Subsection (d) to read as follows:

(d) Money from the fund may not be used to finance the construction, improvement, or renovation of a building or land unless the construction, improvement, or renovation is approved by the commission, according to rules adopted by the executive commissioner for that purpose.

(d) Section 531.502(g), Government Code, is repealed.

SECTION 13. REPORT ON MEDICAID LONG-TERM CARE SERVICES. (a) In this section:

(1) "Long-term care services" has the meaning assigned by Section 22.0011, Human Resources Code.

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

(3) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code.

(b) The Health and Human Services Commission, in

cooperation with the Department of Aging and Disability Services, shall prepare a written report regarding individuals who receive long-term care services in nursing facilities under the medical assistance program. The report must be based on existing data and information, and must use that data and information to identify:

(1) the reasons medical assistance 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;

(2) the types of medical assistance services recipients residing in nursing facilities typically receive and where and from whom those services are typically provided;

(3) the community-based services and supports available under a Medicaid state plan program, including the primary home care and community attendant services programs, or under a medical assistance waiver granted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for which recipients residing in nursing facilities may be eligible; and

(4) ways to expedite recipients' access to community-based services and supports identified under Subdivision (3) of this subsection for which interest lists or other waiting lists exist.

(c) Not later than September 1, 2012, the Health and Human Services Commission shall submit the report described by Subsection (b) of this section, together with the commission's 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 recommendations must address options for expediting access to community-based services and supports by recipients described by Subsection (b)(3) of this section.

SECTION 14. FEDERAL AUTHORIZATION. 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 15. EFFECTIVE DATE. This Act takes effect September 1, 2011.