By: Hinojosa H.B. No. 602

A BILL TO BE ENTITLED

AN ACT

relating to the provision of comprehensive health care benefits coverage through a publicly funded program to be known as the Healthy Texas Program; authorizing a fee.

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

SECTION 1. Title 8, Insurance Code, is amended by adding Subtitle N to read as follows:

SUBTITLE N. HEALTHY TEXAS PROGRAM

CHAPTER 1698. HEALTHY TEXAS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1698.0001. DEFINITIONS. Unless the context indicates otherwise, in this chapter:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

(2) "Allied health practitioner":

(A) means a health care professional who:

(i) works to prevent disease transmission, or diagnose, treat, or rehabilitate individuals; and

(ii) delivers direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions; and

(B) includes technical and support staff, audiologists, occupational therapists, social workers, and

radiographers.

(3) "Board" means the Healthy Texas Board established under Section 1698.0051.

(4) "Care coordination" means the services described by Section 1698.0152.

(5) "Care coordinator" means a person approved by the board to provide care coordination.

(6) "Child health plan program" means the state children's health insurance program established under Title XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), or the programs established under Chapters 62 and 63, Health and Safety Code, as appropriate.

(7) "Essential community provider" means a person acting as a safety net clinic, safety net health care provider, or rural hospital.

(8) "Federally matched public health program" means:

(A) Medicaid; or

(B) the child health plan program.

(9) "Fund" means the healthy Texas fund established under Section 1698.0305.

(10) "Health benefit plan issuer" means an insurance company, health maintenance organization, or other entity regulated by the department and authorized to issue a health insurance policy or other health benefit plan. The term includes:

(A) a stock life, health, or accident insurance company;

(B) a mutual life, health, or accident insurance

company;

(C) a stock casualty insurance company;

(D) a mutual casualty insurance company;

(E) a Lloyd's plan;

(F) a reciprocal or interinsurance exchange;

(G) a fraternal benefit society;

(H) a stipulated premium company; and

(I) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842.

(11) "Health care organization" means a not-for-profit or public organization that is approved by the board to provide health care services to members under the program.

(12) "Health care provider" means a person that is licensed, certified, or otherwise authorized by the laws of this state to provide health care services in the ordinary course of business or practice of a profession.

(13) "Health care providers' representative" means a third party that is authorized by health care providers to negotiate on their behalf with the program related to terms and conditions affecting those health care providers.

(14) "Health care service" means any health care service, including care coordination, that is included as a benefit under the program.

(15) "Integrated health care delivery system" means a provider organization that is:

(A) fully integrated operationally and clinically to provide a broad range of health care services,

including preventive care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services; and

(B) compensated by the program using capitation or facility budgets for the provision of health care services.

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

(17) "Medicaid" means the medical assistance program established under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), or the medical assistance program established under Chapter 32, Human Resources Code, as appropriate.

(18) "Medicare" means the Health Insurance for the Aged and Disabled Act under Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.).

(19) "Member" means an individual who is enrolled in the program.

(20) "Out-of-state health care service":

(A) means a health care service that:

(i) is provided in person to a member while the member is physically located outside this state; and

(ii) is:

(a) medically necessary to be provided while the member is physically outside this state; or

(b) clinically appropriate and necessary and cannot be provided in this state because the health care service can be provided only by a particular health care

provider physically located outside this state; and

(B) does not include a health care service provided to a member by a health care provider qualified under Section 1698.0201 that is physically located outside this state.

(21) "Participating provider" means:

(A) a health care provider qualified under Section 1698.0201 that provides health care services to members under the program; or

(B) a health care organization.

(22) "Prescription drug" has the meaning assigned by Section 551.003, Occupations Code.

(23) "Program" means the Healthy Texas Program established under this chapter.

(24) "Resident" means an individual whose primary place of residence is located in this state without regard to the individual's immigration status.

Sec. 1698.0002. COVERAGE NOT EXCLUSIVE. This chapter does not preempt a political subdivision from adopting additional health care coverage that provides additional protections and benefits to residents in the political subdivision's jurisdiction.

Sec. 1698.0003. CONFLICT WITH OTHER LAW. (a) To the extent any provision of state law is inconsistent with this chapter, this chapter prevails, except as explicitly provided otherwise by this chapter.

(b) This chapter may not be construed to alter in any way the professional practice of health care providers or licensure standards established under Title 3, Occupations Code.

SUBCHAPTER B. HEALTHY TEXAS BOARD

Sec. 1698.0051. HEALTHY TEXAS BOARD. The Healthy Texas Board is an agency of this state.

Sec. 1698.0052. COMPOSITION OF BOARD. The board is composed of the following nine members:

(1) four appointed by the governor;

(2) two appointed by the lieutenant governor;

(3) two appointed by the speaker of the house of representatives; and

(4) the executive commissioner of the Health and Human Services Commission, or the executive commissioner's designee, who serves as a voting, ex officio member.

Sec. 1698.0053. TERM; VACANCY. (a) Board members other than an ex officio member shall be appointed for a term of two years.

(b) A vacancy must be filled for the unexpired term in the same manner as the original appointment.

Sec. 1698.0054. BOARD MEMBER QUALIFICATIONS. (a) Each board member must:

(1) be a resident; and

(2) have demonstrated and acknowledged expertise in health care.

(b) An individual may not be a board member unless the individual is a program member. This subsection does not apply to an ex officio member.

(c) Of the eight board members appointed by the governor, lieutenant governor, and speaker of the house of representatives:

(1) at least one board member must represent a labor organization representing registered nurses;

(2) at least one board member must represent the public;

(3) at least one board member must represent a labor organization; and

(4) at least one board member must represent the medical provider community.

(d) The governor, lieutenant governor, and speaker of the house of representatives shall consider:

(1) the expertise of each board member and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care; and

(2) the cultural, ethnic, and geographic diversity of this state and attempt to make appointments so that the board's composition reflects the communities of this state.

(e) Each board member shall:

(1) meet the requirements of this chapter, the Affordable Care Act, and all applicable state and federal laws and regulations;

(2) serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through the program; and

(3) ensure the operational well-being and fiscal solvency of the program.

Sec. 1698.0055. BOARD MEMBER COMPENSATION. A board member may not receive compensation but is entitled to reimbursement of

the travel expenses incurred by the board member while conducting board business, as provided in the General Appropriations Act.

Sec. 1698.0056. CONFLICT OF INTEREST. (a) A board member may not make, participate in making, or in any way attempt to make use of the board member's official position to influence the making of a decision the board member knows or has reason to know will have a material financial effect, distinguishable from its effect on the public generally, on:

(1) the board member or the board member's immediate family;

(2) a person or entity that was the source of a benefit aggregating $250 or more in value received by or promised to the board member within 12 months before the date the decision is made; or

(3) a business entity in which the board member is a director, officer, partner, trustee, or employee, or holds any management position.

(b) For purposes of Subsection (a), "benefit" has the meaning assigned by Section 36.01, Penal Code, but does not include:

(1) a gift; or

(2) a loan by a commercial lending institution in the regular course of business on terms available to the public.

(c) A board member, officer, or employee may not:

(1) be employed by, be a consultant to, be a member of the board of directors of, be affiliated with, or otherwise be a representative of a health care provider, a health care facility,

or a health clinic while serving as a board member, officer, or employee;

(2) be a member, a board member, or an employee of a trade association of health care facilities, health clinics, or health care providers while serving as a board member, officer, or employee; or

(3) be a health care provider unless the board member, officer, or employee receives no compensation for providing services as a health care provider and does not have an ownership interest in a health care practice.

Sec. 1698.0057. IMMUNITY. The following persons are not liable, and a cause of action does not arise against any of the following persons, for a good faith act or omission in exercising powers and performing duties under this chapter:

(1) the board;

(2) a board member; or

(3) a board officer or employee.

Sec. 1698.0058. BOARD ELECTION. The board annually shall elect a chairperson.

Sec. 1698.0059. EXECUTIVE DIRECTOR. The board shall hire an executive director to organize, administer, and manage the program and board operations. The executive director serves at the pleasure of the board.

Sec. 1698.0060. OPEN MEETINGS; OPEN RECORDS. The board is subject to Chapters 551 and 552, Government Code. The board may conduct a closed meeting to deliberate:

(1) business and financial issues relating to a

contract being negotiated; or

(2) rates to be paid under the program.

Sec. 1698.0061. RULES. (a) The board may adopt rules necessary to implement and enforce this chapter.

(b) The board by rule shall set fees in amounts reasonable and necessary to implement this chapter.

(c) The board by rule shall establish dispute resolution procedures to address member disputes. Dispute resolution procedures must:

(1) include a patient advocate to assist members in the dispute resolution process; and

(2) provide for a member to withdraw from the program.

(d) The board may adopt narrowly focused rules relating solely to health care organizations for the specific purpose of ensuring consistent compliance with this chapter.

Sec. 1698.0062. ADVISORY COMMITTEE. (a) The executive commissioner of the Health and Human Services Commission shall establish an advisory committee to advise the board on all policy matters for the program.

(b) The advisory committee is composed of 22 members appointed by the governor, lieutenant governor, or speaker of the house of representatives as follows:

(1) the governor shall appoint:

(A) one board-certified physician;

(B) one dentist;

(C) one representative of private hospitals;

(D) one representative of public hospitals;

(E) one representative of an integrated health care delivery system;

(F) two consumers of health care, one of whom is a person with a disability; and

(G) one representative of a business that employs fewer than 25 people;

(2) the lieutenant governor shall appoint:

(A) one board-certified physician;

(B) two registered nurses;

(C) one mental health care provider;

(D) one consumer of health care who is at least 65 years of age;

(E) one representative of essential community providers; and

(F) one representative of organized labor; and

(3) the speaker of the house of representatives shall appoint:

(A) two board-certified physicians, both of whom must be primary care providers;

(B) one allied health practitioner who holds a license to practice a health care profession;

(C) one pharmacist;

(D) one consumer of health care;

(E) one representative of organized labor; and

(F) one representative of a business that employs more than 250 people.

(c) Of the board-certified physicians appointed under

Subsections (b)(1)(A), (b)(2)(A), and (b)(3)(A), at least one must be a psychiatrist.

(d) In making appointments under this section, the governor, lieutenant governor, and speaker of the house of representatives shall attempt to reflect the geographic and economic diversity of this state. Appointments to the advisory committee shall be made without regard to the race, color, sex, religion, age, or national origin of the appointees.

(e) An advisory committee member serves a four-year term and may be reappointed.

(f) The executive commissioner of the Health and Human Services Commission shall notify the appropriate appointing authority of any expected vacancies on the advisory committee. If a vacancy occurs on the committee, the appropriate appointing authority shall appoint a successor, in the same manner as the original appointment, to serve for the remainder of the unexpired term. The appropriate appointing authority shall appoint the successor not later than the 30th day after the date the vacancy occurs.

(g) An advisory committee member:

(1) may not receive compensation for serving on the committee;

(2) is entitled to reimbursement for travel expenses incurred by the committee member while conducting committee business; and

(3) is entitled to the per diem provided by the General Appropriations Act for attending committee meetings.

(h) The advisory committee shall meet at least six times per year in a place convenient to the public.

(i) The advisory committee is subject to Chapters 551 and 552, Government Code.

(j) The advisory committee shall elect a chairperson who shall serve for two years and may be reelected for an additional two years.

(k) To be eligible for appointment to the advisory committee, an individual must have worked in the field the individual represents on the committee for a period of at least two years before being appointed to the committee.

(l) An advisory committee member or individual working with or for a committee member may not use for personal benefit any information that is filed with or obtained by the committee and that is not generally available to the public.

(m) The board shall provide administrative support, including staff, for the advisory committee.

(n) The advisory committee is not subject to Chapter 2110, Government Code.

Sec. 1698.0063. POWERS AND DUTIES OF BOARD; HEALTHY TEXAS PROGRAM. (a) The board has all the powers and duties necessary to establish and implement the program.

(b) The board shall, to the extent possible, organize, administer, and market the program and services as a comprehensive universal single-payer program under the name "Healthy Texas Program" or any other name the board adopts. The program shall be administered regardless of the law or source in which the

definition of a benefit is found, including, subject to the election of the retiree, retiree health benefits.

(c) In implementing this chapter, the board shall avoid jeopardizing federal financial participation in the federally supported programs that are incorporated into the program.

(d) The board shall promote public understanding and awareness of available benefits and programs.

(e) The board may consider any matter necessary to implement this chapter and the purposes of this chapter. The board does not have any executive, administrative, or appointive duties except as provided by this chapter or other law.

(f) The board shall employ necessary staff and authorize reasonable expenditures, as necessary, from the fund to pay program expenses and to administer the program.

(g) The board may:

(1) sue and be sued;

(2) receive and accept gifts, grants, or donations of money from any agency of the federal government, any agency of this state, or any municipality, county, or other political subdivision of this state;

(3) receive and accept gifts, grants, or donations from individuals, associations, private foundations, or corporations, in compliance with the conflict-of-interest provisions adopted by board rule; and

(4) share information with relevant state governmental entities, in a manner that is consistent with the confidentiality provisions in this chapter, necessary for

administering the program.

Sec. 1698.0064. CONTRACTS. (a) The board may enter into any necessary contracts, including contracts with health care providers, integrated health care delivery systems, and care coordinators.

(b) The board may contract with a not-for-profit organization to provide assistance to:

(1) consumers with respect to selecting a care coordinator or health care organization, enrolling to obtain services available through the program, obtaining health care services, withdrawing from the program or from an aspect of the program, and other matters relating to the program; or

(2) health care providers providing, seeking, or considering whether to provide health care services under the program with respect to participating in a health care organization and interacting with a health care organization.

Sec. 1698.0065. DATA TRANSPARENCY. (a) To promote transparency, assess adherence to patient care standards, compare patient outcomes, and review use of health care services paid for by the program, the board shall provide for the collection and availability of:

(1) inpatient discharge data, including acuity and risk of mortality;

(2) emergency department and ambulatory surgery data, including charge data, length of stay, and patients' unit of observation; and

(3) hospital annual financial data, including:

(A) community benefits by hospital in dollar value;

(B) number and classification of employees by hospital unit;

(C) number of hours worked by hospital unit;

(D) employee wage information by job title and hospital unit;

(E) number of registered nurses per staffed bed by hospital unit;

(F) type and value of health information technology; and

(G) annual spending on health information technology, including purchases, upgrades, and maintenance.

(b) The board shall make all disclosed data collected under Subsection (a) publicly available and searchable on an Internet website established and maintained by the Health and Human Services Commission.

(c) The board shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the program to promote and protect public, environmental, and occupational health, including cooperation with other data collection and research programs of the Department of State Health Services and the Health and Human Services Commission, consistent with this chapter and other applicable law.

Sec. 1698.0066. DISCLOSURE OF PERSONALLY IDENTIFIABLE INFORMATION. (a) Notwithstanding any other law, the board, the program, a state or local agency, or a public employee acting under

color of law may not provide or disclose to anyone, including the federal government, any personally identifiable information obtained under this chapter, including an individual's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status for law enforcement or immigration purposes.

(b) Notwithstanding any other law, a law enforcement agency may not use the money, facilities, property, equipment, or personnel of the board or the program to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

SUBCHAPTER C. ELIGIBILITY AND ENROLLMENT

Sec. 1698.0101. ELIGIBILITY AND ENROLLMENT. (a) Every resident is eligible and entitled to enroll as a member.

(b) A member may not be required to pay:

(1) any fee, payment, or other charge for enrolling in the program or being a member; or

(2) any premium, copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits.

(c) A college, university, or other institution of higher education in this state may purchase coverage under the program for a student, or a student's dependent, who is not a resident.

SUBCHAPTER D. BENEFITS

Sec. 1698.0151. BENEFITS. (a) Covered health care benefits under the program include all health care services

determined to be clinically appropriate by a member's health care provider.

(b) Covered health care benefits for a member include:

(1) inpatient and outpatient health care services and health facility services;

(2) inpatient and outpatient professional health care provider health care services;

(3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(4) medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for individual use;

(5) inpatient and outpatient rehabilitative care;

(6) emergency care services;

(7) emergency transportation;

(8) necessary transportation for health care services for an individual with a disability or who may qualify as low income;

(9) child and adult immunizations and preventive care;

(10) health and wellness education;

(11) hospice care;

(12) care in a skilled nursing facility;

(13) home health care, including health care provided in an assisted living facility;

(14) mental health services;

(15) substance abuse treatment;

(16) dental care;

(17) vision care;

(18) prescription drugs;

(19) pediatric care;

(20) prenatal and postnatal care;

(21) podiatric care;

(22) chiropractic care;

(23) acupuncture;

(24) therapies that are shown by the National Center for Complementary and Integrative Health of the National Institutes of Health to be safe and effective;

(25) blood and blood products;

(26) dialysis;

(27) adult day care;

(28) rehabilitative and habilitative services;

(29) ancillary health care or social services covered by a local health care system before the effective date of the program;

(30) ancillary health care or social services covered by a community center for persons with developmental disabilities under Chapter 534, Health and Safety Code, before the effective date of the program;

(31) case management and care coordination;

(32) language interpretation and translation for health care services, including sign language, Braille, or other services needed for individuals with communication barriers; and

(33) health care and long-term supportive services

covered under Medicaid or the child health plan program before the effective date of the program.

(c) Covered health care benefits for a member also include all health care services required to be covered under any of the following programs or by the following providers, without regard to whether the member would otherwise be eligible for or covered by the program or source listed:

(1) the child health plan program;

(2) Medicaid;

(3) Medicare;

(4) a health benefit plan issuer under this code;

(5) any additional health care service authorized to be added to the program's benefits by the board; and

(6) all essential health benefits mandated by the Affordable Care Act.

Sec. 1698.0152. BENEFITS OFFERED BY HEALTH BENEFIT PLAN ISSUER. (a) Except as provided by Subsection (b), a health benefit plan issuer may not offer benefits or cover any services for which coverage is offered to members but may, if otherwise authorized, offer benefits to cover health care services that are not offered to members.

(b) This chapter does not prohibit a health benefit plan issuer from offering benefits to or for individuals, including their families, who are employed or self-employed in this state but who are not residents.

SUBCHAPTER E. DELIVERY OF CARE

Sec. 1698.0201. HEALTH CARE PROVIDERS. (a) A health care

provider may participate in the program to perform health care services in this state.

(b) The board shall establish and maintain procedures and standards for recognizing health care providers physically located outside this state to provide coverage under the program for members who require out-of-state health care services while temporarily located outside this state.

(c) A participating provider may provide covered health care services under the program that the provider is authorized to perform for the member under the applicable circumstances.

(d) A member may choose to receive health care services under the program from any participating provider, consistent with:

(1) this chapter;

(2) the willingness or availability of the provider, subject to provisions of this chapter relating to discrimination; and

(3) the applicable clinically relevant circumstances.

(e) Subject to Subsection (f), a member who chooses to enroll with an integrated health care delivery system, group medical practice, or essential community provider that offers comprehensive services must retain membership with the system, practice, or provider until the first anniversary of the date an initial 90-day evaluation period expires. The member may withdraw from the system, practice, or provider for any reason during the evaluation period. The initial 90-day evaluation period begins on the date the member first receives health care services from a primary care provider.

(f) A member who wants to withdraw after the initial 90-day evaluation period must request a withdrawal under the dispute resolution procedures established by the board and may request assistance from the patient advocate in resolving the dispute. The dispute must be resolved in a timely manner and may not have an adverse effect on the care the member receives.

Sec. 1698.0202. CARE COORDINATION. (a) A member's care coordinator shall provide care coordination to the member. A care coordinator may employ or use the services of other individuals or entities to assist in providing care coordination for the member consistent with board rules, statutory requirements, and applicable occupational regulations.

(b) Care coordination includes administrative tracking and medical recordkeeping services for members, except as otherwise specified for integrated health care delivery systems.

(c) Care coordination administrative tracking and medical recordkeeping services for members may not be required to use a certified electronic health record, meet any other requirements of the Health Information Technology for Economic and Clinical Health Act, enacted under the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5), or meet certification requirements of the Centers for Medicare and Medicaid Services' electronic health record incentive programs, including meaningful use requirements.

(d) A referral from a care coordinator is not required for a member to see an eligible provider.

Sec. 1698.0203. CARE COORDINATORS. (a) A care coordinator shall comply with all federal and state privacy laws, including:

(1) the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) and regulations adopted under that Act;

(2) state law relating to the confidentiality of medical information, including Chapter 181, Health and Safety Code;

(3) Subtitle D, Title 5; and

(4) Title 11, Business & Commerce Code.

(b) A care coordinator may be an individual or entity approved by the program that is:

(1) a health care practitioner who is:

(A) the member's primary care provider;

(B) the member's provider of primary gynecological care; or

(C) at the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment to the member for that condition;

(2) an entity that is:

(A) a health facility;

(B) a health maintenance organization;

(C) a nursing facility or assisted living facility under Chapter 242 or 247, Health and Safety Code, or a program for long-term care services coverage developed by the board;

(D) a county medical facility;

(E) a residential care facility for individuals with chronic, life-threatening illness;

(F) an Alzheimer's day care resource center;

(G) a residential care facility for the elderly;

(H) a home health agency;

(I) a private duty nursing agency;

(J) a hospice;

(K) a pediatric day health and respite care facility;

(L) a home care service; or

(M) a mental health care provider;

(3) a health care organization;

(4) a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employer that is authorized under 29 U.S.C. Section 157; or

(5) a not-for-profit or governmental entity approved by the program.

(c) Subsection (b)(4) does not preclude a trust described by Subsection (b)(4) from becoming a care coordinator under Subsection (b)(5) or a health care organization under Section 1698.0208.

(d) To maintain approval as a care coordinator under the program, a care coordinator must:

(1) renew its license every three years as prescribed by board rule; and

(2) provide to the program any data required by the Department of State Health Services under Chapter 108, Health and Safety Code, that would enable the board to evaluate the impact of

care coordinators on quality, outcomes, and cost of health care.

(e) An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

Sec. 1698.0204. ENROLLMENT WITH CARE COORDINATOR. (a) Before receiving health care services to be paid for under the program, a member must be encouraged to enroll with a care coordinator that agrees to provide care coordination. If a member receives health care services before choosing a care coordinator, the program shall assist the member, when appropriate, with choosing a care coordinator. The member must remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member.

(b) A member may change care coordinators on terms at least as permissive as those under Medicaid relating to an individual changing primary care providers or managed care organizations.

(c) A health care provider may be reimbursed for services only if the member is enrolled with a care coordinator at the time the health care service is provided.

(d) A health care organization may establish rules relating to care coordination for its members that are different from this subchapter but otherwise consistent with this chapter and other applicable laws.

Sec. 1698.0205. PROCEDURES AND STANDARDS FOR CARE COORDINATION. (a) The board by rule shall develop and implement procedures and standards for an individual or entity to be approved

as a care coordinator in the program, including procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity:

(1) is incompetent to be a care coordinator;

(2) has exhibited a course of conduct that is inconsistent with program standards and rules;

(3) exhibits an unwillingness to comply with program standards and rules; or

(4) is a potential threat to the public health or safety.

(b) The procedures and standards adopted by the board must be consistent with professional practice, licensure standards, and rules established under the Government Code, Health and Safety Code, Human Resources Code, Insurance Code, and Occupations Code, as applicable.

(c) In developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the board shall consult with the Health and Human Services Commission.

Sec. 1698.0206. OCCUPATIONAL LAWS NOT AFFECTED. Nothing in Section 1698.0202, 1698.0203, 1698.0204, or 1698.0205 authorizes an individual to engage in any act in violation of Title 3, Occupations Code.

Sec. 1698.0207. PAYMENT FOR HEALTH CARE SERVICES AND CARE COORDINATION. (a) The board shall adopt rules related to contracting and establishing payment methodologies for covered

health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. A variety of different payment methodologies may be used, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services.

(b) Health care services provided to a member under the program, except for care coordination, must be paid for on a fee-for-service basis unless the board establishes another payment methodology.

(c) Notwithstanding Subsection (b), integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated system operating budget or a noncapitated system operating budget that covers all costs of providing health care services.

(d) The program shall engage in good faith negotiations with health care providers' representatives under Subchapter H, including in relation to rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies. Those negotiations shall be through a single entity on behalf of the entire program for prescription and nonprescription drugs.

(e) Payment for health care services established under this chapter is considered payment in full. A participating provider may

not charge a rate in excess of the payment established under this chapter for any health care service provided to a member under the program and may not solicit or accept payment from any member or third party for any health care service, except as provided under a federal program. This section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(f) The board by rule may adopt payment methodologies for the payment of capital-related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities that are health facilities under Subtitle B, Title 4, Health and Safety Code. Any capital-related expense generated by a capital expenditure that requires prior approval must have received that approval before being paid by the program. The approval must be based on achievement of the program standards described by Subchapter F.

(g) Payment methodologies and payment rates must include a distinct component of reimbursement for direct and indirect graduate medical education.

(h) The board by rule shall adopt payment methodologies and procedures for paying for health care services provided to a member while the member is located outside this state.

Sec. 1698.0208. HEALTH CARE ORGANIZATIONS. (a) A member may choose to enroll with and receive program care coordination and ancillary health care services from a health care organization.

(b) The health care organization must be a not-for-profit or governmental entity that is approved by the board and is:

(1) a local health care system; or

(2) a community center for persons with developmental disabilities under Chapter 534, Health and Safety Code.

(c) To maintain approval under the program, a health care organization must:

(1) renew the approval as frequently as prescribed by board rule; and

(2) provide to the program any data required by the Department of State Health Services under Chapter 108, Health and Safety Code, that would enable the board to evaluate the impact of health care organizations on quality outcomes and cost of health care.

Sec. 1698.0209. PROCEDURES AND STANDARDS FOR HEALTH CARE ORGANIZATIONS. (a) The board by rule shall develop and implement procedures and standards for an entity to be approved as a health care organization in the program, including procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity:

(1) is incompetent to be a health care organization;

(2) has exhibited a course of conduct that is inconsistent with program standards and rules;

(3) exhibits an unwillingness to comply with program standards and rules; or

(4) is a potential threat to the public health or safety.

(b) The procedures and standards adopted by the board must be consistent with professional practice, licensure standards, and

rules established under the Government Code, Health and Safety Code, Human Resources Code, Insurance Code, and Occupations Code, as applicable.

(c) In developing and implementing standards of approval of health care organizations, the board shall consult with the Health and Human Services Commission.

Sec. 1698.0210. BEST INTEREST OF PATIENT. A health care organization may not use health information technology or clinical practice guidelines that limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

SUBCHAPTER F. PROGRAM STANDARDS

Sec. 1698.0251. PROGRAM STANDARDS. (a) The board by rule shall establish requirements and standards for the program and for health care organizations, care coordinators, and health care providers, consistent with this chapter and applicable professional practice, licensure standards, and rules of health care providers and health care professionals established under the Government Code, Health and Safety Code, Human Resources Code, Insurance Code, and Occupations Code, including requirements and standards related to:

(1) the scope, quality, and accessibility of health care services;

(2) relations between health care organizations or

health care providers and members; and

(3) relations between health care organizations and health care providers, including credentialing and participation in the health care organization, and terms, methods, and rates of payment.

(b) The board by rule shall establish requirements and standards under the program that include provisions to promote:

(1) simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable;

(2) in-person primary and preventive care, care coordination, efficient and effective health care services, quality assurance, and promotion of public, environmental, and occupational health;

(3) elimination of health care disparities;

(4) nondiscrimination with respect to members and health care providers on the basis of race, color, ancestry, national origin, religion, citizenship, immigration status, primary language, mental or physical disability, age, sex, gender, sexual orientation, gender identity or expression, medical condition, genetic information, marital status, familial status, military or veteran status, or source of income;

(5) accessibility of care coordination, health care organization services, and health care services, including accessibility for people with disabilities and people with limited

ability to speak or understand English; and

(6) the provision of care coordination, health care organization services, and health care services in a culturally competent manner.

(c) Notwithstanding Subsection (b)(4), health care services provided under the program must be appropriate to the member's clinically relevant circumstances.

(d) The board by rule shall establish requirements and standards, to the extent authorized by federal law, for replacing and merging with the program health care services and ancillary services currently provided by other programs, including:

(1) Medicare;

(2) the Affordable Care Act; and

(3) other federally matched public health programs.

Sec. 1698.0252. EQUAL REQUIREMENTS AND STANDARDS. Any participating provider or care coordinator that is organized as a for-profit entity shall meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program paid to for-profit entities may not be calculated to accommodate the generation of profit, revenue for dividends, or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

Sec. 1698.0253. INFORMATION REQUIRED. Each participating provider shall furnish information as required by the Department of State Health Services under Chapter 108, Health and Safety Code, and permit examination of that information by the program as may be reasonably required for purposes of reviewing accessibility and use

of health care services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental, and occupational health.

Sec. 1698.0254. CONSULTATION ON POLICY DETERMINATIONS. In developing requirements and standards and making other policy determinations under this subchapter, the board shall consult with representatives of members, health care providers, care coordinators, health care organizations, labor organizations representing health care employees, and other interested parties.

SUBCHAPTER G. FUNDING

Sec. 1698.0301. FEDERAL HEALTH PROGRAMS AND FUNDING GENERALLY. (a) The board shall seek any federal waiver or other federal approval and arrangement and submit each state plan amendment necessary to operate the program.

(b) The board shall apply to the United States secretary of health and human services or other appropriate federal official for any waiver of a requirement and make any other arrangement under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal program that provides federal money for payment for health care services necessary so that:

(1) each member receives all benefits under the program through the program;

(2) the state may implement this chapter; and

(3) the state receives all federal payments under the applicable program, including money that may be provided in lieu of

premium tax credits, cost-sharing subsidies, and small business tax credits.

(c) The state shall deposit money received under Subsection (b)(3) in the state treasury to the credit of the fund and shall use that money for the program and to implement this chapter.

(d) To the extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to the program in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs.

(e) The board may require members or applicants to provide information necessary for the program to comply with any waiver or arrangement under this chapter. Information provided by a member to the board for the purposes of this subsection may not be used for any other purpose.

(f) The board may take any additional actions necessary to effectively fund implementation of the program to the extent possible as a single-payer program consistent with this chapter.

Sec. 1698.0302. ADMINISTRATION OF MEDICARE AND FEDERALLY MATCHED PUBLIC HEALTH PROGRAMS. (a) The board may take actions consistent with this subchapter to enable the program to administer Medicare in this state, and the program shall be a provider of Medicare Part B supplemental insurance coverage and shall provide premium assistance drug coverage under Medicare Part D for eligible members of the program.

(b) The board may waive or modify the applicability of any provision of this subchapter relating to any federally matched

public health program or Medicare, as necessary, to implement any waiver or arrangement under this subchapter or to maximize the federal benefits to the program under this subchapter, provided that the board, in consultation with the comptroller, determines that the waiver or modification is in the best interest of the state and members affected by the action.

(c) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare may not cause any member to lose any health care service provided by the federal program or Medicare or diminish any right the member would otherwise have.

(d) Notwithstanding Subsection (c) or any other law, the board by rule shall increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act. The board may act under this subsection on a finding approved by the comptroller and the board that the action:

(1) will help increase the number of members who are:

(A) eligible for and enrolled in federally matched public health programs; or

(B) eligible for any program to reduce or

eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act;

(2) will not diminish any individual's access to any health care service or right the individual would otherwise have;

(3) is in the interest of the program; and

(4) does not require or has already received any required federal waiver or approval to ensure federal financial participation.

(e) Any action taken under Subsection (d) may not apply to eligibility for payment for long-term care services.

(f) To enable the board to apply for coverage for and enroll any eligible member under any federally matched public health program or Medicare, the board may require that each member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(g) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare must enroll in Medicare, including Parts A, B, and D.

Sec. 1698.0303. PREMIUM ASSISTANCE AND SUBSIDIES FOR MEDICARE PART D. (a) The program shall provide premium assistance for each member enrolling in a Medicare Part D drug coverage plan under 42 U.S.C. Section 1395w-101 et seq., limited to the low-income benchmark premium amount established by the Centers for Medicare and Medicaid Services and any other amount the federal

agency establishes under its de minimis premium policy, except that those payments made on behalf of a member enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(b) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under 42 U.S.C. Section 1395w-114, the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member's eligibility for that subsidy. Before requesting information or documentation from a member under this subsection, the board shall attempt to obtain as much of the information and documentation as possible from records that are available to the board.

Sec. 1698.0304. PROGRAM AND BOARD DUTIES. (a) The program shall make a reasonable effort to notify each member of the member's obligations under this subchapter. After a reasonable effort has been made to contact the member, the program shall notify the member in writing that the member has 60 days to provide the required information. If the member does not provide the required information within the 60-day period, the program may terminate the member's coverage under the program. Information provided by a member to the board for the purposes of this subchapter may not be used for any other purpose.

(b) The board shall assume responsibility for all benefits and services paid for by the federal government with that money.

Sec. 1698.0305. FUND; ADMINISTRATION. (a) The healthy Texas fund is a special fund in the state treasury outside the

general revenue fund.

(b) In conjunction with the enactment of the General Appropriations Act, the legislature shall develop a revenue plan, taking into consideration anticipated federal revenue available for the program, and appropriate money for the program as necessary. In developing the revenue plan, members of the legislature shall consult with appropriate officials and stakeholders.

(c) Notwithstanding any other law, money in the fund may not be loaned to or borrowed by any other special fund or the general revenue fund.

(d) The board shall establish and maintain a prudent reserve in the fund.

(e) The board or staff of the board may not use any money intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(f) Notwithstanding any other law, all interest earned on the money that has been deposited into the fund is retained in the fund and used for purposes consistent with the fund.

(g) The fund consists of:

(1) federal payments received as a result of any waiver of requirements granted or other arrangement agreed to by the United States secretary of health and human services or other appropriate federal official for health care programs established under Medicare, any federally matched public health program, or the

Affordable Care Act;

(2) amounts paid by the Health and Human Services Commission that are equivalent to the amounts that are paid on behalf of residents under Medicare, any federally matched public health program, or the Affordable Care Act for health benefits that are equivalent to health benefits covered under the program;

(3) federal and state money for purposes of the provision of services authorized under Title XX of the Social Security Act (42 U.S.C. Section 1397 et seq.) that would otherwise be covered under the program; and

(4) state money that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care services for services and benefits covered under the program.

(h) Money in the fund may be used only for the purposes established in this chapter.

SUBCHAPTER H. COLLECTIVE NEGOTIATION AND BARGAINING

Sec. 1698.0351. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to a health care provider that is:

(1) an individual who practices that profession as a health care provider or as an independent contractor;

(2) an owner, officer, shareholder, or proprietor of a health care provider; or

(3) an entity that employs or uses health care providers to provide health care services, including a health facility licensed under the Health and Safety Code.

(b) A health care provider licensed or otherwise certified

under Title 3, Occupations Code, who practices as an employee of a health care provider is not a health care provider for purposes of this subchapter.

Sec. 1698.0352. COLLECTIVE NEGOTIATION AUTHORIZED. (a) Health care providers may meet and communicate for the purpose of collectively negotiating with the program on any matter relating to the program, including rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies.

(b) This subchapter may not be construed to allow or authorize:

(1) an alteration of the terms of the internal and external review procedures prescribed by law;

(2) a strike of the program by health care providers related to the collective negotiations; or

(3) terms or conditions that would impede the ability of the program to obtain or retain accreditation by the National Committee for Quality Assurance or a similar body, or to comply with applicable state or federal law.

Sec. 1698.0353. COLLECTIVE NEGOTIATION. (a) Collective negotiation rights granted by this subchapter must provide that:

(1) a health care provider may communicate with other health care providers regarding the terms and conditions to be negotiated with the program;

(2) a health care provider may communicate with a health care providers' representative;

(3) a health care providers' representative is the

only party authorized to negotiate with the program on behalf of the health care providers as a group;

(4) a health care provider may be bound by the terms and conditions negotiated by the health care providers' representative; and

(5) in communicating or negotiating with the health care providers' representative, the program is entitled to offer and provide different terms and conditions to individual competing health care providers.

(b) This subchapter does not affect or limit:

(1) the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law or board rule; or

(2) collective action or collective bargaining on the part of a health care provider with that health care provider's employer or any other lawful collective action or collective bargaining.

Sec. 1698.0354. DUTIES OF HEALTH CARE PROVIDERS' REPRESENTATIVE. (a) Before engaging in collective negotiations with the program on behalf of health care providers, a health care providers' representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this subchapter.

(b) Each person who acts as the representative of a negotiating party under this subchapter shall pay a fee, as adopted

by board rule, to the board to act as a representative.

Sec. 1698.0355. PROHIBITED COLLECTIVE ACTION. (a) This subchapter does not authorize competing health care providers to act in concert in response to a health care providers' representative's discussions or negotiations with the program, except as authorized by other law.

(b) A health care providers' representative may not negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

SECTION 2. Not later than two years after the effective date of this Act, the Healthy Texas Board created by this Act shall:

(1) in consultation with an advisory committee appointed by the chairperson of the board, including representatives of consumers and potential consumers of long-term care services, providers of long-term care services, members of organized labor, and other interested parties, develop a proposal consistent with the principles of Chapter 1698, Insurance Code, as added by this Act, for providing and funding long-term care services coverage by the Healthy Texas Program;

(2) develop a proposal for accommodating employer retiree health benefits for people who have been members of the Healthy Texas Program but live as retirees outside this state;

(3) develop a proposal for accommodating employer

retiree health benefits for people who earned or accrued those benefits while residing in this state before the implementation of the Healthy Texas Program and live as retirees outside this state; and

(4) develop a proposal for Healthy Texas Program coverage of health care services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

SECTION 3. (a) The Healthy Texas Board created by this Act shall determine when individuals may begin enrolling in the Healthy Texas Program. An implementation period begins on the date that individuals may begin enrolling in the program and ends on a date determined by the board. During the implementation period, the Healthy Texas Program is subject to special eligibility and financing provisions determined by the board until the program is fully implemented.

(b) This Act does not prohibit a health benefit plan issuer from offering any benefits during the implementation period to individuals who enrolled or may enroll as members of the Healthy Texas Program.

(c) Before full implementation of the Healthy Texas Program, the Healthy Texas Board shall provide for the collection and availability of data on the number of patients served by hospitals and the dollar value of the care provided, at cost, for the following categories:

(1) patients receiving charity care;

(2) contractual adjustments of county and indigent programs, including traditional and managed care; and

(3) bad debts.

(d) Notwithstanding Section 1698.0054(b), Insurance Code, as added by this Act, a Healthy Texas Board member is not required to enroll as a member of the Healthy Texas Program until the implementation period has ended.

SECTION 4. The Healthy Texas Board created by this Act shall provide money from the healthy Texas fund established by Section 1698.0305, Insurance Code, as added by this Act, or from funds otherwise appropriated for this purpose to the Texas Workforce Commission for a program for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care or those individuals providing services to health care providers to deal with third-party payers for health care, whose jobs may be ending or have ended as a result of the implementation of the Healthy Texas Program.

SECTION 5. (a) Notwithstanding any other law, Chapter 1698, Insurance Code, as added by this Act, may not be implemented until the date the executive commissioner of the Health and Human Services Commission notifies the secretary of the Texas Senate and the chief clerk of the Texas House of Representatives in writing that the executive commissioner has determined that the healthy Texas fund has the revenue to fund the costs of implementing Chapter 1698.

(b) The Health and Human Services Commission shall publish a

copy of the notice required by Subsection (a) of this section on the commission's Internet website.

SECTION 6. This Act takes effect September 1, 2021.