AN ACT

relating to access and assignment requirements for, support and information regarding, and investigations of certain providers of health care and long-term services.

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

SECTION 1. The heading to Section 261.404, Family Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

Sec. 261.404. INVESTIGATIONS REGARDING CERTAIN CHILDREN RECEIVING SERVICES FROM CERTAIN PROVIDERS [~~WITH MENTAL ILLNESS OR AN INTELLECTUAL DISABILITY~~].

SECTION 2. Section 261.404, Family Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended by amending Subsections (a) and (b) and adding Subsections (a-1), (a-2), and (a-3) to read as follows:

(a) The department shall investigate a report of abuse, neglect, or exploitation of a child receiving services from a provider, as those terms are defined by Section 48.251, Human Resources Code, or as otherwise defined by rule. The department shall also investigate, under Subchapter F, Chapter 48, Human Resources Code, a report of abuse, neglect, or exploitation of a child receiving services from an officer, employee, agent, contractor, or subcontractor of a home and community support services agency licensed under Chapter 142, Health and Safety Code,

if the officer, employee, agent, contractor, or subcontractor is or may be the person alleged to have committed the abuse, neglect, or exploitation[~~:~~

[~~(1) in a facility operated by the Department of Aging and Disability Services or a mental health facility operated by the Department of State Health Services;~~

[~~(2) in or from a community center, a local mental health authority, or a local intellectual and developmental disability authority;~~

[~~(3) through a program providing services to that child by contract with a facility operated by the Department of Aging and Disability Services, a mental health facility operated by the Department of State Health Services, a community center, a local mental health authority, or a local intellectual and developmental disability authority;~~

[~~(4) from a provider of home and community-based services who contracts with the Department of Aging and Disability Services; or~~

[~~(5) in a facility licensed under Chapter 252, Health and Safety Code~~].

(a-1) For an investigation of a child living in a residence owned, operated, or controlled by a provider of services under the home and community-based services waiver program described by Section 534.001(11)(B), Government Code, the department, in accordance with Subchapter E, Chapter 48, Human Resources Code, may provide emergency protective services necessary to immediately protect the child from serious physical harm or death and, if

necessary, obtain an emergency order for protective services under Section 48.208, Human Resources Code.

(a-2) For an investigation of a child living in a residence owned, operated, or controlled by a provider of services under the home and community-based services waiver program described by Section 534.001(11)(B), Government Code, regardless of whether the child is receiving services under that waiver program from the provider, the department shall provide protective services to the child in accordance with Subchapter E, Chapter 48, Human Resources Code.

(a-3) For purposes of this section, Subchapters E and F, Chapter 48, Human Resources Code, apply to an investigation of a child and to the provision of protective services to that child in the same manner those subchapters apply to an investigation of an elderly person or person with a disability and the provision of protective services to that person.

(b) The department shall investigate the report under rules developed by the executive commissioner [~~with the advice and assistance of the department, the Department of Aging and Disability Services, and the Department of State Health Services~~].

SECTION 3. Section 531.0213, Government Code, is amended by adding Subsections (b-1) and (e), amending Subsection (c), and amending Subsection (d), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, to read as follows:

(b-1) The commission shall provide support and information services required by this section through a network of entities coordinated by the commission's office of the ombudsman or other

division of the commission designated by the executive commissioner and composed of:

(1) the commission's office of the ombudsman or other division of the commission designated by the executive commissioner to coordinate the network;

(2) the office of the state long-term care ombudsman required under Subchapter F, Chapter 101A, Human Resources Code;

(3) the division within the commission responsible for oversight of Medicaid managed care contracts;

(4) area agencies on aging;

(5) aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services; and

(6) any other entity the executive commissioner determines appropriate, including nonprofit organizations with which the commission contracts under Subsection (c).

(c) The commission may provide support and information services by contracting with [~~a~~] nonprofit organizations [~~organization~~] that are [~~is~~] not involved in providing health care, health insurance, or health benefits.

(d) As a part of the support and information services required by this section, the commission [~~or nonprofit organization~~] shall:

(1) operate a statewide toll-free assistance telephone number that includes relay services for persons with speech or hearing disabilities [~~TDD lines~~] and assistance for

persons who speak Spanish;

(2) intervene promptly with the state Medicaid office, managed care organizations and providers, and any other appropriate entity on behalf of a person who has an urgent need for medical services;

(3) assist a person who is experiencing barriers in the Medicaid application and enrollment process and refer the person for further assistance if appropriate;

(4) educate persons so that they:

(A) understand the concept of managed care;

(B) understand their rights under Medicaid, including grievance and appeal procedures; and

(C) are able to advocate for themselves;

(5) collect and maintain statistical information on a regional basis regarding calls received by the assistance lines and publish quarterly reports that:

(A) list the number of calls received by region;

(B) identify trends in delivery and access problems;

(C) identify recurring barriers in the Medicaid system; and

(D) indicate other problems identified with Medicaid managed care; [~~and~~]

(6) assist the state Medicaid office and managed care organizations and providers in identifying and correcting problems, including site visits to affected regions if necessary;

(7) meet the needs of all current and future Medicaid

managed care recipients, including children receiving dental benefits and other recipients receiving benefits, under the:

(A) STAR Medicaid managed care program;

(B) STAR + PLUS Medicaid managed care program, including the Texas Dual Eligibles Integrated Care Demonstration Project provided under that program;

(C) STAR Kids managed care program established under Section 533.00253; and

(D) STAR Health program;

(8) incorporate support services for children enrolled in the child health plan established under Chapter 62, Health and Safety Code; and

(9) ensure that staff providing support and information services receives sufficient training, including training in the Medicare program for the purpose of assisting recipients who are dually eligible for Medicare and Medicaid, and has sufficient authority to resolve barriers experienced by recipients to health care and long-term services and supports.

(e) The commission's office of the ombudsman, or other division of the commission designated by the executive commissioner to coordinate the network of entities responsible for providing support and information services under this section, must be sufficiently independent from other aspects of Medicaid managed care to represent the best interests of recipients in problem resolution.

SECTION 4. Section 533.005(a), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session,

2015, 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 on any claim for

payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the 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, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in

the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

(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;

(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;

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

(D) the managed care organization to allow a provider with a claim that has not been paid before the time

prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

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

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care organization:

(A) 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 complies with the provider access standards established under Section 533.0061 [~~will provide recipients sufficient access to:~~

[~~(i) preventive care;~~

[~~(ii) primary care;~~

[~~(iii) specialty care;~~

[~~(iv) after-hours urgent care;~~

[~~(v) chronic care;~~

[~~(vi) long-term services and supports;~~

[~~(vii) nursing services; and~~

[~~(viii) therapy services, including services provided in a clinical setting or in a home or community-based setting~~]; [~~and~~]

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a) [~~Paragraph (A)~~] and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services [~~Paragraphs (A)(iii), (vi), (vii), and (viii)~~] on the average

length of time between:

(i) the date a provider requests prior authorization [~~makes a referral~~] for the care or service and the date the organization approves or denies the request [~~referral~~]; and

(ii) the date the organization approves a request for prior authorization [~~referral~~] for the care or service and the date the care or service is initiated;

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that, subject to the provider access standards established under Section 533.0061:

(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;

(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(iv) 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 a comparable 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;

(22) 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;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under Medicaid;

(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;

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs,

and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(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 financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code; and

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, must ensure that:

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(b) the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(iii) must review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing;

(iv) must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(v) must establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(vi) must:

(a) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

(b) respond to a challenge not later

than the 15th day after the date the challenge is made;

(c) if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved, and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager, as appropriate;

(d) if the challenge is denied, provide the reason for the denial; and

(e) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail; and

(viii) must provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider;

(24) 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; [~~and~~]

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reduction; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; and

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.0061, 533.0062, 533.0063, and 533.0064 to read as follows:

Sec. 533.0061. PROVIDER ACCESS STANDARDS; REPORT. (a) The commission shall establish minimum provider access standards for the provider network of a managed care organization that contracts with the commission to provide health care services to recipients. The access standards must ensure that a managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services identified by the commission.

(b) To the extent it is feasible, the provider access standards established under this section must:

(1) distinguish between access to providers in urban and rural settings; and

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area.

(c) The commission shall biennially submit to the legislature and make available to the public a report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations and managed care organization compliance with contractual obligations related to provider access standards established under this section. The report must contain:

(1) a compilation and analysis of information submitted to the commission under Section 533.005(a)(20)(D);

(2) for both primary care providers and specialty providers, information on provider-to-recipient ratios in an organization's provider network, as well as benchmark ratios to indicate whether deficiencies exist in a given network; and

(3) a description of, and analysis of the results from, the commission's monitoring process established under Section 533.007(l).

Sec. 533.0062. PENALTIES AND OTHER REMEDIES FOR FAILURE TO

COMPLY WITH PROVIDER ACCESS STANDARDS. If a managed care organization that has contracted with the commission to provide health care services to recipients fails to comply with one or more provider access standards established under Section 533.0061 and the commission determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, the commission:

(1) may:

(A) elect to not retain or renew the commission's contract with the organization; or

(B) require the organization to pay liquidated damages in accordance with Section 533.005(a)(20)(C); and

(2) shall suspend default enrollment to the organization in a given service delivery area for at least one calendar quarter if the organization's noncompliance occurs in the service delivery area for two consecutive calendar quarters.

Sec. 533.0063. PROVIDER NETWORK DIRECTORIES. (a) The commission shall ensure that a managed care organization that contracts with the commission to provide health care services to recipients:

(1) posts on the organization's Internet website:

(A) the organization's provider network directory; and

(B) a direct telephone number and e-mail address through which a recipient enrolled in the organization's managed care plan or the recipient's provider may contact the organization to receive assistance with:

(i) identifying in-network providers and

services available to the recipient; and

(ii) scheduling an appointment for the recipient with an available in-network provider or to access available in-network services; and

(2) updates the online directory required under Subdivision (1)(A) at least monthly.

(b) Except as provided by Subsection (c), a managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who requests to receive the directory in paper form.

(c) A managed care organization participating in the STAR + PLUS Medicaid managed care program or STAR Kids Medicaid managed care program established under Section 533.00253 shall, for a recipient in that program, issue a provider network directory for the program in paper form unless the recipient opts out of receiving the directory in paper form.

Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a physician or other health care provider applying for expedited credentialing under this section.

(b) Notwithstanding any other law and subject to Subsection (c), a managed care organization that contracts with the commission to provide health services to recipients shall, in accordance with this section, establish and implement an expedited credentialing process that would allow applicant providers to provide services to recipients on a provisional basis.

(c) The commission shall identify the types of providers for

which an expedited credentialing process must be established and implemented under this section.

(d) To qualify for expedited credentialing under this section and payment under Subsection (e), an applicant provider must:

(1) be a member of an established health care provider group that has a current contract in force with a managed care organization described by Subsection (b);

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) submit all documentation and other information required by the managed care organization as necessary to enable the organization to begin the credentialing process required by the organization to include a provider in the organization's provider network.

(e) On submission by the applicant provider of the information required by the managed care organization under Subsection (d), and for Medicaid reimbursement purposes only, the organization shall treat the provider as if the provider were in the organization's provider network when the provider provides services to recipients, subject to Subsections (f) and (g).

(f) Except as provided by Subsection (g), if, on completion of the credentialing process, a managed care organization determines that the applicant provider does not meet the organization's credentialing requirements, the organization may recover from the provider the difference between payments for

in-network benefits and out-of-network benefits.

(g) If a managed care organization determines on completion of the credentialing process that the applicant provider does not meet the organization's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing, the organization may recover from the provider the entire amount of any payment paid to the provider.

SECTION 6. Section 533.007, Government Code, is amended by adding Subsection (l) to read as follows:

(l) The commission shall establish and implement a process for the direct monitoring of a managed care organization's provider network and providers in the network. The process:

(1) must be used to ensure compliance with contractual obligations related to:

(A) the number of providers accepting new patients under the Medicaid managed care program; and

(B) the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider;

(2) may use reasonable methods to ensure compliance with contractual obligations, including telephone calls made at random times without notice to assess the availability of providers and services to new and existing recipients; and

(3) may be implemented directly by the commission or through a contractor.

SECTION 7. Section 142.009(c), Health and Safety Code, is amended to read as follows:

(c) The department or its authorized representative shall investigate each complaint received regarding the provision of home health, hospice, or personal assistance services[~~, including any allegation of abuse, neglect, or exploitation of a child under the age of 18,~~] and may, as a part of the investigation:

(1) conduct an unannounced survey of a place of business, including an inspection of medical and personnel records, if the department has reasonable cause to believe that the place of business is in violation of this chapter or a rule adopted under this chapter;

(2) conduct an interview with a recipient of home health, hospice, or personal assistance services, which may be conducted in the recipient's home if the recipient consents;

(3) conduct an interview with a family member of a recipient of home health, hospice, or personal assistance services who is deceased or other person who may have knowledge of the care received by the deceased recipient of the home health, hospice, or personal assistance services; or

(4) interview a physician or other health care practitioner, including a member of the personnel of a home and community support services agency, who cares for a recipient of home health, hospice, or personal assistance services.

SECTION 8. Section 260A.002, Health and Safety Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) Notwithstanding any other provision of this chapter, a report made under this section that a provider is or may be alleged to have committed abuse, neglect, or exploitation of a

resident of a facility other than a prescribed pediatric extended care center shall be investigated by the Department of Family and Protective Services in accordance with Subchapter F, Chapter 48, Human Resources Code, and this chapter does not apply to that investigation. In this subsection, "facility" and "provider" have the meanings assigned by Section 48.251, Human Resources Code.

SECTION 9. Section 48.002(a), Human Resources Code, is amended by adding Subdivision (11) to read as follows:

(11) "Home and community-based services" has the meaning assigned by Section 48.251.

SECTION 10. Section 48.002(b), Human Resources Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

(b) The definitions of "abuse," "neglect," [~~and~~] "exploitation," and "an individual receiving services" adopted by the executive commissioner as prescribed by Section 48.251(b) [~~48.251~~] apply to an investigation of abuse, neglect, or exploitation conducted under Subchapter F [~~or H~~].

SECTION 11. Section 48.003, Human Resources Code, is amended to read as follows:

Sec. 48.003. INVESTIGATIONS IN NURSING FACILITIES [~~HOMES~~], ASSISTED LIVING FACILITIES, AND SIMILAR FACILITIES. (a) Except as provided by Subsection (c), this [~~This~~] chapter does not apply if the alleged or suspected abuse, neglect, or exploitation occurs in a facility licensed under Chapter 242 or 247, Health and Safety Code.

(b) Alleged or suspected abuse, neglect, or exploitation

that occurs in a facility licensed under Chapter 242 or 247, Health and Safety Code, is governed by Chapter 260A, Health and Safety Code, except as otherwise provided by Subsection (c).

(c) Subchapter F applies to an investigation of alleged or suspected abuse, neglect, or exploitation in which a provider of home and community-based services is or may be alleged to have committed the abuse, neglect, or exploitation, regardless of whether the facility in which those services were provided is licensed under Chapter 242 or 247, Health and Safety Code.

SECTION 12. Sections 48.051(a) and (b), Human Resources Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, are amended to read as follows:

(a) Except as prescribed by Subsection (b), a person having cause to believe that an elderly person, a [~~or~~] person with a disability, or an individual receiving services from a provider as described by Subchapter F is in the state of abuse, neglect, or exploitation[~~, including a person with a disability who is receiving services as described by Section 48.252,~~] shall report the information required by Subsection (d) immediately to the department.

(b) If a person has cause to believe that an elderly person or a person with a disability, other than an individual [~~a person with a disability~~] receiving services from a provider as described by Subchapter F [~~Section 48.252~~], has been abused, neglected, or exploited in a facility operated, licensed, certified, or registered by a state agency, the person shall report the information to the state agency that operates, licenses, certifies,

or registers the facility for investigation by that agency.

SECTION 13. Section 48.103, Human Resources Code, is amended by amending Subsection (a), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, and adding Subsection (c) to read as follows:

(a) Except as otherwise provided by Subsection (c), on [~~On~~] determining after an investigation that an elderly person or a person with a disability has been abused, exploited, or neglected by an employee of a home and community support services agency licensed under Chapter 142, Health and Safety Code, the department shall:

(1) notify the state agency responsible for licensing the home and community support services agency of the department's determination;

(2) notify any health and human services agency, as defined by Section 531.001, Government Code, that contracts with the home and community support services agency for the delivery of health care services of the department's determination; and

(3) provide to the licensing state agency and any contracting health and human services agency access to the department's records or documents relating to the department's investigation.

(c) This section does not apply to an investigation of alleged or suspected abuse, neglect, or exploitation in which a provider, as defined by Section 48.251, is or may be alleged to have committed the abuse, neglect, or exploitation. An investigation described by this subsection is governed by Subchapter F.

SECTION 14. Section 48.151(e), Human Resources Code, is amended to read as follows:

(e) This section does not apply to investigations conducted under Subchapter F [~~or H~~].

SECTION 15. Section 48.201, Human Resources Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

Sec. 48.201. APPLICATION OF SUBCHAPTER. Except as otherwise provided, this subchapter does not apply to an investigation conducted under Subchapter F [~~or H~~].

SECTION 16. Subchapter F, Chapter 48, Human Resources Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

SUBCHAPTER F. INVESTIGATIONS OF ABUSE, NEGLECT, OR EXPLOITATION OF INDIVIDUALS RECEIVING SERVICES FROM CERTAIN PROVIDERS [~~IN CERTAIN FACILITIES, COMMUNITY CENTERS, AND LOCAL MENTAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES~~]

Sec. 48.251. DEFINITIONS. (a) In this subchapter:

(1) "Behavioral health services" means:

(A) mental health services, as defined by Section 531.002, Health and Safety Code; and

(B) interventions provided to treat chemical dependency, as defined by Section 461A.002, Health and Safety Code.

(2) "Community center" has the meaning assigned by Section 531.002, Health and Safety Code.

(3) "Facility" means:

(A) a facility listed in Section 532.001(b) or

532A.001(b), Health and Safety Code, including community services operated by the Department of State Health Services or Department of Aging and Disability Services, as described by those sections, or a person contracting with a health and human services agency to provide inpatient mental health services; and

(B) a facility licensed under Chapter 252, Health and Safety Code.

(4) "Health and human services agency" has the meaning assigned by Section 531.001, Government Code.

(5) "Home and community-based services" means services provided in the home or community in accordance with 42 U.S.C. Section 1315, 42 U.S.C. Section 1315a, 42 U.S.C. Section 1396a, or 42 U.S.C. Section 1396n, and as otherwise provided by department rule.

(6) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(7) "Local mental health authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(8) "Managed care organization" has the meaning assigned by Section 533.001, Government Code.

(9) "Provider" means:

(A) a facility;

(B) a community center, local mental health authority, and local intellectual and developmental disability authority;

(C) a person who contracts with a health and

human services agency or managed care organization to provide home and community-based services;

(D) a person who contracts with a Medicaid managed care organization to provide behavioral health services;

(E) a managed care organization;

(F) an officer, employee, agent, contractor, or subcontractor of a person or entity listed in Paragraphs (A)-(E); and

(G) an employee, fiscal agent, case manager, or service coordinator of an individual employer participating in the consumer-directed service option, as defined by Section 531.051, Government Code.

(b) The executive commissioner by rule shall adopt definitions of "abuse," "neglect," "exploitation," and "an individual receiving services" for purposes of this subchapter and [~~"exploitation" to govern~~] investigations conducted under this subchapter [~~and Subchapter H~~].

Sec. 48.252. INVESTIGATION OF REPORTS OF ABUSE, NEGLECT, OR EXPLOITATION BY PROVIDER [~~IN CERTAIN FACILITIES AND IN COMMUNITY CENTERS~~]. (a) The department shall receive and, except as provided by Subsection (b), shall investigate under this subchapter reports of the abuse, neglect, or exploitation of an individual [~~with a disability~~] receiving services if the person alleged or suspected to have committed the abuse, neglect, or exploitation is a provider[~~:~~

[~~(1) in:~~

[~~(A) a mental health facility operated by the~~

~~Department of State Health Services; or~~

[~~(B) a facility licensed under Chapter 252, Health and Safety Code;~~

[~~(2) in or from a community center, a local mental health authority, or a local intellectual and developmental disability authority; or~~

[~~(3) through a program providing services to that person by contract with a mental health facility operated by the Department of State Health Services, a community center, a local mental health authority, or a local intellectual and developmental disability authority~~].

(b) The department may not [~~shall receive and shall~~] investigate under this subchapter reports of [~~the~~] abuse, neglect, or exploitation alleged or suspected to have been committed by a provider that is operated, licensed, certified, or registered by a state agency that has authority under this chapter or other law to investigate reports of abuse, neglect, or exploitation of an individual by the provider. The department shall forward any report of abuse, neglect, or exploitation alleged or suspected to have been committed by a provider described by this subsection to the appropriate state agency for investigation [~~of an individual with a disability receiving services:~~

[~~(1) in a state supported living center or the ICF-IID component of the Rio Grande State Center; or~~

[~~(2) through a program providing services to that person by contract with a state supported living center or the ICF-IID component of the Rio Grande State Center~~].

(c) The department shall receive and investigate under this subchapter reports of abuse, neglect, or exploitation of an individual who lives in a residence that is owned, operated, or controlled by a provider who provides home and community-based services under the home and community-based services waiver program described by Section 534.001(11)(B), Government Code, regardless of whether the individual is receiving services under that waiver program from the provider. [~~The executive commissioner by rule shall define who is "an individual with a disability receiving services."~~

[~~(d) In this section, "community center," "local mental health authority," and "local intellectual and developmental disability authority" have the meanings assigned by Section 531.002, Health and Safety Code.~~]

Sec. 48.253. ACTION ON REPORT. (a) On receipt by the department of a report of alleged abuse, neglect, or exploitation under this subchapter, the department shall initiate a prompt and thorough investigation as needed to evaluate the accuracy of the report and to assess the need for emergency protective services, unless the department, in accordance with rules adopted under this subchapter, determines that the report:

(1) is frivolous or patently without a factual basis; or

(2) does not concern abuse, neglect, or exploitation.

(b) After receiving a report that alleges that a provider is or may be the person who committed the alleged abuse, neglect, or exploitation, the department shall notify the provider and the

appropriate health and human services agency in accordance with rules adopted by the executive commissioner.

(c) The provider identified under Subsection (b) shall:

(1) cooperate completely with an investigation conducted under this subchapter; and

(2) provide the department complete access during an investigation to:

(A) all sites owned, operated, or controlled by the provider; and

(B) clients and client records.

(d) The executive commissioner shall adopt rules governing investigations conducted under this subchapter.

Sec. 48.254. FORWARDING OF CERTAIN REPORTS. (a) The executive commissioner by rule shall establish procedures for the department to use to [~~In accordance with department rules, the department shall~~] forward a copy of the initial intake report and a copy of the completed provider investigation report relating to alleged or suspected abuse, neglect, or exploitation to the appropriate provider and health and human services agency [~~facility, community center, local mental health authority, local intellectual and developmental disability authority, or program providing mental health or intellectual disability services under contract with the facility, community center, or authority~~].

(b) The department shall redact from an initial intake report and from the copy of the completed provider investigation report any identifying information contained in the report relating to the person who reported the alleged or suspected abuse, neglect,

or exploitation under Section 48.051.

(c) A provider that receives a completed investigation report under Subsection (a) shall forward the report to the managed care organization with which the provider contracts for services for the alleged victim.

Sec. 48.255. RULES FOR INVESTIGATIONS UNDER THIS SUBCHAPTER. (a) The executive commissioner [~~department, the Department of Aging and Disability Services, and the Department of State Health Services~~] shall adopt [~~develop~~] rules to:

(1) prioritize investigations conducted under this subchapter with the primary criterion being whether there is a risk that a delay in the investigation will impede the collection of evidence in that investigation;

(2) [~~facilitate investigations in state mental health facilities and state supported living centers.~~

[~~(b) The executive commissioner by rule shall~~] establish procedures for resolving disagreements between the department and health and human services agencies [~~the Department of Aging and Disability Services or the Department of State Health Services~~] concerning the department's investigation findings; and

(3) provide for an appeals process by the department for the alleged victim of abuse, neglect, or exploitation.

(b) [~~(c) The department, the Department of Aging and Disability Services, and the Department of State Health Services shall develop and propose to the executive commissioner rules to facilitate investigations in community centers, local mental health authorities, and local intellectual and developmental~~

~~disability authorities.~~

[~~(c-1) The executive commissioner shall adopt rules regarding investigations in a facility licensed under Chapter 252, Health and Safety Code, to ensure that those investigations are as consistent as practicable with other investigations conducted under this subchapter.~~

[~~(d)~~] A confirmed investigation finding by the department may not be changed by the administrator [~~a superintendent~~] of a [~~state mental health~~] facility, [~~by a director of a state supported living center, by a director of~~] a community center, [~~or by~~] a local mental health authority, or a local intellectual and developmental disability authority.

[~~(e) The executive commissioner shall provide by rule for an appeals process by the alleged victim of abuse, neglect, or exploitation under this section.~~

[~~(f) The executive commissioner by rule may assign priorities to an investigation conducted by the department under this section. The primary criterion used by the executive commissioner in assigning a priority must be the risk that a delay in the investigation will impede the collection of evidence.~~]

Sec. 48.256. SHARING PROVIDER INFORMATION. (a) The executive commissioner shall adopt rules that prescribe the appropriate manner in which health and human services agencies and managed care organizations provide the department with information necessary to facilitate identification of individuals receiving services from providers and to facilitate notification of providers by the department.

(b) The executive commissioner shall adopt rules requiring a provider to provide information to the administering health and human services agency necessary to facilitate identification by the department of individuals receiving services from providers and to facilitate notification of providers by the department.

(c) A provider of home and community-based services under the home and community-based services waiver program described by Section 534.001(11)(B), Government Code, shall post in a conspicuous location inside any residence owned, operated, or controlled by the provider in which home and community-based waiver services are provided, a sign that states:

(1) the name, address, and telephone number of the provider;

(2) the effective date of the provider's contract with the applicable health and human services agency to provide home and community-based services; and

(3) the name of the legal entity that contracted with the applicable health and human services agency to provide those services.

Sec. 48.257. RETALIATION PROHIBITED. (a) A provider of home and community-based services may not retaliate against a person for filing a report or providing information in good faith relating to the possible abuse, neglect, or exploitation of an individual receiving services.

(b) This section does not prohibit a provider of home and community-based services from terminating an employee for a reason other than retaliation.

Sec. 48.258. [~~SINGLE~~] TRACKING SYSTEM FOR REPORTS AND INVESTIGATIONS. (a) The health and human services agencies [~~department, the Department of Aging and Disability Services, and the Department of State Health Services~~] shall, at the direction of the executive commissioner, jointly develop and implement a [~~single~~] system to track reports and investigations under this subchapter.

(b) To facilitate implementation of the system, the health and human services agencies [~~department, the Department of Aging and Disability Services, and the Department of State Health Services~~] shall use appropriate methods of measuring the number and outcome of reports and investigations under this subchapter.

SECTION 17. Section 48.301, Human Resources Code, is amended by amending Subsection (a), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, and adding Subsection (a-1) to read as follows:

(a) If the department receives a report of suspected abuse, neglect, or exploitation of an elderly person or a person with a disability[~~, other than a person with a disability who is~~] receiving services [~~as described by Section 48.252,~~] in a facility operated, licensed, certified, or registered by a state agency, the department shall refer the report to that agency.

(a-1) This subchapter does not apply to a report of suspected abuse, neglect, or exploitation of an individual receiving services from a provider as described by Subchapter F.

SECTION 18. Sections 48.401(1) and (3), Human Resources Code, are amended to read as follows:

(1) "Agency" means:

(A) an entity licensed under Chapter 142, Health and Safety Code;

(B) a person exempt from licensing under Section 142.003(a)(19), Health and Safety Code;

(C) a facility licensed under Chapter 252, Health and Safety Code; or

(D) a provider [~~an entity~~] investigated by the department under Subchapter F or under Section 261.404, Family Code.

(3) "Employee" means a person who:

(A) works for:

(i) an agency; or

(ii) an individual employer participating in the consumer-directed service option, as defined by Section 531.051, Government Code;

(B) provides personal care services, active treatment, or any other [~~personal~~] services to an individual receiving agency services, an individual who is a child for whom an investigation is authorized under Section 261.404, Family Code, or an individual receiving services through the consumer-directed service option, as defined by Section 531.051, Government Code; and

(C) is not licensed by the state to perform the services the person performs for the agency or the individual employer participating in the consumer-directed service option, as defined by Section 531.051, Government Code.

SECTION 19. The following are repealed:

(1) Section 261.404(f), Family Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015; and

(2) Subchapter H, Chapter 48, Human Resources Code.

SECTION 20. (a) The Health and Human Services Commission, 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, shall require that the managed care organization comply with:

(1) Section 533.005(a), Government Code, as amended by this Act;

(2) the standards established under Section 533.0061(a), Government Code, as added by this Act; and

(3) Section 533.0063, Government Code, as added by this Act.

(b) The Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to require that those managed care organizations comply with the provisions specified in Subsection (a) of this section. To the extent of a conflict between those provisions and a provision of a contract with a managed care organization entered into before the effective date of this Act, the contract provision prevails.

SECTION 21. The Health and Human Services Commission shall submit to the legislature the initial report required under Section 533.0061(c), Government Code, as added by this Act, not later than December 1, 2016.

SECTION 22. 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 23. This Act takes effect September 1, 2015.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 760 passed the Senate on April 7, 2015, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendments on May 28, 2015, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 760 passed the House, with amendments, on May 22, 2015, by the following vote: Yeas 140, Nays 0, two present not voting.

Chief Clerk of the House

Approved:

Date

Governor