AN ACT

relating to the nonsubstantive revision of the health and human services laws governing the Health and Human Services Commission, Medicaid, and other social services.

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

ARTICLE 1. NONSUBSTANTIVE REVISION OF SUBTITLE I, TITLE 4, GOVERNMENT CODE

SECTION 1.01. Subtitle I, Title 4, Government Code, is amended by adding Chapters 521, 522, 523, 524, 525, 526, 532, 540, 540A, 542, 543, 543A, 544, 545, 546, 547, 547A, 548, 549, and 550 to read as follows:

CHAPTER 521. GENERAL PROVISIONS

Sec. 521.0001. DEFINITIONS

Sec. 521.0002. REFERENCES IN LAW MEANING COMMISSION OR COMMISSION DIVISION

Sec. 521.0003. REFERENCES IN LAW MEANING EXECUTIVE COMMISSIONER, EXECUTIVE COMMISSIONER'S DESIGNEE, OR DIVISION DIRECTOR

Sec. 521.0004. REFERENCES IN LAW TO PROVISIONS DERIVED FROM FORMER CHAPTER 531

CHAPTER 521. GENERAL PROVISIONS

Sec. 521.0001. DEFINITIONS. In this subtitle:

(1) "Child health plan program" means the programs

established under Chapters 62 and 63, Health and Safety Code.

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

(3) "Executive commissioner" means the executive commissioner of the commission.

(4) "Executive council" means the council established under Subchapter C, Chapter 523.

(5) "Health and human services agencies" includes the Department of State Health Services.

(6) "Health and human services system" means the system for providing or otherwise administering health and human services in this state by the commission, including through:

(A) an office or division of the commission; or

(B) another entity under the administrative and operational control of the executive commissioner.

(7) "Home telemonitoring service" means a health service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home and community support services agency or hospital, as those terms are defined by Section 548.0251.

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

(9) "Medicaid managed care organization" means a managed care organization as defined by Section 540.0001 that contracts with the commission under Chapter 540 or 540A to provide health care services to Medicaid recipients.

(10) "Platform" means the technology, system,

software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service, teledentistry dental service, or telehealth service.

(11) "Section 1915(c) waiver program" means a federally funded state Medicaid program authorized under Section 1915(c) of the Social Security Act (42 U.S.C. Section 1396n(c)).

(12) "Teledentistry dental service," "telehealth service," and "telemedicine medical service" have the meanings assigned by Section 111.001, Occupations Code. (Gov. Code, Secs. 531.001(1-a), (2), (3), (3-a), (4), (4-a), (4-b), (4-c), (4-d), (6), (6-a), (7), (8); New.)

Sec. 521.0002. REFERENCES IN LAW MEANING COMMISSION OR COMMISSION DIVISION. (a) This section applies notwithstanding Section 521.0001(5).

(b) A reference in any law to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, means the commission or the division of the commission performing the function previously performed by the state agency or entity before the transfer, as appropriate:

(1) health and human services agency;

(2) the Department of State Health Services;

(3) the Department of Aging and Disability Services;

(4) subject to Chapter 316 (H.B. 5), Acts of the 85th

Legislature, Regular Session, 2017, the Department of Family and Protective Services; or

(5) the Department of Assistive and Rehabilitative Services.

(c) Notwithstanding any other law, a reference in any law to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, from the state agency that assumed the relevant function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, means the commission or the division of the commission performing the function previously performed by the agency that assumed the function before the transfer, as appropriate:

(1) the Texas Department on Aging;

(2) the Texas Commission on Alcohol and Drug Abuse;

(3) the Texas Commission for the Blind;

(4) the Texas Commission for the Deaf and Hard of Hearing;

(5) the Texas Department of Health;

(6) the Texas Department of Human Services;

(7) the Texas Department of Mental Health and Mental Retardation;

(8) the Texas Rehabilitation Commission;

(9) the Texas Health Care Information Council; or

(10) the Interagency Council on Early Childhood Intervention.

(d) Notwithstanding any other law and subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, a reference in any law to the Department of Protective and Regulatory Services in relation to a function transferred under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, from the Department of Family and Protective Services means the commission or the division of the commission performing the function previously performed by the Department of Family and Protective Services before the transfer. (Gov. Code, Sec. 531.0011.)

Sec. 521.0003. REFERENCES IN LAW MEANING EXECUTIVE COMMISSIONER, EXECUTIVE COMMISSIONER'S DESIGNEE, OR DIVISION DIRECTOR. (a) A reference in any law to any of the following persons in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, means the executive commissioner, the executive commissioner's designee, or the director of the commission division performing the function previously performed by the state agency from which the function was transferred and that the person represented, as appropriate:

(1) the commissioner of aging and disability services;

(2) the commissioner of assistive and rehabilitative services;

(3) the commissioner of state health services; or

(4) subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, the commissioner of the

Department of Family and Protective Services.

(b) Notwithstanding any other law and subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, a reference in any law to any of the following persons or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as those sections existed immediately before their expiration on September 1, 2023, from the state agency that assumed or continued to perform the function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, means the executive commissioner or the director of the commission division performing the function performed before the enactment of Chapter 198 (H.B. 2292) by the state agency that was abolished or renamed by Chapter 198 (H.B. 2292) and that the person or entity represented:

(1) an executive director or other chief administrative officer of a state agency listed in Section 521.0002(c) or of the Department of Protective and Regulatory Services; or

(2) the governing body of a state agency listed in Section 521.0002(c) or of the Department of Protective and Regulatory Services.

(c) A reference to any of the following councils means the executive commissioner or the executive commissioner's designee, as appropriate, and a function of any of the following councils is a function of that appropriate person:

(1) the Health and Human Services Council;

(2) the Aging and Disability Services Council;

(3) the Assistive and Rehabilitative Services Council;

(4) subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, the Family and Protective Services Council; or

(5) the State Health Services Council. (Gov. Code, Sec. 531.0012.)

Sec. 521.0004. REFERENCES IN LAW TO PROVISIONS DERIVED FROM FORMER CHAPTER 531. A reference in any law to "revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025," is a reference to the following:

(1) Sections 532.0051, 532.0052, 532.0053, 532.0054, 532.0055, 532.0057, 532.0058, 532.0059, 532.0060, 532.0061, and 540.0051;

(2) Subchapters B, C, D, E, F, G, H, I, and J, Chapter 532, Subchapters A, B, C, D, E, F, G, H, and I, Chapter 548, and Subchapters D, D-1, and E, Chapter 550; and

(3) this chapter and Chapters 522, 523, 524, 525, 526, 544, 545, 546, 547, and 549. (New.)

CHAPTER 522. PROVISIONS APPLICABLE TO ALL HEALTH AND HUMAN SERVICES AGENCIES AND CERTAIN OTHER STATE ENTITIES

SUBCHAPTER A. FISCAL PROVISIONS

Sec. 522.0001. LEGISLATIVE APPROPRIATIONS REQUEST BY HEALTH AND HUMAN SERVICES AGENCY

Sec. 522.0002. ACCEPTANCE OF CERTAIN GIFTS AND GRANTS BY HEALTH AND HUMAN SERVICES AGENCY

CHAPTER 522. PROVISIONS APPLICABLE TO ALL HEALTH AND HUMAN SERVICES AGENCIES AND CERTAIN OTHER STATE ENTITIES

SUBCHAPTER A. FISCAL PROVISIONS

Sec. 522.0001. LEGISLATIVE APPROPRIATIONS REQUEST BY HEALTH AND HUMAN SERVICES AGENCY. (a) Each health and human services agency shall submit to the commission a biennial agency legislative appropriations request on a date determined by commission rule.

(b) A health and human services agency may not submit the agency's legislative appropriations request to the legislature or the governor until the commission reviews and comments on the request. (Gov. Code, Sec. 531.027.)

Sec. 522.0002. ACCEPTANCE OF CERTAIN GIFTS AND GRANTS BY HEALTH AND HUMAN SERVICES AGENCY. (a) Subject to the executive commissioner's written approval, a health and human services agency

may accept a gift or grant of money, drugs, equipment, or any other item of value from a pharmaceutical manufacturer, distributor, provider, or other entity engaged in a pharmaceutical-related business.

(b) Chapter 575 does not apply to a gift or grant under this section.

(c) The executive commissioner may adopt rules and procedures to implement this section. The rules must ensure that acceptance of a gift or grant under this section:

(1) is consistent with federal laws and regulations; and

(2) does not adversely affect federal financial participation in any state program, including Medicaid.

(d) This section does not affect the commission's or a health and human services agency's authority under other law to accept a gift or grant from a person other than a pharmaceutical manufacturer, distributor, provider, or other entity engaged in a pharmaceutical-related business. (Gov. Code, Sec. 531.0381.)

SUBCHAPTER B. CONTRACTS

Sec. 522.0051. NEGOTIATION AND REVIEW OF CERTAIN CONTRACTS FOR HEALTH CARE PURPOSES. (a) This section applies to a contract with a contract amount of $250 million or more:

(1) under which a person will provide goods or services in connection with the provision of medical or health care services, coverage, or benefits; and

(2) that will be entered into by the person and:

(A) the commission;

(B) a health and human services agency; or

(C) any other state agency under the commission's jurisdiction.

(b) An agency described by Subsection (a)(2) must notify the office of the attorney general at the time the agency initiates the planning phase of the contracting process for a contract described by Subsection (a). A representative of the office of the attorney general or another attorney advising the agency as provided by Subsection (d) may:

(1) participate in negotiations or discussions with proposed contractors; and

(2) be physically present during those negotiations or discussions.

(c) Notwithstanding any other law, before an agency described by Subsection (a)(2) may enter into a contract described by Subsection (a), a representative of the office of the attorney general shall review the form and terms of the contract and may make recommendations to the agency for changes to the contract if the attorney general determines that the office of the attorney general has sufficient subject matter expertise and resources available to provide this service.

(d) If the attorney general determines that the office of the attorney general does not have sufficient subject matter expertise or resources available to provide the services described by this section, the office of the attorney general may require the agency described by Subsection (a)(2) to enter into an interagency agreement or obtain outside legal services under Section 402.0212

for the provision of services described by this section.

(e) The agency described by Subsection (a)(2) shall provide to the office of the attorney general any information the office of the attorney general determines is necessary to administer this section. (Gov. Code, Sec. 531.018.)

Sec. 522.0052. PERFORMANCE STANDARDS FOR CONTRACTED SERVICES PROVIDED TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY. (a) This section does not apply to 2-1-1 services provided by the Texas Information and Referral Network.

(b) Each contract with the commission or a health and human services agency that requires the provision of call center services or written communications related to call center services must include performance standards that measure the effectiveness, promptness, and accuracy of the contractor's oral and written communications with individuals with limited English proficiency.

(c) A person who seeks to enter into a contract described by Subsection (b) must include in the bid or other applicable expression of interest for the contract a proposal for providing call center services or written communications related to call center services to individuals with limited English proficiency. The proposal must include a language access plan that describes how the contractor will:

(1) achieve any performance standards described in the request for bids or other applicable expressions of interest;

(2) identify individuals who need language assistance;

(3) provide language assistance measures, including

the translation of forms into languages other than English and the provision of translators and interpreters;

(4) inform individuals with limited English proficiency of the language services available to them and how to obtain those services;

(5) develop and implement qualifications for bilingual staff; and

(6) monitor compliance with the plan.

(d) In determining which bid or other applicable expression of interest offers the best value, the commission or a health and human services agency, as applicable, shall evaluate the extent to which the proposal for providing call center services or written communications related to call center services in languages other than English will provide meaningful access to the services for individuals with limited English proficiency.

(e) In determining the extent to which a proposal will provide meaningful access under Subsection (d), the commission or health and human services agency, as applicable, shall consider:

(1) the language access plan described by Subsection (c);

(2) the number or proportion of individuals with limited English proficiency in the commission's or agency's eligible service population;

(3) the frequency with which individuals with limited English proficiency seek information regarding the commission's or agency's programs;

(4) the importance of the services provided by the

commission's or agency's programs; and

(5) the resources available to the commission or agency.

(f) The commission or health and human services agency, as applicable, shall avoid selecting a contractor that the commission or agency reasonably believes will:

(1) provide information in languages other than English that is limited in scope;

(2) unreasonably delay the provision of information in languages other than English; or

(3) provide program information, including forms, notices, and correspondence, in English only. (Gov. Code, Sec. 531.0191.)

SUBCHAPTER C. DATA SHARING

Sec. 522.0101. SHARING OF DATA RELATED TO CERTAIN GENERAL REVENUE FUNDED PROGRAMS. To the extent permitted under federal law and notwithstanding any provision of Chapter 191 or 192, Health and Safety Code, the commission and other health and human services agencies shall share data to facilitate patient care coordination, quality improvement, and cost savings in Medicaid, the child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund. (Gov. Code, Sec. 531.024(a-1).)

SUBCHAPTER D. COORDINATION OF MULTIAGENCY SERVICES

Sec. 522.0151. DEFINITION. In this subchapter, "least restrictive setting" means a service setting for an individual that, in comparison to other available service settings:

(1) is most able to meet the individual's identified needs;

(2) prioritizes a home and community-based care setting; and

(3) engages the strengths of the family. (Gov. Code, Sec. 531.055(f).)

Sec. 522.0152. APPLICABILITY OF SUBCHAPTER TO CERTAIN STATE ENTITIES. This subchapter applies to the following state entities:

(1) the commission;

(2) the Department of Family and Protective Services;

(3) the Department of State Health Services;

(4) the Texas Education Agency;

(5) the Texas Correctional Office on Offenders with Medical or Mental Impairments;

(6) the Texas Department of Criminal Justice;

(7) the Texas Department of Housing and Community Affairs;

(8) the Texas Workforce Commission; and

(9) the Texas Juvenile Justice Department. (Gov. Code, Sec. 531.055(a) (part).)

Sec. 522.0153. MEMORANDUM OF UNDERSTANDING REQUIRED. The state entities to which this subchapter applies shall enter into a joint memorandum of understanding to promote a system of local-level interagency staffing groups for the identification and coordination of services for individuals needing multiagency services that:

(1) are to be provided in the least restrictive

setting appropriate; and

(2) use residential, institutional, or congregate care settings only as a last resort. (Gov. Code, Sec. 531.055(a) (part).)

Sec. 522.0154. DEVELOPMENT AND IMPLEMENTATION OF MEMORANDUM OF UNDERSTANDING. (a) The division within the commission that coordinates the policy for and delivery of mental health services shall oversee the development and implementation of the memorandum of understanding required by this subchapter.

(b) The state entities that participate in developing the memorandum of understanding shall consult with and solicit input from advocacy and consumer groups. (Gov. Code, Secs. 531.055(a) (part), (c).)

Sec. 522.0155. CONTENTS OF MEMORANDUM OF UNDERSTANDING. The memorandum of understanding required by this subchapter must:

(1) clarify the statutory responsibilities of each state entity to which this subchapter applies in relation to individuals needing multiagency services, including subcategories for different services such as:

(A) family preservation and strengthening;

(B) physical and behavioral health care;

(C) prevention and early intervention services, including services designed to prevent:

(i) child abuse;

(ii) neglect; or

(iii) delinquency, truancy, or school dropout;

(D) diversion from juvenile or criminal justice involvement;

(E) housing;

(F) aging in place;

(G) emergency shelter;

(H) residential care;

(I) after-care;

(J) information and referral; and

(K) investigation services;

(2) include a functional definition of "individuals needing multiagency services";

(3) outline membership, officers, and necessary standing committees of local-level interagency staffing groups;

(4) define procedures aimed at eliminating duplication of services relating to assessment and diagnosis, treatment, residential placement and care, and case management of individuals needing multiagency services;

(5) define procedures for addressing disputes between the state entities that relate to the entities' areas of service responsibilities;

(6) provide that each local-level interagency staffing group includes:

(A) a local representative of each state entity;

(B) representatives of local private sector agencies; and

(C) family members or caregivers of individuals needing multiagency services or other current or previous consumers

of multiagency services acting as general consumer advocates;

(7) provide that the local representative of each state entity has authority to contribute entity resources to solving problems identified by the local-level interagency staffing group;

(8) provide that if an individual's needs exceed the resources of a state entity, the entity may, with the consent of the individual's legal guardian, if applicable, submit a referral on behalf of the individual to the local-level interagency staffing group for consideration;

(9) provide that a local-level interagency staffing group may be called together by a representative of any member state entity;

(10) provide that a state entity representative may be excused from attending a meeting if the staffing group determines that the age or needs of the individual to be considered are clearly not within the entity's service responsibilities, provided that each entity representative is encouraged to attend all meetings to contribute to the collective ability of the staffing group to solve an individual's need for multiagency services;

(11) define the relationship between state-level interagency staffing groups and local-level interagency staffing groups in a manner that defines, supports, and maintains local autonomy;

(12) provide that records used or developed by a local-level interagency staffing group or the group's members that relate to a particular individual are confidential and may not be

released to any other person or agency except as provided by this subchapter or other law; and

(13) provide a procedure that permits the state entities to share confidential information while preserving the confidential nature of the information. (Gov. Code, Sec. 531.055(b).)

Sec. 522.0156. ADOPTION OF MEMORANDUM OF UNDERSTANDING; REVISIONS. Each state entity to which this subchapter applies shall adopt the memorandum of understanding required by this subchapter and all revisions to the memorandum. The entities shall develop revisions as necessary to reflect major reorganizations or statutory changes affecting the entities. (Gov. Code, Sec. 531.055(d).)

Sec. 522.0157. STATE-LEVEL INTERAGENCY STAFFING GROUP DUTIES; BIENNIAL REPORT. The state entities to which this subchapter applies shall ensure that a state-level interagency staffing group provides:

(1) information and guidance to local-level interagency staffing groups regarding:

(A) the availability of programs and resources in the community; and

(B) best practices for addressing the needs of individuals with complex needs in the least restrictive setting appropriate; and

(2) a biennial report to the administrative head of each entity, the legislature, and the governor that includes:

(A) the number of individuals served through the

local-level interagency staffing groups and the outcomes of the services provided;

(B) a description of any identified barriers to the state's ability to provide effective services to individuals needing multiagency services; and

(C) any other information relevant to improving the delivery of services to individuals needing multiagency services. (Gov. Code, Sec. 531.055(e).)

SUBCHAPTER E. PUBLIC ACCESS TO MEETINGS

Sec. 522.0201. DEFINITION. In this subchapter, "agency" means the commission or a health and human services agency. (Gov. Code, Sec. 531.0165(a).)

Sec. 522.0202. ADDITIONAL APPLICABILITY TO CERTAIN ADVISORY BODIES. (a) The requirements of this subchapter also apply to the meetings of any advisory body that advises the executive commissioner or an agency.

(b) The archived video and audio recording of an advisory body's meeting must be made available through the Internet website of the agency to which the advisory body provides advice. (Gov. Code, Sec. 531.0165(h).)

Sec. 522.0203. INTERNET BROADCAST AND ARCHIVE OF OPEN MEETING. (a) An agency shall:

(1) broadcast over the Internet live video and audio of each open meeting of the agency;

(2) make a video and audio recording of reasonable quality of the broadcast; and

(3) provide access to the archived video and audio

recording on the agency's Internet website in accordance with Subsection (c).

(b) An agency may use for an Internet broadcast of an open meeting of the agency a room made available to the agency on request in any state building, as that term is defined by Section 2165.301.

(c) Not later than the seventh day after the date an open meeting is broadcast under this section, the agency shall make available through the agency's Internet website the archived video and audio recording of the open meeting. The agency shall maintain the archived video and audio recording on the agency's Internet website until at least the second anniversary of the date the recording was first made available on the website. (Gov. Code, Secs. 531.0165(b), (c), (e).)

Sec. 522.0204. INTERNET NOTICE OF OPEN MEETING. An agency shall provide on the agency's Internet website the same notice of an open meeting that the agency is required to post under Subchapter C, Chapter 551. The notice must be posted within the time required for posting notice under Subchapter C, Chapter 551. (Gov. Code, Sec. 531.0165(d).)

Sec. 522.0205. EXEMPTION UNDER CERTAIN CIRCUMSTANCES. An agency is exempt from the requirements of this subchapter to the extent a catastrophe, as defined by Section 551.0411, or a technical breakdown prevents the agency from complying with this subchapter. Following the catastrophe or technical breakdown, the agency shall make all reasonable efforts to make available in a timely manner the required video and audio recording of the open meeting. (Gov. Code, Sec. 531.0165(f).)

Sec. 522.0206. CONTRACTING AUTHORIZED. The commission shall consider contracting through competitive bidding with a private individual or entity to broadcast and archive an open meeting subject to this subchapter to minimize the cost of complying with this subchapter. (Gov. Code, Sec. 531.0165(g).)

SUBCHAPTER F. FACILITIES

Sec. 522.0251. LEASE OR SUBLEASE OF CERTAIN OFFICE SPACE. (a) A health and human services agency, with the commission's approval, or the Texas Workforce Commission or any other state agency that administers employment services programs may lease or sublease office space to a private service entity or lease or sublease office space from a private service entity that provides publicly funded health, human, or workforce services to enable agency eligibility and enrollment personnel to work with the entity if:

(1) client access to services would be enhanced; and

(2) the colocation of offices would improve the efficiency of the administration and delivery of services.

(b) Subchapters D and E, Chapter 2165, do not apply to a state agency that leases or subleases office space to a private service entity under this section.

(c) Subchapter B, Chapter 2167, does not apply to a state agency that leases or subleases office space from a private service entity under this section.

(d) A state agency is delegated the authority to enter into a lease or sublease under this section and may negotiate the terms of the lease or sublease.

(e) To the extent authorized by federal law, a state agency may share business resources with a private service entity that enters into a lease or sublease agreement with the agency under this section. (Gov. Code, Sec. 531.053.)

Sec. 522.0252. ASSUMPTION OF LEASE FOR IMPLEMENTATION OF INTEGRATED ENROLLMENT SERVICES INITIATIVE. (a) A health and human services agency, with the commission's approval, or the Texas Workforce Commission or any other state agency that administers employment services programs may assume a lease from an integrated enrollment services initiative contractor or subcontractor to implement the initiative at one development center, one mail center, or 10 or more call or change centers.

(b) Subchapter B, Chapter 2167, does not apply to a state agency that assumes a lease from a contractor or subcontractor under this section. (Gov. Code, Sec. 531.054.)

Sec. 522.0253. PREREQUISITES FOR ESTABLISHING NEW HEALTH AND HUMAN SERVICES FACILITY IN CERTAIN COUNTIES. A health and human services agency may not establish a new facility in a county with a population of less than 200,000 until the agency provides notice about the facility and the facility's location and purpose to:

(1) each state representative and state senator who represents all or part of the county;

(2) the county judge who represents the county; and

(3) the mayor of any municipality in which the facility would be located. (Gov. Code, Sec. 531.015.)

CHAPTER 523. HEALTH AND HUMAN SERVICES COMMISSION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 523.0001. HEALTH AND HUMAN SERVICES COMMISSION; RESPONSIBILITY FOR DELIVERY OF HEALTH AND HUMAN SERVICES

Sec. 523.0002. GOALS

Sec. 523.0003. SUNSET PROVISION

Sec. 523.0004. APPLICABILITY OF OTHER LAW

SUBCHAPTER B. EXECUTIVE COMMISSIONER; PERSONNEL

Sec. 523.0051. EXECUTIVE COMMISSIONER

Sec. 523.0052. ELIGIBILITY FOR APPOINTMENT AS EXECUTIVE COMMISSIONER OR TO SERVE IN CERTAIN EMPLOYMENT POSITIONS

Sec. 523.0053. TERM

Sec. 523.0054. MEDICAL DIRECTOR; OTHER PERSONNEL

Sec. 523.0055. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS

Sec. 523.0056. MERIT SYSTEM

Sec. 523.0057. QUALIFICATIONS AND STANDARDS OF CONDUCT INFORMATION

Sec. 523.0058. EQUAL EMPLOYMENT OPPORTUNITY POLICY

Sec. 523.0059. USE OF AGENCY STAFF

Sec. 523.0060. CRIMINAL HISTORY BACKGROUND CHECKS

SUBCHAPTER C. EXECUTIVE COUNCIL

Sec. 523.0101. HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL

Sec. 523.0102. POWERS AND DUTIES

CHAPTER 523. HEALTH AND HUMAN SERVICES COMMISSION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 523.0001. HEALTH AND HUMAN SERVICES COMMISSION; RESPONSIBILITY FOR DELIVERY OF HEALTH AND HUMAN SERVICES. (a) The Health and Human Services Commission is an agency of this state.

(b) The commission is the state agency with primary responsibility for ensuring the delivery of state health and human services in a manner that:

(1) uses an integrated system to determine client eligibility;

(2) maximizes the use of federal, state, and local funds; and

(3) emphasizes coordination, flexibility, and

decision-making at the local level. (Gov. Code, Sec. 531.002.)

Sec. 523.0002. GOALS. The commission's goals are to:

(1) maximize federal funds through the efficient use of available state and local resources;

(2) provide a system that delivers prompt, comprehensive, effective services to individuals of this state by:

(A) improving access to health and human services at the local level; and

(B) eliminating architectural, communication, programmatic, and transportation barriers;

(3) promote the health of individuals of this state by:

(A) reducing the incidence of disease and disabling conditions;

(B) increasing the availability and improving the quality of health care services;

(C) addressing the high incidence of certain illnesses and conditions in minority populations;

(D) increasing the availability of trained health care professionals;

(E) improving knowledge of health care needs;

(F) reducing infant death and disease;

(G) reducing the impacts of mental disorders in adults and emotional disturbances in children;

(H) increasing nutritional education and participation in nutrition programs; and

(I) reducing substance abuse;

(4) foster the development of responsible, productive, and self-sufficient citizens by:

(A) improving workforce skills;

(B) increasing employment, earnings, and benefits;

(C) increasing housing opportunities;

(D) increasing child-care and other dependent-care services;

(E) improving education and vocational training to meet specific career goals;

(F) reducing school dropouts and teen pregnancy;

(G) improving parental effectiveness;

(H) increasing support services for individuals with disabilities and services to help those individuals maintain or increase their independence;

(I) improving access to work sites, accommodations, transportation, and other public places and activities covered by the Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.); and

(J) improving services for juvenile offenders;

(5) provide needed resources and services to individuals of this state when they cannot provide or care for themselves by:

(A) increasing support services for adults and their families during periods of unemployment, financial need, or homelessness;

(B) reducing extended dependency on basic

support services; and

(C) increasing the availability and diversity of long-term care provided to support individuals with chronic conditions in settings that focus on community-based services, with options ranging from their own homes to total-care facilities;

(6) protect the physical and emotional safety of all individuals of this state by:

(A) reducing abuse, neglect, and exploitation of elderly individuals and adults with disabilities;

(B) reducing child abuse and neglect;

(C) reducing family violence;

(D) increasing services to children who are truant or who run away, or who are at risk of truancy or running away, and their families;

(E) reducing crime and juvenile delinquency;

(F) reducing community health risks; and

(G) improving regulation of human services providers; and

(7) improve the coordination and delivery of children's services. (Gov. Code, Sec. 531.003.)

Sec. 523.0003. SUNSET PROVISION. The Health and Human Services Commission is subject to Chapter 325 (Texas Sunset Act). Unless continued in existence as provided by that chapter, the commission is abolished September 1, 2027, and Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025, expire on that date. (Gov. Code, Sec. 531.004.)

Sec. 523.0004. APPLICABILITY OF OTHER LAW. The commission is subject to Chapters 2001 and 2002. (Gov. Code, Sec. 531.032.)

SUBCHAPTER B. EXECUTIVE COMMISSIONER; PERSONNEL

Sec. 523.0051. EXECUTIVE COMMISSIONER. (a) The commission is governed by an executive commissioner.

(b) The governor appoints the executive commissioner with the advice and consent of the senate, and shall make the appointment without regard to race, color, disability, sex, religion, age, or national origin. (Gov. Code, Sec. 531.005.)

Sec. 523.0052. ELIGIBILITY FOR APPOINTMENT AS EXECUTIVE COMMISSIONER OR TO SERVE IN CERTAIN EMPLOYMENT POSITIONS. (a) In this section, "Texas trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) An individual may not be appointed as executive commissioner or be a commission employee employed in a "bona fide executive, administrative, or professional capacity," as that phrase is used for purposes of establishing an exemption to the overtime provisions of the Fair Labor Standards Act of 1938 (29 U.S.C. Section 201 et seq.), if:

(1) the individual is an officer, employee, or paid consultant of a Texas trade association in the field of health and human services; or

(2) the individual's spouse is an officer, manager, or

paid consultant of a Texas trade association in the field of health and human services.

(c) An individual may not be appointed as executive commissioner or act as the commission's general counsel if the individual is required to register as a lobbyist under Chapter 305 because of the individual's activities for compensation on behalf of a profession related to the commission's operation.

(d) An individual may not be appointed as executive commissioner if the individual has a financial interest in a corporation, organization, or association under contract with:

(1) the commission or a health and human services agency;

(2) a local mental health or intellectual and developmental disability authority; or

(3) a community center. (Gov. Code, Secs. 531.006(a), (a-1) (part), (b), (c).)

Sec. 523.0053. TERM. The executive commissioner serves a two-year term expiring February 1 of each odd-numbered year. (Gov. Code, Sec. 531.007.)

Sec. 523.0054. MEDICAL DIRECTOR; OTHER PERSONNEL. The executive commissioner:

(1) shall employ a medical director to provide medical expertise to the executive commissioner and the commission; and

(2) may employ other personnel necessary to administer the commission's duties. (Gov. Code, Sec. 531.009(a).)

Sec. 523.0055. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS. (a) The executive commissioner shall develop an

intra-agency career ladder program. The program must require the intra-agency posting of all non-entry-level positions concurrently with any public posting.

(b) The executive commissioner shall develop a system of annual performance evaluations based on measurable job tasks. All merit pay for commission employees must be based on the system established under this subsection. (Gov. Code, Secs. 531.009(b), (c).)

Sec. 523.0056. MERIT SYSTEM. (a) The commission may establish a merit system for commission employees.

(b) The merit system may be maintained in conjunction with other state agencies that are required by federal law to operate under a merit system. (Gov. Code, Sec. 531.010.)

Sec. 523.0057. QUALIFICATIONS AND STANDARDS OF CONDUCT INFORMATION. The executive commissioner shall provide to commission employees as often as necessary information regarding their qualifications under this chapter and their responsibilities under applicable laws relating to standards of conduct for state employees. (Gov. Code, Sec. 531.009(d).)

Sec. 523.0058. EQUAL EMPLOYMENT OPPORTUNITY POLICY. (a) The executive commissioner shall prepare and maintain a written policy statement that implements a program of equal employment opportunity to ensure that all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin.

(b) The policy statement must include:

(1) personnel policies, including policies relating

to recruitment, evaluation, selection, training, and promotion of personnel, that show the commission's intent to avoid the unlawful employment practices described by Chapter 21, Labor Code; and

(2) an analysis of the extent to which the composition of the commission's personnel is in accordance with state and federal law and a description of reasonable methods to achieve compliance with state and federal law.

(c) The policy statement must be:

(1) updated annually;

(2) reviewed by the Texas Workforce Commission civil rights division for compliance with Subsection (b)(1); and

(3) filed with the governor's office. (Gov. Code, Secs. 531.009(e), (f), (g).)

Sec. 523.0059. USE OF AGENCY STAFF. To the extent the commission requests, a health and human services agency shall assign existing staff to perform a function imposed under Chapter 531 or revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025. (Gov. Code, Sec. 531.0242.)

Sec. 523.0060. CRIMINAL HISTORY BACKGROUND CHECKS. (a) In this section, "eligible individual" means an individual whose criminal history record information the executive commissioner or the executive commissioner's designee is entitled to obtain from the Department of Public Safety under Section 411.1106.

(b) The executive commissioner may require an eligible individual to submit fingerprints in a form and of a quality acceptable to the Department of Public Safety and the Federal Bureau of Investigation for use in conducting a criminal history

background check by obtaining criminal history record information under Sections 411.087 and 411.1106.

(c) Criminal history record information the executive commissioner obtains under Sections 411.087 and 411.1106 may be used only to evaluate the qualification or suitability for employment, including continued employment, of an eligible individual.

(d) Notwithstanding Subsection (c), the executive commissioner or the executive commissioner's designee may release or disclose criminal history record information obtained under Section 411.087 only to a governmental entity or as otherwise authorized by federal law, including federal regulations and executive orders. (Gov. Code, Sec. 531.00554.)

SUBCHAPTER C. EXECUTIVE COUNCIL

Sec. 523.0101. HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL. The Health and Human Services Commission Executive Council is established to receive public comment and advise the executive commissioner regarding the commission's operation. (Gov. Code, Sec. 531.0051(a) (part).)

Sec. 523.0102. POWERS AND DUTIES. (a) The executive council shall seek and receive public comment on:

(1) proposed rules;

(2) advisory committee recommendations;

(3) legislative appropriations requests or other documents related to the appropriations process;

(4) the operation of health and human services programs; and

(5) other items the executive commissioner determines appropriate.

(b) The executive council does not have authority to make administrative or policy decisions. (Gov. Code, Secs. 531.0051(a) (part), (b).)

Sec. 523.0103. COMPOSITION. (a) The executive council is composed of:

(1) the executive commissioner;

(2) the director of each division the executive commissioner established under former Section 531.008(c) before the expiration of that subsection on September 1, 2023;

(3) the commissioner of a health and human services agency;

(4) the commissioner of the Department of Family and Protective Services, regardless of whether that agency continues as a state agency separate from the commission; and

(5) other individuals the executive commissioner appoints as the executive commissioner determines necessary.

(b) To the extent the executive commissioner appoints members to the executive council under Subsection (a)(5), the executive commissioner shall make every effort to ensure that those appointments result in the executive council including:

(1) a balanced representation of a broad range of health and human services industry and consumer interests; and

(2) representation from broad geographic regions of this state.

(c) An executive council member appointed under Subsection

(a)(5) serves at the executive commissioner's pleasure. (Gov. Code, Secs. 531.0051(c), (c-1), (e) (part).)

Sec. 523.0104. ELIGIBILITY TO SERVE ON EXECUTIVE COUNCIL. (a) In this section, "Texas trade association" has the meaning assigned by Section 523.0052.

(b) An individual may not serve on the executive council if:

(1) the individual is an officer, employee, or paid consultant of a Texas trade association in the field of health and human services; or

(2) the individual's spouse is an officer, manager, or paid consultant of a Texas trade association in the field of health and human services. (Gov. Code, Secs. 531.0051(e) (part), 531.006(a), (a-1) (part).)

Sec. 523.0105. PRESIDING OFFICER; RULES FOR OPERATION. The executive commissioner serves as the chair of the executive council and shall adopt rules for the council's operation. (Gov. Code, Sec. 531.0051(d).)

Sec. 523.0106. MEETINGS; QUORUM. (a) The executive council shall meet at the executive commissioner's call at least quarterly. The executive commissioner may call additional meetings as the executive commissioner determines necessary.

(b) A majority of the executive council members constitutes a quorum for the transaction of business.

(c) The executive council shall comply with the requirements of Subchapter E, Chapter 522. The archived video and audio recording of a council meeting must be made available through the commission's Internet website.

(d) A meeting of individual executive council members that occurs in the ordinary course of commission operation is not a council meeting, and the requirements of Subsection (c) do not apply to the meeting. (Gov. Code, Secs. 531.0051(f), (g), (h), (k).)

Sec. 523.0107. COMPENSATION; REIMBURSEMENT FOR EXPENSES. An executive council member appointed under Section 523.0103(a)(5) may not receive compensation for service as a council member but is entitled to reimbursement for travel expenses the member incurs while conducting council business as provided by the General Appropriations Act. (Gov. Code, Sec. 531.0051(i).)

Sec. 523.0108. PUBLIC COMMENT. The executive commissioner shall develop and implement policies that provide the public with a reasonable opportunity to appear before the executive council which may include holding meetings in various geographic areas across this state or allowing public comment at teleconferencing centers in various geographic areas across this state and to speak on any issue under the commission's jurisdiction. (Gov. Code, Sec. 531.0051(j).)

Sec. 523.0109. CONSTRUCTION OF SUBCHAPTER. This subchapter does not limit the executive commissioner's authority to establish additional advisory committees or councils. (Gov. Code, Sec. 531.0051(l).)

Sec. 523.0110. INAPPLICABILITY OF CERTAIN OTHER LAW. Except as provided by Section 522.0204, Chapters 551 and 2110 do not apply to the executive council. (Gov. Code, Sec. 531.0051(m).)

SUBCHAPTER D. COMMISSION ORGANIZATION

Sec. 523.0151. COMMISSION DIVISIONS. (a) The executive commissioner shall establish divisions within the commission along functional lines as necessary for effective administration and the discharge of the commission's functions.

(b) The executive commissioner may allocate and reallocate functions among the commission's divisions. (Gov. Code, Secs. 531.008(a), (b).)

Sec. 523.0152. DIVISION DIRECTOR APPOINTMENT AND QUALIFICATIONS. (a) The executive commissioner shall appoint a director for each division established within the commission under Section 523.0151, except that the director of the office of inspector general is appointed in accordance with Section 544.0101.

(b) The executive commissioner shall:

(1) develop clear qualifications for each director appointed under this section to ensure the director has:

(A) demonstrated experience in fields relevant to the director position; and

(B) executive-level administrative and leadership experience; and

(2) ensure the qualifications developed under Subdivision (1) are publicly available. (Gov. Code, Sec. 531.00561.)

Sec. 523.0153. DIVISION DIRECTOR DUTIES. (a) The executive commissioner shall clearly define the duties and responsibilities of a division director.

(b) The executive commissioner shall develop clear policies

for the delegation to division directors of specific decision-making authority, including budget authority. The delegation should be significant enough to ensure the efficient administration of the commission's programs and services. (Gov. Code, Sec. 531.00562.)

Sec. 523.0154. DATA ANALYSIS UNIT; QUARTERLY UPDATE. (a) The executive commissioner shall establish a data analysis unit within the commission to establish, employ, and oversee data analysis processes designed to:

(1) improve contract management;

(2) detect data trends; and

(3) identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts.

(b) The commission shall assign to the data analysis unit staff who perform duties only in relation to the unit.

(c) The data analysis unit shall use all available data and tools for data analysis when establishing, employing, and overseeing data analysis processes under this section.

(d) Not later than the 30th day following the end of each calendar quarter, the data analysis unit shall provide an update on the unit's activities and findings to the governor, the lieutenant governor, the speaker of the house of representatives, the chair of the Senate Finance Committee, the chair of the House Appropriations Committee, and the chairs of the standing committees of the senate and house of representatives having jurisdiction over Medicaid.

(Gov. Code, Sec. 531.0082.)

Sec. 523.0155. OFFICE OF POLICY AND PERFORMANCE. (a) In this section, "office" means the office of policy and performance established under this section.

(b) The executive commissioner shall establish the office of policy and performance as an executive-level office designed to coordinate policy and performance efforts across the health and human services system. To coordinate those efforts, the office shall:

(1) develop a performance management system;

(2) take the lead in providing support and oversight for the implementation of major policy changes and in managing organizational changes; and

(3) act as a centralized body of experts within the commission that offers program evaluation and process improvement expertise.

(c) In developing a performance management system under Subsection (b)(1), the office shall:

(1) gather, measure, and evaluate performance measures and accountability systems the health and human services system uses;

(2) develop new and refined performance measures as appropriate; and

(3) establish targeted, high-level system metrics capable of measuring overall performance and achievement of goals by the health and human services system and of communicating that performance and achievement to both internal and public audiences

through various mechanisms, including the Internet.

(d) In providing support and oversight for the implementation of policy or organizational changes within the health and human services system under Subsection (b)(2), the office shall:

(1) ensure individuals receiving services from or participating in programs administered through the health and human services system do not lose visibility or attention during the implementation of any new policy or organizational change by:

(A) establishing timelines and milestones for any transition;

(B) supporting health and human services system staff in any change between service delivery methods; and

(C) providing feedback to executive management on technical assistance and other support needed to achieve a successful transition;

(2) address cultural differences among health and human services system staff; and

(3) track and oversee changes in policy or organization mandated by legislation or administrative rule.

(e) In acting as a centralized body of experts under Subsection (b)(3), the office shall:

(1) for the health and human services system, provide program evaluation and process improvement guidance both generally and for specific projects identified with executive or stakeholder input or through risk analysis; and

(2) identify and monitor cross-functional efforts

involving different administrative components within the health and human services system and the establishment of cross-functional teams when necessary to improve the coordination of services provided through the system.

(f) Except as otherwise provided by this section, the executive commissioner may develop the office's structure and duties as the executive commissioner determines appropriate. (Gov. Code, Sec. 531.0083.)

Sec. 523.0156. PURCHASING UNIT. (a) The commission shall establish a purchasing unit to manage administrative activities related to the purchasing functions within the health and human services system.

(b) The purchasing unit shall:

(1) seek to achieve targeted cost reductions, increase process efficiencies, improve technological support and customer services, and enhance purchasing support within the health and human services system; and

(2) if cost-effective, contract with private entities to perform purchasing functions for the health and human services system. (Gov. Code, Sec. 531.017.)

SUBCHAPTER E. ADVISORY COMMITTEES

Sec. 523.0201. ESTABLISHMENT OF ADVISORY COMMITTEES. The executive commissioner shall establish and maintain advisory committees to consider issues and solicit public input across all major areas of the health and human services system which may be from various geographic areas across this state, which may be done either in person or through teleconferencing centers, including

relating to the following issues:

(1) Medicaid and other social services programs;

(2) managed care under Medicaid and the child health plan program;

(3) health care quality initiatives;

(4) aging;

(5) individuals with disabilities, including individuals with autism;

(6) rehabilitation, including for individuals with brain injuries;

(7) children;

(8) public health;

(9) behavioral health;

(10) regulatory matters;

(11) protective services; and

(12) prevention efforts. (Gov. Code, Sec. 531.012(a).)

Sec. 523.0202. APPLICABILITY OF OTHER LAW. Chapter 2110 applies to an advisory committee established under this subchapter. (Gov. Code, Sec. 531.012(b).)

Sec. 523.0203. RULES FOR ADVISORY COMMITTEES. The executive commissioner shall adopt rules:

(1) in compliance with Chapter 2110 to govern the purpose, tasks, reporting requirements, and date of abolition of an advisory committee established under this subchapter; and

(2) related to an advisory committee's:

(A) size and quorum requirements;

(B) membership, including:

(i) member qualifications and any experience requirements;

(ii) required geographic representation;

(iii) appointment procedures; and

(iv) members' terms; and

(C) duty to comply with the requirements for open meetings under Chapter 551. (Gov. Code, Sec. 531.012(c).)

Sec. 523.0204. PUBLIC ACCESS TO ADVISORY COMMITTEE MEETINGS. (a) This section applies to an advisory committee established under this subchapter.

(b) The commission shall create a master calendar that includes all advisory committee meetings across the health and human services system.

(c) The commission shall make available on the commission's Internet website:

(1) the master calendar;

(2) all meeting materials for an advisory committee meeting; and

(3) streaming live video and audio of each advisory committee meeting.

(d) The commission shall provide Internet access in each room used for a meeting that appears on the master calendar.

(e) The commission shall ensure that, to the same extent and in the same manner as the broadcast, archiving, and notice of agency meetings are required under Subchapter E, Chapter 522, advisory committee meetings are:

(1) broadcast;

(2) archived on the Internet website of the agency to which the advisory committee provides advice; and

(3) subject to public notice requirements. (Gov. Code, Sec. 531.0121.)

Sec. 523.0205. ADVISORY COMMITTEE REPORTING. An advisory committee established under this subchapter shall:

(1) report any recommendations to the executive commissioner; and

(2) submit a written report to the legislature of any policy recommendations the advisory committee made to the executive commissioner under Subdivision (1). (Gov. Code, Sec. 531.012(d), as added Acts 84th Leg., R.S., Ch. 946.)

SUBCHAPTER F. PUBLIC INTEREST INFORMATION, INPUT, AND COMPLAINTS

Sec. 523.0251. PUBLIC INTEREST INFORMATION AND INPUT GENERALLY. (a) The commission shall develop and implement policies that provide the public a reasonable opportunity to appear before the commission and speak on any issue under the commission's jurisdiction.

(b) The commission shall develop and implement routine and ongoing mechanisms, in accessible formats, to:

(1) receive consumer input;

(2) involve consumers in the planning, delivery, and evaluation of programs and services under the commission's jurisdiction; and

(3) communicate to the public regarding the input the commission receives under this section and actions taken in

response to that input.

(c) The commission shall prepare information of public interest describing the commission's functions. The commission shall make the information available to the public and appropriate state agencies. (Gov. Code, Secs. 531.011(a), (b), (c) (part).)

Sec. 523.0252. PUBLIC HEARINGS. (a) The commission biennially shall conduct a series of public hearings in diverse locations throughout this state to give citizens of this state an opportunity to comment on health and human services issues. The commission shall conduct a sufficient number of hearings to allow reasonable access by citizens in both rural and urban areas, with an emphasis on geographic diversity.

(b) In conducting a public hearing under this section, the commission shall, to the greatest extent possible, encourage participation in the hearings process by diverse groups of citizens in this state.

(c) A public hearing held under this section is subject to Chapter 551. (Gov. Code, Sec. 531.036.)

Sec. 523.0253. NOTICE OF PUBLIC HEARING. (a) In addition to the notice required by Chapter 551, the commission shall:

(1) publish notice of a public hearing under Section 523.0252 in a newspaper of general circulation in the county in which the hearing is to be held; and

(2) provide written notice of the hearing to public officials in the affected area.

(b) If the county in which the public hearing is to be held does not have a newspaper of general circulation, the commission

shall publish notice in a newspaper of general circulation in an adjacent county or in the nearest county in which a newspaper of general circulation is published.

(c) Notice must be published once a week for two consecutive weeks before the public hearing, with the first publication appearing not later than the 15th day before the date set for the hearing. (Gov. Code, Sec. 531.037.)

Sec. 523.0254. COMPLAINTS. (a) The commission shall prepare information of public interest describing the commission's procedures by which complaints are filed with and resolved by the commission. The commission shall make the information available to the public and appropriate state agencies.

(b) The executive commissioner by rule shall establish methods by which the public, consumers, and service recipients can be notified of the mailing addresses and telephone numbers of appropriate agency personnel for the purpose of directing complaints to the commission. The commission may provide for that notice:

(1) on each registration form, application, or written contract for services of a person the commission regulates;

(2) on a sign prominently displayed in the place of business of each person the commission regulates; or

(3) in a bill for service provided by a person the commission regulates.

(c) The commission shall:

(1) keep an information file about each complaint filed with the commission relating to:

(A) a license holder or entity the commission regulates; or

(B) a service the commission delivers; and

(2) maintain an information file about each complaint the commission receives relating to any other matter or agency under the commission's jurisdiction.

(d) If a written complaint is filed with the commission relating to a license holder or entity the commission regulates or a service the commission delivers, the commission, at least quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless notice would jeopardize an undercover investigation. (Gov. Code, Secs. 531.011(c) (part), (d), (e), (f), (g).)

Sec. 523.0255. OFFICE OF OMBUDSMAN. (a) The executive commissioner shall establish the commission's office of the ombudsman with authority and responsibility over the health and human services system in performing the following functions:

(1) providing dispute resolution services for the health and human services system;

(2) performing consumer protection and advocacy functions related to health and human services, including assisting a consumer or other interested person with:

(A) raising a matter within the health and human services system that the person feels is being ignored; and

(B) obtaining information regarding a filed complaint; and

(3) collecting inquiry and complaint data related to

the health and human services system.

(b) The office of the ombudsman does not have the authority to provide a separate process for resolving complaints or appeals.

(c) The executive commissioner shall develop a standard process for tracking and reporting received inquiries and complaints within the health and human services system. The process must provide for the centralized tracking of inquiries and complaints submitted to field, regional, or other local health and human services system offices.

(d) Using the process developed under Subsection (c), the office of the ombudsman shall collect inquiry and complaint data from all agencies, divisions, offices, and other entities within the health and human services system. To assist with the collection of data under this subsection, the office may access any system or process for recording inquiries and complaints the health and human services system uses or maintains. (Gov. Code, Sec. 531.0171.)

SUBCHAPTER G. OFFICE OF HEALTH COORDINATION AND CONSUMER SERVICES

Sec. 523.0301. DEFINITION. In this subchapter, "office" means the Office of Health Coordination and Consumer Services. (Gov. Code, Sec. 531.281.)

Sec. 523.0302. OFFICE; STAFF. (a) The Office of Health Coordination and Consumer Services is an office within the commission.

(b) The executive commissioner shall employ staff as needed to carry out the duties of the office. (Gov. Code, Sec. 531.282.)

Sec. 523.0303. GOALS. The goals of the office are to:

(1) promote community support for parents of children

younger than six years of age through an integrated state and local-level decision-making process; and

(2) provide for the seamless delivery of health and human services to children younger than six years of age to ensure that children are prepared to succeed in school. (Gov. Code, Sec. 531.283.)

Sec. 523.0304. STRATEGIC PLAN. (a) The office shall create and implement a statewide strategic plan for the delivery of health and human services to children younger than six years of age.

(b) In developing the statewide strategic plan, the office shall:

(1) consider existing programs and models to serve children younger than six years of age, including:

(A) community resource coordination groups;

(B) the Texas System of Care; and

(C) the Texas Information and Referral Network and the 2-1-1 telephone number for access to human services;

(2) attempt to maximize federal funds and local existing infrastructure and funds; and

(3) provide for local participation to the greatest extent possible.

(c) The statewide strategic plan must address the needs of children with disabilities who are younger than six years of age. (Gov. Code, Sec. 531.284.)

Sec. 523.0305. POWERS AND DUTIES. (a) The office shall identify:

(1) gaps in early childhood services by functional

area and geographical area;

(2) state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing available services;

(3) sources of funds for early childhood services, including federal, state, and private-public venture sources;

(4) opportunities for collaboration between the Texas Education Agency and health and human services agencies to better serve the needs of children younger than six years of age;

(5) methods for coordinating early childhood services provided by the Texas Head Start State Collaboration Office, the Texas Education Agency, and the Texas Workforce Commission;

(6) quantifiable benchmarks for success within early childhood service delivery; and

(7) national best practices in early care and educational delivery models.

(b) The office shall establish community outreach efforts and ensure adequate communication lines that provide:

(1) the office with information about community-level efforts; and

(2) communities with information about funds and programs available to communities.

(c) The office shall make recommendations to the commission on strategies to:

(1) ensure optimum collaboration and coordination between state agencies serving the needs of children younger than six years of age and other community stakeholders;

(2) fill functional and geographical gaps in early childhood services; and

(3) amend state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing services. (Gov. Code, Sec. 531.285.)

Sec. 523.0306. TEXAS HOME VISITING PROGRAM TRUST FUND. (a) The Texas Home Visiting Program trust fund is a trust fund outside the treasury with the comptroller. The fund is administered by the office under this section and rules the executive commissioner adopts. Money in the fund is not state money and is not subject to legislative appropriation.

(b) The fund consists of money from voluntary contributions under Section 191.0048, Health and Safety Code, and Section 118.018, Local Government Code.

(c) The office may spend money in the fund without appropriation and only for the purpose of the Texas Home Visiting Program the commission administers.

(d) Interest and income from fund assets shall be credited to and deposited in the fund. (Gov. Code, Sec. 531.287.)

CHAPTER 524. AUTHORITY OVER HEALTH AND HUMAN SERVICES SYSTEM

SUBCHAPTER A. SYSTEM OVERSIGHT AUTHORITY OF COMMISSION

Sec. 524.0001. GENERAL RESPONSIBILITY OF COMMISSION FOR HEALTH AND HUMAN SERVICES SYSTEM; PRIORITIZATION OF CERTAIN DUTIES

Sec. 524.0002. GENERAL RESPONSIBILITY OF EXECUTIVE COMMISSIONER FOR HEALTH AND HUMAN SERVICES SYSTEM

CHAPTER 524. AUTHORITY OVER HEALTH AND HUMAN SERVICES SYSTEM

SUBCHAPTER A. SYSTEM OVERSIGHT AUTHORITY OF COMMISSION

Sec. 524.0001. GENERAL RESPONSIBILITY OF COMMISSION FOR HEALTH AND HUMAN SERVICES SYSTEM; PRIORITIZATION OF CERTAIN DUTIES. (a) The commission shall:

(1) supervise the administration and operation of Medicaid, including the administration and operation of the Medicaid managed care system in accordance with Sections 532.0051 and 532.0057;

(2) perform information resources planning and management for the health and human services system under Section 525.0251, with:

(A) the provision of information technology services for the health and human services system as a centralized administrative support service performed either by commission personnel or under a contract with the commission; and

(B) an emphasis on research and implementation on a demonstration or pilot basis of appropriate and efficient uses of new and existing technology to improve the operation of the health and human services system and delivery of health and human

services;

(3) monitor and ensure the effective use of all federal funds received for the health and human services system in accordance with Section 525.0052 and the General Appropriations Act;

(4) implement Texas Integrated Enrollment Services as required by Subchapter A, Chapter 545, except that notwithstanding that subchapter, the commission is responsible for determining and must centralize benefits eligibility under the following programs:

(A) the child health plan program;

(B) the financial assistance program under Chapter 31, Human Resources Code;

(C) Medicaid;

(D) the supplemental nutrition assistance program under Chapter 33, Human Resources Code;

(E) long-term care services as defined by Section 22.0011, Human Resources Code;

(F) community-based support services identified or provided in accordance with Subchapter D, Chapter 546; and

(G) other health and human services programs, as appropriate; and

(5) implement programs intended to prevent family violence and provide services to victims of family violence.

(b) The commission shall implement the powers and duties given to the commission under Sections 525.0002, 525.0153, 2155.144, and 2167.004.

(c) After implementing the commission's duties under

Subsections (a) and (b), the commission shall implement the powers and duties given to the commission under Section 525.0160.

(d) Nothing in the priorities established by this section is intended to limit the commission's authority to work simultaneously to achieve the multiple tasks assigned to the commission in this section and Section 524.0202(a)(1) when that approach is beneficial in the commission's judgment. (Gov. Code, Secs. 531.0055(b), (c), (d) (part).)

Sec. 524.0002. GENERAL RESPONSIBILITY OF EXECUTIVE COMMISSIONER FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) The executive commissioner, as necessary to perform the functions described by Section 524.0001 and Subchapter E in implementing applicable policies the executive commissioner establishes for a health and human services agency or division, shall:

(1) manage and direct the operations of each agency or division, as applicable;

(2) supervise and direct the activities of each agency commissioner or division director, as applicable; and

(3) be responsible for the administrative supervision of the internal audit program for the agencies, including:

(A) selecting the director of internal audit;

(B) ensuring the director of internal audit reports directly to the executive commissioner; and

(C) ensuring the independence of the internal audit function.

(b) The executive commissioner's operational authority and responsibility for purposes of Subsection (a) and Section

524.0151(a)(2) for each health and human services agency or division, as applicable, includes authority over and responsibility for:

(1) daily operations management of the agency or division, including the organization, management, and operating procedures of the agency or division;

(2) resource allocation within the agency or division, including the use of federal funds the agency or division receives;

(3) personnel and employment policies;

(4) contracting, purchasing, and related policies, subject to this chapter and other laws relating to contracting and purchasing by a state agency;

(5) information resources systems the agency or division uses;

(6) facility location; and

(7) the coordination of agency or division activities with activities of other components of the health and human services system and state agencies. (Gov. Code, Secs. 531.0055(a) (part), (e) (part), (f).)

Sec. 524.0003. ADOPTION OR APPROVAL OF PAYMENT RATES. Notwithstanding any other law, the executive commissioner's operational authority and responsibility for purposes of Sections 524.0002(a) and 524.0151(a)(2) for each health and human services agency or division, as applicable, include the authority and responsibility to adopt or approve, subject to applicable limitations, any payment rate or similar provision a health and human services agency is required by law to adopt or approve. (Gov.

Code, Sec. 531.0055(g).)

Sec. 524.0004. PROGRAM TO EVALUATE AND SUPERVISE DAILY OPERATIONS. (a) For each health and human services agency and division, as applicable, the executive commissioner shall implement a program to evaluate and supervise daily operations.

(b) The program must include:

(1) measurable performance objectives for each agency commissioner or division director; and

(2) adequate reporting requirements to permit the executive commissioner to perform the duties assigned to the executive commissioner under:

(A) this subchapter;

(B) Sections 524.0101(a), 524.0151(a)(2) and (b), and 525.0254(b); and

(C) Section 524.0202 with respect to the health and human services system. (Gov. Code, Secs. 531.0055(a) (part), (h).)

Sec. 524.0005. RULES. The executive commissioner shall adopt rules to implement the executive commissioner's authority under this subchapter with respect to the health and human services system. (Gov. Code, Sec. 531.0055(j).)

SUBCHAPTER B. COMMISSIONERS OF HEALTH AND HUMAN SERVICES AGENCIES

Sec. 524.0051. APPOINTMENT OF AGENCY COMMISSIONER BY EXECUTIVE COMMISSIONER. (a) The executive commissioner, with the governor's approval, shall appoint a commissioner for each health and human services agency.

(b) A health and human services agency commissioner serves

at the executive commissioner's pleasure. (Gov. Code, Secs. 531.0055(a) (part), 531.0056(a), (b).)

Sec. 524.0052. EVALUATION OF AGENCY COMMISSIONER. Based on the performance objectives outlined in the memorandum of understanding entered into under Section 524.0101(a), the executive commissioner shall perform an employment evaluation of each health and human services agency commissioner. The executive commissioner shall submit the evaluation to the governor not later than January 1 of each even-numbered year. (Gov. Code, Secs. 531.0055(a) (part), 531.0056(c) (part), (e), (f).)

SUBCHAPTER C. MEMORANDUM OF UNDERSTANDING FOR OPERATION OF SYSTEM

Sec. 524.0101. MEMORANDUM OF UNDERSTANDING BETWEEN EXECUTIVE COMMISSIONER AND HEALTH AND HUMAN SERVICES AGENCY COMMISSIONER. (a) The executive commissioner and each health and human services agency commissioner shall enter into a memorandum of understanding in the manner prescribed by Section 524.0102 that:

(1) clearly defines the responsibilities of the executive commissioner and the commissioner, including:

(A) the responsibility of the commissioner to:

(i) report to the governor; and

(ii) report to and implement policies of the executive commissioner; and

(B) the extent to which the commissioner acts as a liaison between the health and human services agency the commissioner serves and the commission;

(2) establishes the program to evaluate and supervise daily operations required by Section 524.0004;

(3) describes each power or duty delegated to a commissioner; and

(4) ensures the commission and each health and human services agency has access to databases or other information each other agency maintains or keeps that is necessary for the operation of a function the commission or the health and human services agency performs, to the extent not prohibited by other law.

(b) The memorandum of understanding must also outline specific performance objectives, as the executive commissioner defines, to be fulfilled by the health and human services agency commissioner with whom the executive commissioner enters into the memorandum of understanding, including the performance objectives required by Section 524.0004. (Gov. Code, Secs. 531.0055(a) (part), (k), 531.0056(c), (d).)

Sec. 524.0102. ADOPTION AND AMENDMENT OF MEMORANDUM OF UNDERSTANDING. (a) The executive commissioner by rule shall adopt the memorandum of understanding under Section 524.0101 in accordance with the procedures prescribed by Subchapter B, Chapter 2001, for adopting rules, except that the requirements of Sections 2001.033(a)(1)(A) and (C) do not apply with respect to any part of the memorandum of understanding that:

(1) concerns only internal management or organization within or among health and human services agencies and does not affect private rights or procedures; or

(2) relates solely to the internal personnel practices of health and human services agencies.

(b) The memorandum of understanding may be amended only by

following the procedures prescribed by Subsection (a). (Gov. Code, Sec. 531.0163.)

SUBCHAPTER D. RULES AND POLICIES FOR HEALTH AND HUMAN SERVICES

Sec. 524.0151. AUTHORITY TO ADOPT RULES AND POLICIES. (a) The executive commissioner shall:

(1) adopt rules necessary to carry out the commission's duties under Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025; and

(2) notwithstanding any other law, adopt rules and policies for the operation of the health and human services system and the provision of health and human services by that system.

(b) Notwithstanding any other law, the executive commissioner has the authority to adopt rules and policies governing:

(1) the delivery of services to persons the health and human services system serves; and

(2) the rights and duties of persons the system serves or regulates. (Gov. Code, Secs. 531.0055(e) (part), (l), 531.033.)

Sec. 524.0152. PROCEDURES FOR ADOPTING RULES AND POLICIES. (a) The executive commissioner shall develop procedures for adopting rules for the health and human services agencies. The procedures must specify the manner in which the agencies may participate in the rulemaking process.

(b) A health and human services agency shall assist the executive commissioner in developing policies and guidelines needed for the administration of the agency's functions and shall

submit any proposed policies and guidelines to the executive commissioner. The agency may implement a proposed policy or guideline only if the executive commissioner approves the policy or guideline. (Gov. Code, Sec. 531.00551.)

Sec. 524.0153. POLICY FOR NEGOTIATED RULEMAKING AND ALTERNATIVE DISPUTE RESOLUTION PROCEDURES. (a) The commission shall develop and implement a policy for the commission and each health and human services agency to encourage the use of:

(1) negotiated rulemaking procedures under Chapter 2008 for the adoption of rules for the commission and each agency; and

(2) appropriate alternative dispute resolution procedures under Chapter 2009 to assist in the resolution of internal and external disputes under the commission's or agency's jurisdiction.

(b) The procedures relating to alternative dispute resolution must conform, to the extent possible, to any model guidelines the State Office of Administrative Hearings issues for the use of alternative dispute resolution by state agencies.

(c) The commission shall:

(1) coordinate the implementation of the policy developed under Subsection (a);

(2) provide training as needed to implement the procedures for negotiated rulemaking or alternative dispute resolution; and

(3) collect data concerning the effectiveness of those procedures. (Gov. Code, Sec. 531.0161.)

Sec. 524.0154. PERSON FIRST RESPECTFUL LANGUAGE PROMOTION. The executive commissioner shall ensure that the commission and each health and human services agency use the terms and phrases listed as preferred under the person first respectful language initiative in Chapter 392 when proposing, adopting, or amending the commission's or agency's rules, reference materials, publications, or electronic media. (Gov. Code, Sec. 531.0227.)

SUBCHAPTER E. ADMINISTRATIVE SUPPORT SERVICES

Sec. 524.0201. DEFINITION. In this subchapter, "administrative support services" includes strategic planning and evaluation, audit, legal, human resources, information resources, purchasing, contracting, financial management, and accounting services. (Gov. Code, Sec. 531.00553(a).)

Sec. 524.0202. CENTRALIZED SYSTEM OF ADMINISTRATIVE SUPPORT SERVICES. (a) Subject to Section 524.0203(a), the executive commissioner shall plan and implement an efficient and effective centralized system of administrative support services for:

(1) the health and human services system; and

(2) the Department of Family and Protective Services.

(b) The commission is responsible for the performance of administrative support services for the health and human services system. The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section with respect to that system. (Gov. Code, Secs. 531.0055(d) (part), (j), 531.00553(b).)

Sec. 524.0203. PRINCIPLES FOR AND REQUIREMENTS OF

CENTRALIZED SYSTEM; MEMORANDUM OF UNDERSTANDING. (a) The executive commissioner shall plan and implement the centralized system of administrative support services in accordance with the following principles and requirements:

(1) the executive commissioner shall consult with the commissioner of each agency and the director of each division within the health and human services system to ensure the commission is responsive to and addresses agency or division needs;

(2) consolidation of staff providing the support services must be done in a manner that ensures each agency or division within the health and human services system that loses staff as a result of the centralization of support services has adequate resources to carry out functions of the agency or division, as appropriate; and

(3) the commission and each agency or division within the health and human services system shall, as appropriate, enter into a memorandum of understanding or other written agreement to ensure accountability for the provision of support services by clearly detailing:

(A) the responsibilities of each agency or division and the commission;

(B) the points of contact for each agency or division and the commission;

(C) the transfer of personnel among each agency or division and the commission;

(D) the agreement's budgetary effect on each agency or division and the commission; and

(E) any other item the executive commissioner determines is critical for maintaining accountability.

(b) A memorandum of understanding or other written agreement entered into under Subsection (a)(3) may be combined with the memorandum of understanding required under Section 524.0101(a), if appropriate. (Gov. Code, Secs. 531.00553(c), (d).)

SUBCHAPTER F. LEGISLATIVE OVERSIGHT

Sec. 524.0251. OVERSIGHT BY LEGISLATIVE COMMITTEES. The standing or other committees of the house of representatives and the senate that have jurisdiction over the commission and other agencies relating to implementation of Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed on March 31, 2025, as identified by the speaker of the house of representatives and the lieutenant governor, shall:

(1) to ensure implementation consistent with law, monitor the commission's:

(A) implementation of Subchapter A, Sections 524.0101(a), 524.0151(a)(2) and (b), and 525.0254(b), and Section 524.0202 with respect to the health and human services system; and

(B) other duties in consolidating and integrating health and human services;

(2) recommend any needed adjustments to the implementation of the provisions listed in Subdivision (1)(A) and the commission's other duties in consolidating and integrating health and human services; and

(3) review the commission's rulemaking process,

including the commission's plan for obtaining public input. (Gov. Code, Sec. 531.171(a).)

Sec. 524.0252. INFORMATION PROVIDED TO LEGISLATIVE COMMITTEES. The commission shall provide the committees described by Section 524.0251 with copies of all required reports and proposed rules. Copies of the proposed rules must be provided to the committees before the rules are published in the Texas Register. At the request of a committee or the executive commissioner, a health and human services agency shall:

(1) provide other information to the committee, including information relating to the health and human services system; and

(2) report on agency progress in implementing statutory directives the committee identifies and the commission's directives. (Gov. Code, Sec. 531.171(b).)

CHAPTER 525. GENERAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

SUBCHAPTER A. HEALTH AND HUMAN SERVICES ADMINISTRATION GENERALLY

CHAPTER 525. GENERAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

SUBCHAPTER A. HEALTH AND HUMAN SERVICES ADMINISTRATION GENERALLY

Sec. 525.0001. POWERS AND DUTIES RELATING TO HEALTH AND HUMAN SERVICES ADMINISTRATION. The commission and the executive commissioner have all the powers and duties necessary to administer Chapter 531 and revised provisions derived from Chapter 531, as that chapter existed March 31, 2025. (Gov. Code, Sec. 531.041.)

Sec. 525.0002. LOCATION OF AND CONSOLIDATION OF CERTAIN SERVICES AMONG HEALTH AND HUMAN SERVICES AGENCIES. (a) The commission may require a health and human services agency, under the commission's direction, to:

(1) ensure that the agency's location is accessible

to:

(A) employees with disabilities; and

(B) agency clients with disabilities; and

(2) consolidate agency support services, including clerical, administrative, and information resources support services, with support services provided to or by another health and human services agency.

(b) The executive commissioner may require a health and human services agency, under the executive commissioner's direction, to locate all or a portion of the agency's employees and programs:

(1) in the same building as another health and human services agency; or

(2) at a location near or adjacent to another health and human services agency's location. (Gov. Code, Sec. 531.0246.)

Sec. 525.0003. CONSOLIDATED INTERNAL AUDIT PROGRAM. (a) Notwithstanding Section 2102.005, the commission shall operate the internal audit program required under Chapter 2102 for the commission and each health and human services agency as a consolidated internal audit program.

(b) For purposes of this section, a reference in Chapter 2102 to the administrator of a state agency with respect to a health and human services agency means the executive commissioner. (Gov. Code, Sec. 531.00552.)

Sec. 525.0004. INTERAGENCY DISPUTE ARBITRATION. The executive commissioner shall arbitrate and render the final decision on interagency disputes. (Gov. Code, Sec. 531.035.)

SUBCHAPTER B. ACCOUNTING AND FISCAL PROVISIONS

Sec. 525.0051. MANAGEMENT INFORMATION AND COST ACCOUNTING SYSTEMS. The executive commissioner shall establish a management information system and a cost accounting system for all health and human services that is compatible with and meets the requirements of the uniform statewide accounting project. (Gov. Code, Sec. 531.031.)

Sec. 525.0052. FEDERAL FUNDS: PLANNING AND MANAGEMENT; ANNUAL REPORT. (a) The commission, subject to the General Appropriations Act, is responsible for planning for and managing the use of federal funds in a manner that maximizes the federal funding available to this state while promoting the delivery of services.

(b) The executive commissioner shall:

(1) establish a federal money management system to coordinate and monitor the use of federal money health and human services agencies receive to ensure that the money is spent in the most efficient manner;

(2) establish priorities for health and human services agencies' use of federal money in coordination with the coordinated strategic plan the executive commissioner develops under Section 525.0154;

(3) coordinate and monitor the use of federal money for health and human services to ensure that the money is spent in the most cost-effective manner throughout the health and human services system;

(4) review and approve all federal funding plans for

health and human services in this state;

(5) estimate available federal money, including earned federal money, and monitor unspent money;

(6) ensure that the state meets federal requirements relating to receipt of federal money for health and human services, including requirements relating to state matching money and maintenance of effort;

(7) transfer appropriated amounts as described by Section 525.0053; and

(8) ensure that each governmental entity the executive commissioner identifies under Section 525.0155 has access to complete and timely information about all sources of federal money for health and human services programs and that technical assistance is available to governmental entities seeking grants of federal money to provide health and human services.

(c) The commission shall prepare an annual report regarding the results of implementing this section. The report must identify strategies to:

(1) maximize the receipt and use of federal funds; and

(2) improve federal funds management.

(d) Not later than December 15 of each year, the commission shall file the report the commission prepares under Subsection (c) with the governor, the lieutenant governor, and the speaker of the house of representatives. (Gov. Code, Sec. 531.028.)

Sec. 525.0053. AUTHORITY TO TRANSFER CERTAIN APPROPRIATED AMOUNTS AMONG HEALTH AND HUMAN SERVICES AGENCIES. The commission may, subject to the General Appropriations Act, transfer amounts

appropriated to health and human services agencies among the agencies to:

(1) enhance the receipt of federal money under the federal money management system the executive commissioner establishes under Section 525.0052;

(2) achieve efficiencies in the agencies' administrative support functions; and

(3) perform the functions assigned to the executive commissioner under:

(A) Subchapter A, Chapter 524; and

(B) Sections 524.0101, 524.0151, 524.0202, and 525.0254. (Gov. Code, Sec. 531.0271.)

Sec. 525.0054. EFFICIENCY AUDIT OF CERTAIN ASSISTANCE PROGRAMS. (a) For purposes of this section, "efficiency audit" means an investigation of the implementation and administration of the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code, and the state temporary assistance and support services program operated under Chapter 34, Human Resources Code, to examine fiscal management, the efficiency of the use of resources, and the effectiveness of state efforts in achieving the goals of the Temporary Assistance for Needy Families program described under 42 U.S.C. Section 601(a).

(b) In 2022 and every sixth year after that year, an external auditor selected under Subsection (c) shall conduct an efficiency audit. The commission shall pay the costs associated with the audit using existing resources.

(c) The state auditor shall:

(1) not later than March 1 of the year in which an efficiency audit is required under this section, select an external auditor to conduct the audit; and

(2) ensure that the external auditor conducts the audit in accordance with this section.

(d) The external auditor shall be independent and not subject to direction from:

(1) the commission; or

(2) any other state agency that:

(A) is subject to evaluation by the auditor for purposes of this section; or

(B) receives or spends money under the programs described by Subsection (a).

(e) The external auditor shall complete the efficiency audit not later than the 90th day after the date the state auditor selects the external auditor.

(f) The Legislative Budget Board shall establish the scope of the efficiency audit and determine the areas of investigation for the audit, including:

(1) reviewing the resources dedicated to a program described by Subsection (a) to determine whether those resources:

(A) are used effectively and efficiently to achieve desired outcomes for individuals receiving benefits under the program; and

(B) are not used for purposes other than the intended goals of the program;

(2) identifying cost savings or reallocations of

resources; and

(3) identifying opportunities to improve services through consolidation of essential functions, outsourcing, and elimination of duplicative efforts.

(g) Not later than November 1 of the year an efficiency audit is conducted, the external auditor shall prepare and submit a report of the audit and recommendations for efficiency improvements to:

(1) the governor;

(2) the Legislative Budget Board;

(3) the state auditor;

(4) the executive commissioner; and

(5) the chairs of the House Human Services Committee and the Senate Health and Human Services Committee.

(h) The executive commissioner and the state auditor shall publish the report, recommendations, and full efficiency audit on the commission's and the state auditor's Internet websites. (Gov. Code, Sec. 531.005522.)

Sec. 525.0055. GIFTS AND GRANTS. The commission may accept a gift or grant from a public or private source to perform any of the commission's powers or duties. (Gov. Code, Sec. 531.038.)

SUBCHAPTER C. CONTRACTS

Sec. 525.0101. GENERAL CONTRACT AUTHORITY. The commission may enter into contracts as necessary to perform any of the commission's powers or duties. (Gov. Code, Sec. 531.039.)

Sec. 525.0102. SUBROGATION AND THIRD-PARTY REIMBURSEMENT CONTRACTS. (a) Except as provided by Subsection (d), the

commission shall enter into a contract under which the contractor is authorized on behalf of the commission or a health and human services agency to recover money under a subrogation or third-party reimbursement right the commission or agency holds that arises from payment of medical expenses. The contract must provide that:

(1) the commission or agency, as appropriate, shall compensate the contractor based on a percentage of the amount of money the contractor recovers for the commission or agency; and

(2) the contractor may represent the commission or agency in a court proceeding to recover money under a subrogation or third-party reimbursement right if:

(A) the attorney required by other law to represent the commission or agency in court approves; and

(B) the representation is cost-effective and specifically authorized by the commission.

(b) The commission shall develop a process to:

(1) identify claims for the recovery of money under a subrogation or third-party reimbursement right described by this section; and

(2) refer the identified claims to a contractor authorized under this section.

(c) A health and human services agency shall cooperate with a contractor authorized under this section on a claim the agency refers to the contractor for recovery.

(d) If the commission cannot identify a contractor who is willing to contract with the commission under this section on reasonable terms, the commission:

(1) is not required to enter into a contract under Subsection (a); and

(2) shall develop and implement alternative policies to ensure the recovery of money under a subrogation or third-party reimbursement right.

(e) The commission may allow a state agency other than a health and human services agency to be a party to the contract required by Subsection (a). If the commission allows an additional state agency to be a party to the contract, the commission shall modify the contract as necessary to reflect the services the contractor is to provide to that agency. (Gov. Code, Sec. 531.0391.)

SUBCHAPTER D. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES

Sec. 525.0151. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES GENERALLY. The executive commissioner shall:

(1) facilitate and enforce coordinated planning and delivery of health and human services, including:

(A) compliance with the coordinated strategic plan;

(B) colocation of services;

(C) integrated intake; and

(D) coordinated referral and case management;

(2) establish and enforce uniform regional boundaries for all health and human services agencies;

(3) carry out statewide health and human services needs surveys and forecasting;

(4) perform independent special-outcome evaluations

of health and human services programs and activities; and

(5) on request of a governmental entity the executive commissioner identifies under Section 525.0155, assist the entity in implementing a coordinated plan that:

(A) may include colocation of services, integrated intake, and coordinated referral and case management; and

(B) is tailored to the entity's needs and priorities. (Gov. Code, Sec. 531.024(a) (part).)

Sec. 525.0152. PLANNING AND POLICY DIRECTION OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM. (a) In this section, "financial assistance program" means the financial assistance program operated under Chapter 31, Human Resources Code.

(b) The commission shall:

(1) plan and direct the financial assistance program, including the procurement, management, and monitoring of contracts necessary to implement the program; and

(2) establish requirements for and define the scope of the ongoing evaluation of the financial assistance program.

(c) The executive commissioner shall adopt rules and standards governing the financial assistance program. (Gov. Code, Sec. 531.0224; New.)

Sec. 525.0153. ANNUAL BUSINESS SERVICES PLANS. The commission shall develop and implement an annual business services plan for each health and human services region that:

(1) establishes performance objectives for all health and human services agencies providing services in the region; and

(2) measures agency effectiveness and efficiency in achieving those objectives. (Gov. Code, Sec. 531.0247.)

Sec. 525.0154. COORDINATED STRATEGIC PLAN AND BIENNIAL PLAN UPDATES FOR HEALTH AND HUMAN SERVICES. (a) The executive commissioner shall:

(1) develop a coordinated, six-year strategic plan for health and human services in this state; and

(2) submit a biennial update of the plan to the governor, the lieutenant governor, and the speaker of the house of representatives not later than October 1 of each even-numbered year.

(b) The coordinated strategic plan must include the following goals:

(1) developing a comprehensive, statewide approach to the planning of health and human services;

(2) creating a continuum of care for families and individuals in need of health and human services;

(3) integrating health and human services to provide for the efficient and timely delivery of those services;

(4) maximizing existing resources through effective funds management and the sharing of administrative functions;

(5) effectively using management information systems to continually improve service delivery;

(6) providing systemwide accountability through effective monitoring mechanisms;

(7) promoting teamwork among the health and human services agencies and providing incentives for creativity;

(8) fostering innovation at the local level; and

(9) encouraging full participation of fathers in programs and services relating to children.

(c) In developing the coordinated strategic plan and plan updates under this section, the executive commissioner shall consider:

(1) existing strategic plans of health and human services agencies;

(2) health and human services priorities and plans governmental entities submit under Section 525.0155;

(3) facilitation of pending reorganizations or consolidations of health and human services agencies and programs;

(4) public comment, including comment documented through public hearings conducted under Section 523.0252; and

(5) budgetary issues, including projected agency needs and projected availability of funds. (Gov. Code, Secs. 531.022(a), (b), (c), (d).)

Sec. 525.0155. COORDINATION WITH LOCAL GOVERNMENTAL ENTITIES. The executive commissioner shall:

(1) identify the governmental entities that coordinate the delivery of health and human services in regions, counties, and municipalities; and

(2) request that each identified governmental entity:

(A) identify the health and human services priorities in the entity's jurisdiction and the most effective ways to deliver and coordinate services in that jurisdiction;

(B) develop a coordinated plan for delivering

health and human services in the jurisdiction, including transition services that prepare special education students for adulthood; and

(C) make available to the commission the information requested under Paragraphs (A) and (B). (Gov. Code, Sec. 531.022(e).)

Sec. 525.0156. SUBMISSION AND REVIEW OF AGENCY STRATEGIC PLANS AND BIENNIAL PLAN UPDATES. (a) Each health and human services agency shall submit to the commission a strategic plan and biennial updates of the plan on a date determined by commission rule.

(b) The commission shall:

(1) review and comment on each strategic plan and biennial update a health and human services agency submits to the commission under this section; and

(2) not later than January 1 of each even-numbered year, begin formal discussions with each health and human services agency regarding that agency's strategic plan or biennial update, as appropriate. (Gov. Code, Sec. 531.023.)

Sec. 525.0157. STATEWIDE NEEDS APPRAISAL PROJECT. (a) The commission may implement the Statewide Needs Appraisal Project to obtain county-specific demographic data concerning health and human services needs in this state.

(b) Any collected data must be made available for use in planning and budgeting for health and human services programs by state agencies.

(c) The commission shall coordinate the commission's activities with the appropriate health and human services agencies.

(Gov. Code, Sec. 531.025.)

Sec. 525.0158. STREAMLINING SERVICE DELIVERY. To integrate and streamline service delivery and facilitate access to services, the executive commissioner may:

(1) request a health and human services agency to take a specific action; and

(2) recommend the manner for accomplishing the streamlining, including requesting each agency to:

(A) simplify or automate agency procedures;

(B) coordinate service planning and management tasks between and among health and human services agencies;

(C) reallocate staff resources;

(D) waive existing rules; or

(E) take other necessary actions. (Gov. Code, Sec. 531.0241.)

Sec. 525.0159. HOTLINE AND CALL CENTER COORDINATION. (a) The commission shall establish a process to ensure all health and human services system hotlines and call centers are necessary and appropriate. Under the process, the commission shall:

(1) develop criteria for use in assessing whether a hotline or call center serves an ongoing purpose;

(2) develop and maintain an inventory of all system hotlines and call centers;

(3) use the inventory and assessment criteria the commission develops under this subsection to periodically consolidate hotlines and call centers along appropriate functional lines;

(4) develop an approval process designed to ensure that a newly established hotline or call center, including the telephone system and contract terms for the hotline or call center, meets policies and standards the commission establishes; and

(5) develop policies and standards for hotlines and call centers that:

(A) include quality and quantity performance measures and benchmarks; and

(B) may include policies and standards for:

(i) client satisfaction with call resolution;

(ii) accuracy of information provided;

(iii) the percentage of received calls that are answered;

(iv) the amount of time a caller spends on hold; and

(v) call abandonment rates.

(b) In consolidating hotlines and call centers under Subsection (a)(3), the commission shall seek to maximize the use and effectiveness of the commission's 2-1-1 telephone number.

(c) In developing policies and standards under Subsection (a)(5), the commission may allow varied performance measures and benchmarks for a hotline or call center based on factors affecting the capacity of the hotline or call center, including factors such as staffing levels and funding. (Gov. Code, Sec. 531.0192.)

Sec. 525.0160. COMMUNITY-BASED SUPPORT SYSTEMS. (a) Subject to Sections 524.0001(c) and (d) and 524.0202(a)(1), the

commission shall assist communities in this state in developing comprehensive, community-based support systems for health and human services. At a community's request, the commission shall provide to the community resources and assistance to enable the community to:

(1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers resulting from the policies and procedures of state health and human services agencies; and

(2) develop a system of blended funds to allow the community to customize services to fit individual community needs.

(b) At the commission's request, a health and human services agency shall provide to a community resources and assistance as necessary to perform the commission's duties under Subsection (a).

(c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the proposal to the commission for review and approval. The commission shall review the proposal to ensure that the proposed initiative:

(1) is consistent with other similar programs offered in communities; and

(2) does not duplicate other services provided in the community.

(d) In implementing this section, the commission shall consider models used in other service delivery systems, including the mental health and intellectual disability service delivery systems. (Gov. Code, Sec. 531.0248.)

SUBCHAPTER E. HEALTH INFORMATION EXCHANGE SYSTEM

Sec. 525.0201. DEFINITIONS. In this subchapter:

(1) "Electronic health record" means an electronic record of an individual's aggregated health-related information that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized health care providers across two or more health care organizations.

(2) "Electronic medical record" means an electronic record of an individual's health-related information that can be created, gathered, managed, and consulted by authorized clinicians and staff within a single health care organization.

(3) "Health information exchange system" means an electronic health information exchange system created under this subchapter that moves health-related information among entities according to nationally recognized standards. (Gov. Code, Secs. 531.901(1), (2), (3).)

Sec. 525.0202. HEALTH INFORMATION EXCHANGE SYSTEM DEVELOPMENT. (a) The commission shall develop an electronic health information exchange system to improve the quality, safety, and efficiency of health care services provided under Medicaid and the child health plan program. In developing the system, the commission shall ensure that:

(1) the confidentiality of patients' health information is protected and patient privacy is maintained in accordance with federal and state law, including:

(A) Section 1902(a)(7), Social Security Act (42 U.S.C. Section 1396a(a)(7));

(B) the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(C) Chapter 552;

(D) Subchapter G, Chapter 241, Health and Safety Code;

(E) Section 12.003, Human Resources Code; and

(F) federal and state rules, including:

(i) 42 C.F.R. Part 431, Subpart F; and

(ii) 45 C.F.R. Part 164;

(2) appropriate information technology systems the commission and health and human services agencies use are interoperable;

(3) the system and external information technology systems are interoperable in receiving and exchanging appropriate electronic health information as necessary to enhance:

(A) the comprehensive nature of information contained in electronic health records; and

(B) health care provider efficiency by supporting integration of the information into the electronic health record health care providers use;

(4) the system and other health information systems not described by Subdivision (3) and data warehousing initiatives are interoperable; and

(5) the system includes the elements described by Subsection (b).

(b) The health information exchange system must include the following elements:

(1) an authentication process that uses multiple forms of identity verification before allowing access to information systems and data;

(2) a formal process for establishing data-sharing agreements within the community of participating providers in accordance with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) and the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5);

(3) a method by which the commission may open or restrict access to the system during a declared state emergency;

(4) the capability of appropriately and securely sharing health information with state and federal emergency responders;

(5) compatibility with the Nationwide Health Information Network (NHIN) and other national health information technology initiatives coordinated by the Office of the National Coordinator for Health Information Technology;

(6) technology that allows for patient identification across multiple systems; and

(7) the capability of allowing a health care provider with technology that meets current national standards to access the system.

(c) The health information exchange system must be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of the Centers for Medicare and Medicaid Services and conform to other standards required under federal law. (Gov. Code, Secs. 531.903(a), (b), (d).)

Sec. 525.0203. HEALTH INFORMATION EXCHANGE SYSTEM IMPLEMENTATION IN STAGES. The commission shall implement the health information exchange system in stages as described by this subchapter, except that the commission may deviate from those stages if technological advances make a deviation advisable or more efficient. (Gov. Code, Sec. 531.903(c).)

Sec. 525.0204. HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ENCOUNTER DATA. In stage one of implementing the health information exchange system and for purposes of the implementation, the commission shall require each managed care organization with which the commission contracts under Chapter 540 or 540A for the provision of Medicaid managed care services or under Chapter 62, Health and Safety Code, for the provision of child health plan program services to submit to the commission complete and accurate encounter data not later than the 30th day after the last day of the month in which the managed care organization adjudicated the claim. (Gov. Code, Sec. 531.9051.)

Sec. 525.0205. HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ELECTRONIC PRESCRIBING. (a) In stage one of implementing the health information exchange system, the commission shall support and coordinate electronic prescribing tools health care providers and health care facilities use under Medicaid and the child health plan program.

(b) The commission shall collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that the electronic prescribing tools described by Subsection (a):

(1) are integrated with existing electronic

prescribing systems otherwise in use in the public and private sectors; and

(2) to the extent feasible:

(A) provide current payer formulary information at the time a health care provider writes a prescription; and

(B) support the electronic transmission of a prescription.

(c) The commission may take any reasonable action to comply with this section, including establishing information exchanges with national electronic prescribing networks or providing health care providers with access to an Internet-based prescribing tool the commission develops.

(d) The commission shall apply for and actively pursue any waiver to the state Medicaid plan or the child health plan program from the Centers for Medicare and Medicaid Services or any other federal agency as necessary to remove an identified impediment to supporting and implementing electronic prescribing tools under this section, including the requirement for handwritten certification of certain drugs under 42 C.F.R. Section 447.512. If the commission, with assistance from the Legislative Budget Board, determines that the implementation of an operational modification in accordance with a waiver the commission obtains as required by this subsection has resulted in a cost increase in Medicaid or the child health plan program, the commission shall take the necessary actions to reverse the operational modification. (Gov. Code, Sec. 531.906.)

Sec. 525.0206. HEALTH INFORMATION EXCHANGE SYSTEM STAGE

TWO: EXPANSION. (a) In stage two of implementing the health information exchange system and based on feedback provided by interested parties, the commission may expand the system by:

(1) providing an electronic health record for each child health plan program enrollee;

(2) including state laboratory results information in an electronic health record, including the results of newborn screenings and tests conducted under the Texas Health Steps program, based on the system developed for the health passport under Section 266.006, Family Code;

(3) improving electronic health record data-gathering capabilities to allow the record to include basic health and clinical information as the executive commissioner determines in addition to available claims information;

(4) using evidence-based technology tools to create a unique health profile to alert health care providers regarding the need for additional care, education, counseling, or health management activities for specific patients; and

(5) continuing to enhance the electronic health record created for each Medicaid recipient as technology becomes available and interoperability capabilities improve.

(b) In expanding the health information exchange system, the commission shall collaborate with, and accept recommendations from, physicians and other stakeholders to ensure that electronic health records provided under this section support health information exchange with electronic medical records systems physicians use in the public and private sectors. (Gov. Code, Sec.

531.907.)

Sec. 525.0207. HEALTH INFORMATION EXCHANGE SYSTEM STAGE THREE: EXPANSION. In stage three of implementing the health information exchange system, the commission may expand the system by:

(1) developing evidence-based benchmarking tools for a health care provider to use in evaluating the provider's own performance on health care outcomes and overall quality of care as compared to aggregated peer performance data; and

(2) expanding the system to include state agencies, additional health care providers, laboratories, diagnostic facilities, hospitals, and medical offices. (Gov. Code, Sec. 531.908.)

Sec. 525.0208. STRATEGIES TO ENCOURAGE HEALTH INFORMATION EXCHANGE SYSTEM USE. The commission shall develop strategies to encourage health care providers to use the health information exchange system, including incentives, education, and outreach tools to increase usage. (Gov. Code, Sec. 531.909.)

Sec. 525.0209. RULES. The executive commissioner may adopt rules to implement this subchapter. (Gov. Code, Sec. 531.911.)

SUBCHAPTER F. INFORMATION RESOURCES AND TECHNOLOGY

Sec. 525.0251. INFORMATION RESOURCES STRATEGIC PLANNING AND MANAGEMENT. (a) The commission is responsible for strategic planning for information resources at each health and human services agency and shall direct the management of information resources at each health and human services agency.

(b) The commission shall:

(1) develop a coordinated strategic plan for information resources management that:

(A) covers a five-year period;

(B) defines objectives for information resources management at each health and human services agency;

(C) prioritizes information resources projects and implementation of new technology for all health and human services agencies;

(D) integrates planning and development of each information resources system a health and human services agency uses into a coordinated information resources management planning and development system the commission establishes;

(E) establishes standards for information resources system security and that promotes the capability of information resources systems operating with each other;

(F) achieves economies of scale and related benefits in purchasing for health and human services information resources systems; and

(G) is consistent with the state strategic plan for information resources developed under Chapter 2054;

(2) establish and ensure compliance with information resources management policies, procedures, and technical standards; and

(3) review and approve the information resources deployment review and biennial operating plan of each health and human services agency.

(c) A health and human services agency may not submit the

agency's plans to the Department of Information Resources or the Legislative Budget Board under Subchapter E, Chapter 2054, until the commission approves the plans. (Gov. Code, Sec. 531.0273.)

Sec. 525.0252. TECHNOLOGICAL SOLUTIONS POLICIES. (a) The commission shall develop and implement a policy requiring the agency commissioner and employees of each health and human services agency to research and propose appropriate technological solutions to improve the agency's ability to perform the agency's functions. The technological solutions must:

(1) ensure that the public is able to easily find information about a health and human services agency on the Internet;

(2) ensure that an individual who wants to use a health and human services agency's services is able to:

(A) interact with the agency through the Internet; and

(B) access any service that can be effectively provided through the Internet;

(3) be cost-effective and developed through the commission's planning process; and

(4) meet federal accessibility standards for individuals with disabilities.

(b) The commission shall develop and implement the policy described by Subsection (a) in relation to the commission's functions. (Gov. Code, Secs. 531.0162(a), (b).)

Sec. 525.0253. TECHNOLOGY USE FOR ADULT PROTECTIVE SERVICES PROGRAM. (a) Subject to available appropriations, the commission

shall use technology whenever possible in connection with the Department of Family and Protective Services' adult protective services program to:

(1) provide for automated collection of information necessary to evaluate program effectiveness using systems that integrate collection of necessary information with other routine duties of caseworkers and other service providers; and

(2) consequently reduce the time required for caseworkers and other service providers to gather and report information necessary for program evaluation.

(b) The commission shall include private sector representatives in the technology planning process used to determine appropriate technology for the Department of Family and Protective Services' adult protective services program. (Gov. Code, Secs. 531.0162(c), (d).)

Sec. 525.0254. ELECTRONIC SIGNATURES. (a) In this section, "transaction" has the meaning assigned by Section 322.002, Business & Commerce Code.

(b) The executive commissioner shall establish standards for the use of electronic signatures in accordance with Chapter 322, Business & Commerce Code, with respect to any transaction in connection with the administration of health and human services programs.

(c) The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section. (Gov. Code, Secs. 531.0055(j), (m).)

Sec. 525.0255. HEALTH AND HUMAN SERVICES SYSTEM INTERNET

WEBSITES. The commission shall establish a process to ensure that Internet websites across the health and human services system are developed and maintained according to standard criteria for uniformity, efficiency, and technical capabilities. Under the process, the commission shall:

(1) develop and maintain an inventory of all health and human services system Internet websites; and

(2) on an ongoing basis, evaluate the inventory the commission maintains under Subdivision (1) to:

(A) determine whether any Internet websites should be consolidated to improve public access to those websites' content and, if appropriate, consolidate those websites; and

(B) ensure that the Internet websites comply with the standard criteria. (Gov. Code, Sec. 531.0164.)

Sec. 525.0256. AUTOMATION STANDARDS FOR DATA SHARING. The executive commissioner, with the Department of Information Resources, shall develop automation standards for computer systems to enable health and human services agencies, including agencies operating at a local level, to share pertinent data. (Gov. Code, Sec. 531.024(a) (part).)

Sec. 525.0257. ELECTRONIC EXCHANGE OF HEALTH INFORMATION; BIENNIAL REPORT. (a) In this section, "health care provider" includes a physician.

(b) The executive commissioner shall ensure that:

(1) all information systems available for the commission or a health and human services agency to use in sending protected health information to a health care provider or receiving

protected health information from a health care provider, and for which planning or procurement begins on or after September 1, 2015, are capable of sending or receiving the information in accordance with the applicable data exchange standards developed by the appropriate standards development organization accredited by the American National Standards Institute;

(2) if national data exchange standards do not exist for a system described by Subdivision (1), the commission makes every effort to ensure that the system is interoperable with the national standards for electronic health record systems; and

(3) the commission and each health and human services agency establish an interoperability standards plan for all information systems that exchange protected health information with health care providers.

(c) Not later than December 1 of each even-numbered year, the executive commissioner shall report to the governor and the Legislative Budget Board on the commission's and the health and human services agencies' measurable progress in ensuring that the information systems described by Subsection (b) are interoperable with one another and meet the appropriate standards specified by that subsection. The report must include an assessment of the progress made in achieving commission goals related to the exchange of health information, including facilitating care coordination among the agencies, ensuring quality improvement, and realizing cost savings. (Gov. Code, Secs. 531.0162(e), (f), (h) (part).)

SUBCHAPTER G. STUDIES, REPORTS, AND PUBLICATIONS

Sec. 525.0301. BIENNIAL REFERENCE GUIDE. (a) The

commission shall:

(1) publish a biennial reference guide describing available public health and human services in this state; and

(2) make the guide available to all interested parties and agencies.

(b) The reference guide must include a dictionary of uniform terms and services. (Gov. Code, Sec. 531.040.)

Sec. 525.0302. CONSOLIDATION OF REPORTS. The commission may consolidate any annual or biennial reports required to be made under this chapter or another law if:

(1) the consolidated report is submitted not later than the earliest deadline for the submission of any component of the report; and

(2) each person required to receive a component of the consolidated report receives the report, and the report identifies the component the person was required to receive. (Gov. Code, Sec. 531.014.)

Sec. 525.0303. ANNUAL REPORT ON SAFEGUARDING PROTECTED HEALTH INFORMATION. (a) The commission, in consultation with the Department of State Health Services, the Texas Medical Board, and the Texas Department of Insurance, shall explore and evaluate new developments in safeguarding protected health information.

(b) Not later than December 1 of each year, the commission shall report to the legislature on:

(1) new developments in safeguarding protected health information; and

(2) recommendations for implementing safeguards

within the commission. (Gov. Code, Sec. 531.0994.)

CHAPTER 526. ADDITIONAL POWERS AND DUTIES OF COMMISSION AND EXECUTIVE COMMISSIONER

SUBCHAPTER A. INTERNET WEBSITES, ELECTRONIC RESOURCES, AND OTHER TECHNOLOGY

Sec. 526.0001. DEFINITIONS. In this subchapter:

(1) "Council" means the Records Management Interagency Coordinating Council.

(2) "Network" means the Texas Information and Referral Network. (New.)

Sec. 526.0002. INTERNET WEBSITE FOR HEALTH AND HUMAN SERVICES INFORMATION. (a) The commission, in cooperation with the Department of Information Resources, shall maintain through the state electronic Internet portal project established by the department a generally accessible and interactive Internet website that contains information for the public regarding the services and programs each health and human services agency provides or administers in this state. The commission shall establish the website in such a manner that allows it to be located easily through electronic means.

(b) The Internet website must:

(1) include information that is:

(A) presented in a concise and easily understandable and accessible format; and

(B) organized by the type of service provided rather than by the agency or provider delivering the service;

(2) provide eligibility criteria for each health and human services agency program;

(3) provide application forms for each of the public assistance programs administered by a health and human services agency, including forms for:

(A) the financial assistance program under Chapter 31, Human Resources Code;

(B) Medicaid; and

(C) the nutritional assistance program under

Chapter 33, Human Resources Code;

(4) to avoid duplication of functions and efforts, provide a link to an Internet website maintained by the network under Section 526.0005;

(5) provide the telephone number and, to the extent available, the e-mail address for each health and human services agency and local health and human services provider;

(6) be designed in a manner that allows a member of the public to electronically:

(A) send questions about each agency's programs or services; and

(B) receive the agency's responses to those questions; and

(7) be updated at least quarterly.

(c) In designing the Internet website, the commission shall comply with any state standards for Internet websites that are prescribed by the Department of Information Resources or any other state agency.

(d) The commission shall ensure that:

(1) the Internet website's design and applications:

(A) comply with generally acceptable standards for Internet accessibility for individuals with disabilities; and

(B) contain appropriate controls for information security; and

(2) the Internet website does not contain any confidential information, including any confidential information regarding a client of a human services provider.

(e) A health and human services agency, the network, and the Department of Information Resources shall cooperate with the commission to the extent necessary to enable the commission to perform its duties under this section. (Gov. Code, Secs. 531.0317(b), (c), (d), (e), (f).)

Sec. 526.0003. INFORMATION ON LONG-TERM CARE SERVICES. (a) The Internet website maintained under Section 526.0002 must include information for consumers concerning long-term care services. The information must:

(1) be presented in a manner that is easily accessible to and understandable by a consumer; and

(2) allow a consumer to make informed choices concerning long-term care services and include:

(A) an explanation of the manner in which long-term care service delivery is administered in different counties through different programs the commission operates so that an individual can easily understand the service options available in the area in which that individual lives; and

(B) for the STAR+PLUS Medicaid managed care program, information in an accessible format, such as a table, that allows a consumer to evaluate the performance of each participating plan issuer, including for each issuer:

(i) the enrollment in each county;

(ii) additional "value-added" services provided;

(iii) a summary of the financial statistical report required under Section 540.0211;

(iv) complaint information;

(v) any sanction or penalty imposed by any state agency, including a sanction or penalty imposed by the commission or the Texas Department of Insurance;

(vi) consumer satisfaction information; and

(vii) other data, including relevant data from reports of external quality review organizations, that may be used by the consumer to evaluate the quality of the services provided.

(b) In addition to providing the information required by this section through the Internet website, the commission shall, on request by a consumer without Internet access, provide the consumer with a printed copy of the information from the Internet website. The commission may charge a reasonable fee for printing the information. The executive commissioner by rule shall establish the fee amount. (Gov. Code, Sec. 531.0318.)

Sec. 526.0004. TEXAS INFORMATION AND REFERRAL NETWORK. (a) The Texas Information and Referral Network is responsible for developing, coordinating, and implementing a statewide information and referral network that integrates existing community-based structures with state and local agencies. The network must:

(1) include information relating to transportation services provided to clients of state and local agencies;

(2) be capable of assisting with statewide disaster response and emergency management, including through the use of interstate agreements with out-of-state call centers to ensure

preparedness and responsiveness;

(3) include technology capable of communicating with clients of state and local agencies using electronic text messaging; and

(4) include a publicly accessible Internet-based system to provide real-time, searchable data about the location and number of clients of state and local agencies using the system and the types of requests the clients made.

(b) The commission shall cooperate with the council and the comptroller to establish a single method of categorizing information about health and human services to be used by the council and the network. The network, in cooperation with the council and the comptroller, shall ensure that:

(1) information relating to health and human services is included in each residential telephone directory published by a for-profit publisher and distributed to the public at minimal or no cost; and

(2) the single method of categorizing information about health and human services is used in the directory.

(c) A health and human services agency or a public or private entity receiving state-appropriated funds to provide health and human services shall provide the council and the network with information about the health and human services the agency or entity provides for inclusion in the statewide information and referral network, residential telephone directories described by Subsection (b), and any other materials produced under the council's or the network's direction. The agency or entity shall

provide the information in the format the council or the network requires and shall update the information at least quarterly or as required by the council or the network.

(d) The Texas Department of Housing and Community Affairs shall provide the network with information regarding the department's housing and community affairs programs for inclusion in the statewide information and referral network. The department shall provide the information in a form the commission determines and shall update the information at least quarterly.

(e) Each local workforce development board, the Texas Head Start State Collaboration Office, and each school district shall provide the network with information regarding eligibility for and availability of child-care and education services as defined by Section 526.0006 for inclusion in the statewide information and referral network. The local workforce development boards, Texas Head Start State Collaboration Office, and school districts shall provide the information in a form the executive commissioner determines. (Gov. Code, Sec. 531.0312.)

Sec. 526.0005. INTERNET WEBSITE FOR HEALTH AND HUMAN SERVICES REFERRAL INFORMATION. (a) The network may develop an Internet website to provide information to the public regarding the health and human services provided by public or private entities throughout this state.

(b) The material on the network Internet website must be:

(1) geographically indexed, including by type of service provided within each geographic area; and

(2) designed to inform an individual about the health

and human services provided in the area in which the individual lives.

(c) The Internet website may contain:

(1) links to the Internet websites of any local health and human services provider;

(2) the name, address, and telephone number of organizations providing health and human services in a county and a description of the type of services those organizations provide; and

(3) any other information that educates the public about the health and human services provided in a county.

(d) The network shall coordinate with the Department of Information Resources to maintain the Internet website through the state electronic Internet portal project established by the department. (Gov. Code, Secs. 531.0313(a), (b), (c), (d).)

Sec. 526.0006. INTERNET WEBSITE FOR CHILD-CARE AND EDUCATION SERVICES REFERRAL INFORMATION. (a) In this section, "child-care and education services" means:

(1) subsidized child-care services administered by the Texas Workforce Commission and local workforce development boards and funded wholly or partly by federal child-care development funds;

(2) child-care and education services provided by a Head Start or Early Head Start program provider;

(3) child-care and education services provided by a school district through a prekindergarten or after-school program; and

(4) any other government-funded child-care and education services, other than education and services a school district provides as part of the general program of public education, designed to educate or provide care for children younger than 13 years of age in middle-income or low-income families.

(b) In addition to providing health and human services information, the network Internet website established under Section 526.0005 must provide information to the public regarding child-care and education services public or private entities provide throughout this state. The Internet website will serve as a single point of access through which an individual may be directed toward information regarding the manner of or location for applying for all child-care and education services available in the individual's community.

(c) To the extent resources are available, the Internet website must:

(1) be geographically indexed and designed to inform an individual about the child-care and education services provided in the area in which the individual lives;

(2) contain prescreening questions to determine an individual's or family's probable eligibility for child-care and education services; and

(3) be designed in a manner that allows network staff to:

(A) provide an applicant with the telephone number, physical address, and e-mail address of the:

(i) nearest Head Start or Early Head Start

office or center and local workforce development center; and

(ii) appropriate school district; and

(B) send an e-mail message to each appropriate entity described by Paragraph (A) containing each applicant's name and contact information and a description of the services for which the applicant is applying.

(d) On receipt of an e-mail message from the network under Subsection (c)(3)(B), each applicable entity shall:

(1) contact the applicant to verify information regarding the applicant's eligibility for available child-care and education services; and

(2) on certifying the applicant's eligibility, match the applicant with entities providing those services in the applicant's community, including local workforce development boards, local child-care providers, or a Head Start or Early Head Start program provider.

(e) The child-care resource and referral network described by Chapter 310, Labor Code, and each entity providing child-care and education services in this state, including local workforce development boards, the Texas Education Agency, school districts, Head Start and Early Head Start program providers, municipalities, counties, and other political subdivisions of this state, shall cooperate with the network as necessary to administer this section. (Gov. Code, Sec. 531.03131.)

Sec. 526.0007. INTERNET WEBSITE FOR REFERRAL INFORMATION ON HOUSING OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS. (a) The commission shall make available through the network Internet

website established under Section 526.0005 information regarding housing options for individuals with mental illness provided by public or private entities throughout this state. The Internet website serves as a single point of access through which an individual may be directed toward information regarding the manner of or where to apply for housing for individuals with mental illness in the individual's community. In this subsection, "private entity" includes any provider of housing specifically for individuals with mental illness other than a state agency, county, municipality, or other political subdivision of this state, regardless of whether the provider accepts payment for providing housing for those individuals.

(b) To the extent resources are available, the Internet website must be geographically indexed and designed to inform an individual about the housing options for individuals with mental illness provided in the area in which the individual lives.

(c) The Internet website must contain a searchable listing of available housing options for individuals with mental illness by type with a definition for each type of housing and an explanation of the populations of individuals with mental illness generally served by that type of housing. The list must include the following types of housing for individuals with mental illness:

(1) state hospitals;

(2) step-down units in state hospitals;

(3) community hospitals;

(4) private psychiatric hospitals;

(5) an inpatient treatment service provider in the

network of service providers assembled by a local mental health authority under Section 533.035(c), Health and Safety Code;

(6) assisted living facilities;

(7) continuing care facilities;

(8) boarding homes;

(9) emergency shelters for individuals who are homeless;

(10) transitional housing intended to move individuals who are homeless to permanent housing;

(11) supportive housing or long-term, community-based affordable housing that provides supportive services;

(12) general residential operations, as defined by Section 42.002, Human Resources Code; and

(13) residential treatment centers or a type of general residential operation that provides services to children with emotional disorders in a structured and supportive environment.

(d) For each housing facility named in the listing of available housing options for individuals with mental illness, the Internet website must indicate whether the provider operating the housing facility is licensed by this state.

(e) The Internet website must display a disclaimer that the information provided is for informational purposes only and is not an endorsement or recommendation of any type of housing or any housing facility.

(f) Each entity providing housing specifically for individuals with mental illness in this state, including the

commission, counties, municipalities, other political subdivisions of this state, and private entities, shall cooperate with the network as necessary to administer this section. (Gov. Code, Sec. 531.03132.)

Sec. 526.0008. COMPLIANCE WITH NATIONAL ELECTRONIC DATA INTERCHANGE STANDARDS FOR HEALTH CARE INFORMATION. Each health and human services agency and other state agency that acts as a health care provider or a claims payer for the provision of health care shall:

(1) process information related to health care in compliance with national data interchange standards adopted under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), within the applicable deadline established under federal law or federal regulations; or

(2) demonstrate to the commission the reasons the agency should not be required to comply with Subdivision (1), and to the extent allowed under federal law, obtain the commission's approval to:

(A) comply with the standards at a later date; or

(B) not comply with one or more of the standards. (Gov. Code, Sec. 531.0315.)

Sec. 526.0009. TECHNICAL ASSISTANCE FOR HUMAN SERVICES PROVIDERS. (a) A health and human services agency shall, in conjunction with the Department of Information Resources, coordinate and enhance the agency's existing Internet website to provide technical assistance for human services providers. The

commission shall take the lead and ensure involvement of the agencies with the greatest potential to produce cost savings.

(b) Assistance provided under this section:

(1) must include information on the impact of federal and state welfare reform changes on human services providers;

(2) may include information in the following subjects:

(A) case management;

(B) contract management;

(C) financial management;

(D) performance measurement and evaluation;

(E) research; and

(F) other matters the commission considers appropriate; and

(3) may not include any confidential information regarding a client of a human services provider. (Gov. Code, Sec. 531.013.)

Sec. 526.0010. INFORMATION RESOURCES MANAGER REPORTS. Notwithstanding Section 2054.075(b), the information resources manager of a health and human services agency shall report directly to the executive commissioner or a deputy executive commissioner the executive commissioner designates. (Gov. Code, Sec. 531.02731.)

SUBCHAPTER B. PROGRAMS AND SERVICES PROVIDED OR ADMINISTERED BY COMMISSION

Sec. 526.0051. RESTRICTIONS ON AWARDS TO FAMILY PLANNING SERVICE PROVIDERS. (a) Notwithstanding any other law, money appropriated to the commission for the purpose of providing family

planning services must be awarded:

(1) to eligible entities in the following order of descending priority:

(A) public entities that provide family planning services, including state, county, and local community health clinics and federally qualified health centers;

(B) nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services; and

(C) nonpublic entities that provide family planning services but do not provide comprehensive primary and preventive care services; or

(2) as otherwise directed by the legislature in the General Appropriations Act.

(b) Notwithstanding Subsection (a), the commission shall, in compliance with federal law, ensure distribution of funds for family planning services in a manner that does not severely limit or eliminate access to those services in any region of this state. (Gov. Code, Sec. 531.0025.)

Sec. 526.0052. INFORMATION FOR CERTAIN ENROLLEES IN HEALTHY TEXAS WOMEN PROGRAM. (a) In this section, "Healthy Texas Women program" means a program the commission operates that is substantially similar to the demonstration project operated under former Section 32.0248, Human Resources Code, and that is intended to expand access to preventive health and family planning services for women in this state.

(b) This section applies to a woman who is automatically

enrolled in the Healthy Texas Women program following a pregnancy for which the woman received Medicaid, but who is no longer eligible to participate in Medicaid.

(c) After a woman to whom this section applies is enrolled in the Healthy Texas Women program, the commission shall provide to the woman:

(1) information about the Healthy Texas Women program, including the services provided under the program; and

(2) a list of health care providers who participate in the Healthy Texas Women program and are located in the same geographical area in which the woman resides.

(d) The commission shall consult with the Texas Maternal Mortality and Morbidity Review Committee established under Chapter 34, Health and Safety Code, to improve the process for providing the information required by Subsection (c), including by determining:

(1) the best time for providing the information; and

(2) the manner of providing the information, including the information about health care providers described by Subsection (c)(2). (Gov. Code, Sec. 531.0995.)

Sec. 526.0053. VACCINES FOR CHILDREN PROGRAM PROVIDER ENROLLMENT; IMMUNIZATION REGISTRY. (a) In this section, "vaccines for children program" means the program the Department of State Health Services operates under 42 U.S.C. Section 1396s.

(b) The commission shall ensure that a provider may enroll in the vaccines for children program on the same form the provider completes to apply as a Medicaid health care provider.

(c) The commission shall allow providers to:

(1) report vaccines administered under the vaccines for children program to the immunization registry established under Section 161.007, Health and Safety Code; and

(2) use the immunization registry, including individually identifiable information in accordance with state and federal law, to determine whether a child received an immunization. (Gov. Code, Sec. 531.064.)

Sec. 526.0054. PRIOR AUTHORIZATION FOR HIGH-COST MEDICAL SERVICES AND PROCEDURES. (a) The commission may:

(1) evaluate and implement, as appropriate, procedures, policies, and methodologies to require prior authorization for high-cost medical services and procedures; and

(2) contract with qualified service providers or organizations to perform those functions.

(b) A procedure, policy, or methodology implemented under this section must comply with any prohibitions in state or federal law on limits in the amount, duration, or scope of medically necessary services for Medicaid recipients who are children. (Gov. Code, Sec. 531.075.)

Sec. 526.0055. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) The commission shall identify state or federal non-Medicaid programs that provide health care services to individuals whose health care needs could be met by providing customized benefits through a system of care that is used under a Medicaid tailored benefit package implemented under Section 532.0351.

(b) If the commission determines it is feasible and to the

extent permitted by federal and state law, the commission shall:

(1) provide the health care services for individuals described by Subsection (a) through the applicable Medicaid tailored benefit package; and

(2) if appropriate or necessary to provide the services as required by Subdivision (1), develop and implement a system of blended funding methodologies to provide the services in that manner. (Gov. Code, Sec. 531.0971.)

Sec. 526.0056. PILOT PROGRAM TO PREVENT SPREAD OF INFECTIOUS OR COMMUNICABLE DISEASES. The commission may provide guidance to the local health authority of Bexar County in establishing a pilot program funded by the county to prevent the spread of HIV, hepatitis B, hepatitis C, and other infectious and communicable diseases. The program may include a disease control program that provides for the anonymous exchange of used hypodermic needles and syringes. (Gov. Code, Sec. 531.0972.)

Sec. 526.0057. APPLICATION REQUIREMENT FOR COLONIAS PROJECTS. (a) In this section, "colonia" means a geographic area that:

(1) is an economically distressed area as defined by Section 17.921, Water Code;

(2) is located in a county any part of which is within 62 miles of an international border; and

(3) consists of 11 or more dwellings located in proximity to each other in an area that may be described as a community or neighborhood.

(b) The commission shall require an applicant for funds

under any project the commission funds that provides assistance to colonias to submit to the commission any existing colonia classification number for each colonia that may be served by the project proposed in the application.

(c) The commission may contact the secretary of state or the secretary of state's representative to obtain a classification number for a colonia that does not have a classification number. On request of the commission, the secretary of state or the secretary of state's representative shall assign a classification number to the colonia. (Gov. Code, Sec. 531.0141.)

Sec. 526.0058. RULES REGARDING REFUGEE RESETTLEMENT. (a) In this section, "local resettlement agency" and "national voluntary agency" have the meanings assigned by 45 C.F.R. Section 400.2.

(b) The executive commissioner shall adopt rules to ensure that:

(1) any refugee placement report required under a federal refugee resettlement program includes local governmental and community input; and

(2) governmental entities and officials are provided with related information.

(c) In adopting the rules, the executive commissioner shall, to the extent permitted by federal law, ensure that meetings are convened at least quarterly in the communities proposed for refugee placement at which representatives of local resettlement agencies have an opportunity to consult with and obtain feedback regarding proposed refugee placement from:

(1) local governmental entities and officials, including:

(A) municipal and county officials;

(B) local school district officials; and

(C) representatives of local law enforcement agencies; and

(2) other community stakeholders, including:

(A) major providers under the local health care system; and

(B) major employers of refugees.

(d) In adopting the rules, the executive commissioner shall, to the extent permitted by federal law, ensure that:

(1) a local resettlement agency:

(A) considers all feedback obtained in meetings conducted under Subsection (c) before preparing a proposed annual report on the placement of refugees for purposes of 8 U.S.C. Section 1522(b)(7)(E);

(B) informs the state and local governmental entities and officials and community stakeholders described by Subsection (c) of the proposed annual report; and

(C) develops a final annual report for the national voluntary agencies and the commission that includes a summary regarding the manner in which stakeholder input contributed to the report; and

(2) the commission:

(A) obtains from local resettlement agencies the preliminary number of refugees the local resettlement agencies

recommended to the national voluntary agencies for placement in communities throughout this state and provides that information to local governmental entities and officials in those communities; and

(B) obtains from the United States Department of State or other appropriate federal agency the number of refugees apportioned to this state and provides that information and information regarding the number of refugees intended to be placed in each community in this state to local governmental entities and officials in those communities. (Gov. Code, Sec. 531.0411.)

Sec. 526.0059. PROHIBITED AWARD OF CONTRACTS TO MANAGED CARE ORGANIZATIONS FOR CERTAIN CRIMINAL CONVICTIONS. The commission may not contract with a managed care organization, including a health maintenance organization, or a pharmacy benefit manager if, in the preceding three years, the organization or manager, in connection with a bid, proposal, or contract with the commission, was subject to a final judgment by a court of competent jurisdiction resulting in:

(1) a conviction for:

(A) a criminal offense under state or federal law related to the delivery of an item or service;

(B) a criminal offense under state or federal law related to neglect or abuse of patients in connection with the delivery of an item or service; or

(C) a felony offense under state or federal law related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

(2) the imposition of a penalty or fine in the amount

of $500,000 or more in a state or federal administrative proceeding based on a conviction for a criminal offense under state or federal law. (Gov. Code, Sec. 531.0696.)

SUBCHAPTER C. COORDINATION OF QUALITY INITIATIVES

Sec. 526.0101. DEFINITION. In this subchapter, "waiver" means the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315). (New.)

Sec. 526.0102. OPERATIONAL PLAN TO COORDINATE MAJOR QUALITY INITIATIVES. (a) The commission shall develop and implement a comprehensive, coordinated operational plan to ensure a consistent approach across the major quality initiatives of the health and human services system for improving the quality of health care. The plan must include broad goals for improving the quality of health care in this state, including health care services provided through Medicaid.

(b) The plan may evaluate:

(1) the Delivery System Reform Incentive Payment (DSRIP) program under the waiver;

(2) enhancing funding to disproportionate share hospitals in this state;

(3) Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. Section 18052);

(4) enhancing uncompensated care pool payments to hospitals in this state under the waiver;

(5) home and community-based services state plan options under Section 1915(i) of the Social Security Act (42 U.S.C.

Section 1396n(i)); and

(6) a contingency plan in the event the commission does not obtain an extension or renewal of the uncompensated care pool provisions or any other provisions of the granted waiver. (Gov. Code, Sec. 531.451.)

Sec. 526.0103. REVISION AND EVALUATION OF MAJOR QUALITY INITIATIVES. Notwithstanding other law, the commission shall revise major quality initiatives of the health and human services system in accordance with the operational plan and health care quality improvement goals developed under Section 526.0102. To the extent possible, the commission shall ensure that outcome measure data is collected and reported consistently across all major quality initiatives to improve the evaluation of the initiatives' statewide impact. (Gov. Code, Sec. 531.452.)

Sec. 526.0104. INCENTIVES FOR MAJOR QUALITY INITIATIVE COORDINATION. The commission shall consider and, if appropriate, develop in accordance with this subchapter, incentives that promote coordination among the various major quality initiatives, including projects and initiatives approved under the granted waiver. (Gov. Code, Sec. 531.453.)

SUBCHAPTER D. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND

Sec. 526.0151. DEFINITION. In this subchapter, "fund" means the Texas health opportunity pool trust fund established under Section 526.0153. (Gov. Code, Sec. 531.501.)

Sec. 526.0152. AUTHORITY TO OBTAIN FEDERAL WAIVER. (a) The executive commissioner may seek a waiver under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to the state Medicaid

plan to allow the commission to more efficiently and effectively use federal money paid to this state under various programs to defray costs associated with providing uncompensated health care in this state by using that federal money, appropriated state money to the extent necessary, and any other money described by this section for purposes consistent with this subchapter.

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

(1) money provided under:

(A) the disproportionate share hospitals program;

(B) the upper payment limit supplemental payment program; or

(C) both;

(2) money provided by the federal government in lieu of some or all of the payments provided under one or both of the programs described by Subdivision (1);

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

(4) any other money available for that purpose, including:

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

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

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

(D) if approved in the waiver, federal money

obtained through the use of certified public expenditures.

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

(1) identifying health care-related state and local funds and program expenditures that, before September 1, 2011, are not being matched with federal money; and

(2) exploring the feasibility of:

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

(B) depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 526.0154, or substituting that federal matching money for federal money that otherwise would be received under the disproportionate share hospitals and upper payment limit supplemental payment programs as a match for local funds received by this state through intergovernmental transfers.

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

(1) include safeguards to ensure that the total amount of federal money provided under the disproportionate share hospitals or upper payment limit supplemental payment program that is deposited as provided by Section 526.0154 is, for a particular state fiscal year, at least equal to the greater of the annualized amount provided to this state under those supplemental payment programs during:

(A) state fiscal year 2011, excluding retroactive payment amounts provided during that state fiscal year;

or

(B) the state fiscal years during which the waiver is in effect; and

(2) allow this state to develop a methodology for allocating money in the fund to:

(A) supplement Medicaid hospital reimbursements under a waiver that includes terms consistent with, or that produce revenues consistent with, disproportionate share hospital and upper payment limit principles;

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

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

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

(1) obtain maximum flexibility in the use of the money in the fund for purposes consistent with this subchapter;

(2) include an annual adjustment to the aggregate caps under the upper payment limit supplemental payment program to account for inflation, population growth, and other appropriate demographic factors that affect the ability of residents of this state to obtain health benefits coverage;

(3) ensure, for the term of the waiver, that the aggregate caps under the upper payment limit supplemental payment program for each of the three classes of hospitals are not less than the aggregate caps applied during state fiscal year 2007; and

(4) to the extent allowed by federal law, including

federal regulations, and federal waiver authority, preserve the federal supplemental payment program payments made to hospitals, the state match with respect to which is funded by intergovernmental transfers or certified public expenditures that are used to optimize Medicaid payments to safety net providers for uncompensated care, and preserve allocation methods for those payments, unless the need for the payments is revised through measures that reduce the Medicaid shortfall or uncompensated care costs.

(f) The executive commissioner shall seek broad-based stakeholder input in the development of the waiver under this section and shall provide information to stakeholders regarding the terms of the waiver for which the executive commissioner seeks federal approval. (Gov. Code, Sec. 531.502.)

Sec. 526.0153. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND ESTABLISHED. (a) Subject to approval of the waiver authorized by Section 526.0152, the Texas health opportunity pool trust fund is created as a trust fund outside the state treasury to be held by the comptroller and administered by the commission as trustee on behalf of residents of this state who do not have private health benefits coverage and health care providers providing uncompensated care to those individuals.

(b) The commission may spend money in the fund only for purposes consistent with this subchapter and the terms of the waiver authorized by Section 526.0152. (Gov. Code, Sec. 531.503.)

Sec. 526.0154. DEPOSITS TO FUND. (a) The comptroller shall deposit in the fund:

(1) federal money provided to this state under the disproportionate share hospitals supplemental payment program, the hospital upper payment limit supplemental payment program, or both, other than money provided under those programs to state-owned and -operated hospitals, and all other nonsupplemental payment program federal money provided to this state that is included in the waiver authorized by Section 526.0152; and

(2) state money appropriated to the fund.

(b) The commission and comptroller may accept gifts, grants, and donations from any source, and receive intergovernmental transfers, for purposes consistent with this subchapter and the terms of the waiver authorized by Section 526.0152. The comptroller shall deposit a gift, grant, or donation made for those purposes in the fund.

(c) Any intergovernmental transfer received, including associated federal matching funds, shall be used, if feasible, for the purposes intended by the transferring entity and in accordance with the terms of the waiver authorized by Section 526.0152. (Gov. Code, Sec. 531.504.)

Sec. 526.0155. USE OF FUND IN GENERAL; RULES FOR ALLOCATION. (a) Except as otherwise provided by the terms of a waiver authorized by Section 526.0152, money in the fund may be used:

(1) subject to Section 526.0156, to provide to health care providers reimbursements that:

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

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

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

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

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

(b) On approval of the waiver authorized by Section 526.0152, the executive commissioner shall:

(1) seek input from a broad base of stakeholder representatives on the development of rules with respect to and for the administration of the fund; and

(2) by rule develop a methodology for allocating money in the fund that is consistent with the terms of the waiver. (Gov. Code, Sec. 531.505.)

Sec. 526.0156. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Except as otherwise provided by the terms of a waiver authorized by Section 526.0152 and subject to Subsections (b) and (c), money in the fund may be allocated to hospitals in this state and political subdivisions of this state to defray the costs of providing uncompensated health care.

(b) To be eligible for money allocated from the fund under this section, a hospital or political subdivision must use a portion of the money to implement strategies that will reduce the need for uncompensated inpatient and outpatient care, including care provided in a hospital emergency room. The strategies may

include:

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

(A) regional or local health care programs;

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

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

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

(c) The allocation methodology the executive commissioner develops under Section 526.0155(b) must specify the percentage of the money from the fund allocated to a hospital or political subdivision that the hospital or political subdivision must use for strategies described by Subsection (b) of this section. (Gov. Code, Sec. 531.506.)

Sec. 526.0157. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Except as otherwise provided by the terms of a waiver authorized by Section 526.0152, money in the fund that is available to reduce the number of individuals in this state who do not have health benefits coverage or to reduce the need for uncompensated health care provided by hospitals in this state may be used for purposes relating to increasing access to health benefits coverage for individuals with low income, including:

(1) providing premium payment assistance to those individuals through a premium payment assistance program developed

under this section;

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

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

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

(1) eligibility criteria for the program;

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

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

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

(c) The commission shall implement the premium payment assistance program developed under Subsection (b), subject to availability of money in the fund for that purpose. (Gov. Code, Sec. 531.507.)

Sec. 526.0158. INFRASTRUCTURE IMPROVEMENTS. (a) Except as

otherwise provided by the terms of a waiver authorized by Section 526.0152 and subject to Subsection (c), money in the fund may be used for purposes related to developing and implementing initiatives to improve the infrastructure of local provider networks that provide services to Medicaid recipients and individuals with low income and without health benefits coverage in this state.

(b) The infrastructure improvements may include developing and implementing a system for maintaining medical records in an electronic format.

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

(d) Money from the fund may not be used to finance the construction, improvement, or renovation of a building or land unless the commission approves the construction, improvement, or renovation in accordance with rules the executive commissioner adopts for that purpose. (Gov. Code, Sec. 531.508.)

SUBCHAPTER E. LONG-TERM CARE FACILITIES

Sec. 526.0201. DEFINITION. In this subchapter, "council" means the Long-Term Care Facilities Council. (Gov. Code, Sec. 531.0581(a)(1).)

Sec. 526.0202. INFORMAL DISPUTE RESOLUTION FOR CERTAIN LONG-TERM CARE FACILITIES. (a) The executive commissioner by rule shall establish an informal dispute resolution process in

accordance with this section. The process must:

(1) provide for adjudication by an appropriate disinterested person of disputes relating to a proposed commission enforcement action or related proceeding under:

(A) Section 32.021(d), Human Resources Code; or

(B) Chapter 242, 247, or 252, Health and Safety Code; and

(2) require:

(A) a facility to request informal dispute resolution not later than the 10th calendar day after the commission notifies the facility of the violation of a standard or standards; and

(B) the completion of the process not later than:

(i) the 30th calendar day after receipt of a request for informal dispute resolution from a facility, other than an assisted living facility; or

(ii) the 90th calendar day after receipt of a request from an assisted living facility for informal dispute resolution.

(b) As part of the informal dispute resolution process, the commission shall contract with an appropriate disinterested person to adjudicate disputes between a facility licensed under Chapter 242 or 247, Health and Safety Code, and the commission concerning a statement of violations the commission prepares in connection with a survey the commission conducts of the facility. The contracting person shall adjudicate all disputes described by this subsection. The informal dispute resolution process for the statement of

violations must require:

(1) the surveyor who conducted the survey for which the statement was prepared to be available to clarify or answer questions asked by the contracting person or by the facility related to the facility or statement; and

(2) the commission's review of the facility's informal dispute resolution request for a standard of care violation to be conducted by a registered nurse with long-term care experience.

(c) Section 2009.053 does not apply to the commission's selection of an appropriate disinterested person under Subsection (b).

(d) The executive commissioner shall adopt rules to adjudicate claims in contested cases.

(e) The commission may not delegate to another state agency the commission's responsibility to administer the informal dispute resolution process.

(f) The rules adopted under Subsection (a) that relate to a dispute described by Section 247.051(a), Health and Safety Code, must incorporate the requirements of Section 247.051, Health and Safety Code. (Gov. Code, Sec. 531.058.)

Sec. 526.0203. LONG-TERM CARE FACILITIES COUNCIL. (a) In this section, "long-term care facility" means a facility subject to regulation under Section 32.021(d), Human Resources Code, or Chapter 242, 247, or 252, Health and Safety Code.

(b) The executive commissioner shall establish a long-term care facilities council as a permanent advisory committee to the commission. The council is composed of the following members the

executive commissioner appoints:

(1) at least one member who is a for-profit nursing facility provider;

(2) at least one member who is a nonprofit nursing facility provider;

(3) at least one member who is an assisted living services provider;

(4) at least one member responsible for survey enforcement within the state survey and certification agency;

(5) at least one member responsible for survey inspection within the state survey and certification agency;

(6) at least one member of the state agency responsible for informal dispute resolution;

(7) at least one member with expertise in Medicaid quality-based payment systems for long-term care facilities;

(8) at least one member who is a practicing medical director of a long-term care facility;

(9) at least one member who is a physician with expertise in infectious disease or public health; and

(10) at least one member who is a community-based provider at an intermediate care facility for individuals with intellectual or developmental disabilities licensed under Chapter 252, Health and Safety Code.

(c) The executive commissioner shall designate a council member to serve as presiding officer. The council members shall elect any other necessary officers.

(d) A council member serves at the will of the executive

commissioner.

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

(f) A council member is not entitled to reimbursement of expenses or to compensation for service on the council.

(g) Chapter 2110 does not apply to the council. (Gov. Code, Secs. 531.0581(a)(2), (b), (c), (d), (e), (f), (i).)

Sec. 526.0204. COUNCIL DUTIES; REPORT. (a) In this section, "long-term care facility" has the meaning assigned by Section 526.0203.

(b) The council shall:

(1) study and make recommendations regarding a consistent survey and informal dispute resolution process for long-term care facilities, Medicaid quality-based payment systems for those facilities, and the allocation of Medicaid beds in those facilities;

(2) study and make recommendations regarding best practices and protocols to make survey, inspection, and informal dispute resolution processes more efficient and less burdensome on long-term care facilities;

(3) recommend uniform standards for those processes;

(4) study and make recommendations regarding Medicaid quality-based payment systems and a rate-setting methodology for long-term care facilities; and

(5) study and make recommendations relating to the allocation of and need for Medicaid beds in long-term care facilities, including studying and making recommendations relating

to:

(A) the effectiveness of rules adopted by the executive commissioner relating to the procedures for certifying and decertifying Medicaid beds in long-term care facilities; and

(B) the need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds in long-term care facilities.

(c) Not later than January 1 of each odd-numbered year, the council shall submit a report on the council's findings and recommendations to the executive commissioner, the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate legislative committees. (Gov. Code, Secs. 531.0581(a)(2), (g), (h).)

SUBCHAPTER F. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS; ADMINISTRATIVE PENALTY

Sec. 526.0251. RULES. The executive commissioner shall adopt rules providing for:

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

(2) a methodology for hospitals in this state to use in computing the cost of uncompensated hospital care that incorporates a standard set of adjustments to a hospital's initial computation of the cost that accounts for all funding streams that:

(A) are not patient-specific; and

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

(3) procedures for hospitals to use in reporting the

cost of uncompensated hospital care to the commission and in analyzing that cost, which may include procedures by which the commission may periodically verify the completeness and accuracy of the reported information. (Gov. Code, Secs. 531.551(a), (b).)

Sec. 526.0252. NOTICE OF FAILURE TO REPORT; ADMINISTRATIVE PENALTY. (a) The commission shall notify the attorney general of a hospital's failure to report the cost of uncompensated hospital care on or before the report due date in accordance with rules adopted under Section 526.0251(3).

(b) On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in the amount of $1,000 for each day after the report due date that the hospital has not submitted the report, not to exceed $10,000. (Gov. Code, Sec. 531.551(c).)

Sec. 526.0253. NOTICE OF INCOMPLETE OR INACCURATE REPORT; ADMINISTRATIVE PENALTY. (a) If the commission determines that a hospital submitted a report with incomplete or inaccurate information using a procedure adopted under Section 526.0251(3), the commission shall:

(1) notify the hospital of the specific information the hospital must submit; and

(2) prescribe a date by which the hospital must provide that information.

(b) If the hospital fails to submit the specified information on or before the date the commission prescribes, the commission shall notify the attorney general of that failure.

(c) On receipt of the commission's notice, the attorney

general shall impose an administrative penalty on the hospital in an amount not to exceed $10,000. In determining the amount of the penalty to be imposed, the attorney general shall consider:

(1) the seriousness of the violation;

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

(3) the amount necessary to deter the hospital from committing future violations. (Gov. Code, Sec. 531.551(d).)

Sec. 526.0254. REQUIREMENTS FOR ATTORNEY GENERAL NOTIFICATION. The commission's notification to the attorney general under Section 526.0252 or 526.0253 must include the facts on which the commission based the determination that the hospital failed to submit a report or failed to completely and accurately report information, as applicable. (Gov. Code, Sec. 531.551(e).)

Sec. 526.0255. ATTORNEY GENERAL NOTICE TO HOSPITAL. The attorney general shall give written notice of the commission's notification to the attorney general under Section 526.0252 or 526.0253 to the hospital that is the subject of the notification. The notice must include:

(1) a brief summary of the alleged violation;

(2) a statement of the amount of the administrative penalty to be imposed; and

(3) a statement of the hospital's right to a hearing on the alleged violation, the amount of the penalty, or both. (Gov. Code, Sec. 531.551(f).)

Sec. 526.0256. PENALTY PAID OR HEARING REQUESTED. Not later than the 20th day after the date the attorney general sends

the notice under Section 526.0255, the hospital receiving the notice must submit a written request for a hearing or remit the amount of the administrative penalty to the attorney general. Failure to timely request a hearing or remit the amount of the administrative penalty results in a waiver of the right to a hearing under this section. (Gov. Code, Sec. 531.551(g) (part).)

Sec. 526.0257. HEARING. (a) If a hospital requests a hearing in accordance with Section 526.0256, the attorney general shall conduct the hearing in accordance with Chapter 2001.

(b) If the hearing results in a finding that a violation has occurred, the attorney general shall:

(1) provide to the hospital written notice of:

(A) the findings established at the hearing; and

(B) the amount of the penalty; and

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

(c) An order entered by the attorney general under this section is subject to judicial review as a contested case under Chapter 2001. (Gov. Code, Secs. 531.551(g) (part), (i).)

Sec. 526.0258. OPTIONS FOLLOWING DECISION: PAY OR APPEAL. Not later than the 30th day after the date the hospital receives the order entered by the attorney general under Section 526.0257, the hospital shall:

(1) pay the amount of the administrative penalty;

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

amount of the penalty, or both; or

(3) without paying the amount of the penalty:

(A) file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both; and

(B) file with the court a sworn affidavit stating that the hospital is financially unable to pay the amount of the penalty. (Gov. Code, Sec. 531.551(h).)

Sec. 526.0259. DECISION BY COURT. (a) If a hospital paid an administrative penalty imposed under this subchapter and on review a court does not sustain the occurrence of the violation or finds that the amount of the penalty should be reduced, the attorney general shall remit the appropriate amount to the hospital not later than the 30th day after the date the court's judgment becomes final.

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

(1) the court:

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

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

(2) the attorney general shall remit the amount of the penalty to the comptroller for deposit in the general revenue fund. (Gov. Code, Secs. 531.551(j), (k).)

Sec. 526.0260. RECOVERY OF PENALTY. If a hospital does not pay the amount of an administrative penalty imposed under this

subchapter after the attorney general's order becomes final for all purposes, the attorney general may enforce the penalty as provided by law for legal judgments. (Gov. Code, Sec. 531.551(l).)

SUBCHAPTER G. RURAL HOSPITAL INITIATIVES

Sec. 526.0301. STRATEGIC PLAN FOR RURAL HOSPITAL SERVICES; REPORT. (a) The commission shall develop and implement a strategic plan to ensure that the citizens in this state residing in rural areas have access to hospital services.

(b) The strategic plan must include:

(1) a proposal for using at least one of the following methods to ensure access to hospital services in the rural areas of this state:

(A) an enhanced cost reimbursement methodology for the payment of rural hospitals participating in the Medicaid managed care program in conjunction with a supplemental payment program for rural hospitals to cover costs incurred in providing services to recipients;

(B) a hospital rate enhancement program applicable only to rural hospitals;

(C) a reduction of punitive actions under Medicaid that require reimbursement for Medicaid payments made to a rural hospital provider, a reduction of the frequency of payment reductions under Medicaid made to rural hospitals, and an enhancement of payments made under merit-based programs or similar programs for rural hospitals;

(D) a reduction of state regulatory-related costs related to the commission's review of rural hospitals; or

(E) in accordance with rules the Centers for Medicare and Medicaid Services adopts, the establishment of a minimum fee schedule that applies to payments made to rural hospitals by Medicaid managed care organizations; and

(2) target dates for achieving goals related to the proposal described by Subdivision (1).

(c) Not later than November 1 of each even-numbered year, the commission shall submit a report regarding the commission's development and implementation of the strategic plan to:

(1) the legislature;

(2) the governor; and

(3) the Legislative Budget Board. (Gov. Code, Secs. 531.201(a), (b), (d).)

Sec. 526.0302. RURAL HOSPITAL ADVISORY COMMITTEE. (a) The commission shall establish the rural hospital advisory committee, either as an advisory committee or as a subcommittee of the hospital payment advisory committee, to advise the commission on issues relating specifically to rural hospitals.

(b) The rural hospital advisory committee is composed of interested individuals the executive commissioner appoints. Section 2110.002 does not apply to the advisory committee.

(c) An advisory committee member serves without compensation. (Gov. Code, Sec. 531.202.)

Sec. 526.0303. COLLABORATION WITH OFFICE OF RURAL AFFAIRS. The commission shall collaborate with the Office of Rural Affairs to ensure that this state is pursuing to the fullest extent possible federal grants, funding opportunities, and support programs

available to rural hospitals as administered by the Health Resources and Services Administration and the Office of Minority Health in the United States Department of Health and Human Services. (Gov. Code, Sec. 531.203.)

SUBCHAPTER H. MEDICAL TRANSPORTATION

Sec. 526.0351. DEFINITIONS. In this subchapter:

(1) "Medical transportation program" means the program that provides nonemergency transportation services to recipients under Medicaid, subject to Section 526.0353, the children with special health care needs program, and the transportation for indigent cancer patients program, who have no other means of transportation.

(2) "Nonemergency transportation service" means nonemergency medical transportation services authorized under:

(A) for a Medicaid recipient, the state Medicaid plan; and

(B) for a recipient under another program described by Subdivision (1), that program.

(3) "Regional contracted broker" means an entity that contracts with the commission to provide or arrange for the provision of nonemergency transportation services under the medical transportation program.

(4) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code. (Gov. Code, Sec. 531.02414(a).)

Sec. 526.0352. DUTY TO PROVIDE MEDICAL TRANSPORTATION SERVICES. (a) The commission shall provide medical transportation

services for clients of eligible health and human services programs.

(b) The commission may contract with any public or private transportation provider or with any regional transportation broker for the provision of public transportation services. (Gov. Code, Sec. 531.0057.)

Sec. 526.0353. APPLICABILITY. Sections 526.0354-526.0360 do not apply to the provision of nonemergency transportation services to a Medicaid recipient who is enrolled in a managed care plan offered by a Medicaid managed care organization. (Gov. Code, Sec. 531.02414(a-1).)

Sec. 526.0354. COMMISSION SUPERVISION OF MEDICAL TRANSPORTATION PROGRAM. Notwithstanding any other law, the commission:

(1) shall directly supervise the administration and operation of the medical transportation program under this subchapter; and

(2) may not delegate the commission's duty to supervise the medical transportation program to any other person, including through a contract with the Texas Department of Transportation for the department to assume any of the commission's responsibilities relating to the provision of services through that program. (Gov. Code, Secs. 531.02414(b), (c).)

Sec. 526.0355. CONTRACT FOR PUBLIC TRANSPORTATION SERVICES. Subject to Subchapter B, Chapter 540A, the commission may contract for the provision of public transportation services, as defined by Section 461.002, Transportation Code, under the

medical transportation program, with:

(1) a public transportation provider, as defined by Section 461.002, Transportation Code;

(2) a private transportation provider; or

(3) a regional transportation broker. (Gov. Code, Sec. 531.02414(d).)

Sec. 526.0356. RULES FOR NONEMERGENCY TRANSPORTATION SERVICES; COMPLIANCE. (a) The executive commissioner shall adopt rules to ensure the safe and efficient provision of nonemergency transportation services under this subchapter. The rules must:

(1) include minimum standards regarding the physical condition and maintenance of motor vehicles used to provide the services, including standards regarding the accessibility of motor vehicles by individuals with disabilities;

(2) require a regional contracted broker to:

(A) verify that each motor vehicle operator providing the services or seeking to provide the services has a valid driver's license;

(B) check the driving record information maintained by the Department of Public Safety under Subchapter C, Chapter 521, Transportation Code, of each motor vehicle operator providing the services or seeking to provide the services; and

(C) check the public criminal record information maintained by the Department of Public Safety and made available to the public through the department's Internet website of each motor vehicle operator providing the services or seeking to provide the services; and

(3) include training requirements for motor vehicle operators providing the services through a regional contracted broker, including training on:

(A) passenger safety;

(B) passenger assistance;

(C) assistive devices, including wheelchair lifts, tie-down equipment, and child safety seats;

(D) sensitivity and diversity;

(E) customer service;

(F) defensive driving techniques; and

(G) prohibited behavior by motor vehicle operators.

(b) Except as provided by Section 526.0358, the commission shall require compliance with the rules adopted under Subsection (a) in any contract entered into with a regional contracted broker to provide nonemergency transportation services under the medical transportation program. (Gov. Code, Secs. 531.02414(e), (f).)

Sec. 526.0357. MEMORANDUM OF UNDERSTANDING; DRIVER AND VEHICLE INFORMATION. (a) The commission shall enter into a memorandum of understanding with the Texas Department of Motor Vehicles and the Department of Public Safety for purposes of obtaining the motor vehicle registration and driver's license information of a medical transportation services provider, including a regional contracted broker and a subcontractor of the broker, to confirm the provider complies with applicable requirements adopted under Section 526.0356(a).

(b) The commission shall establish a process by which

medical transportation services providers, including providers under a managed transportation delivery model, that contract with the commission may request and obtain the information described by Subsection (a) to ensure that subcontractors providing medical transportation services meet applicable requirements adopted under Section 526.0356(a). (Gov. Code, Secs. 531.02414(g), (h).)

Sec. 526.0358. MEDICAL TRANSPORTATION SERVICES SUBCONTRACTS. (a) A regional contracted broker may subcontract with a transportation network company to provide services under this subchapter. A rule or other requirement the executive commissioner adopts under Section 526.0356(a) does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. The commission or the regional contracted broker may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this subchapter.

(b) The commission or a regional contracted broker that subcontracts with a transportation network company under Subsection (a) may require the transportation network company or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

(c) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that

subcontracts with a regional contracted broker under Subsection (a) and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this subchapter. The commission and the regional contracted broker may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this subchapter. (Gov. Code, Secs. 531.02414(j), (k), (l).)

Sec. 526.0359. CERTAIN PROVIDERS PROHIBITED FROM PROVIDING NONEMERGENCY TRANSPORTATION SERVICES. Emergency medical services personnel and emergency medical services vehicles, as those terms are defined by Section 773.003, Health and Safety Code, may not provide nonemergency transportation services under the medical transportation program. (Gov. Code, Sec. 531.02414(i).)

Sec. 526.0360. CERTAIN WHEELCHAIR-ACCESSIBLE VEHICLES AUTHORIZED. For purposes of this section and Sections 526.0354-526.0359 and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under Sections 526.0354-526.0359 may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code. (Gov. Code, Sec. 531.02414(m).)

SUBCHAPTER I. CASEWORKERS AND PROGRAM PERSONNEL

Sec. 526.0401. CASELOAD STANDARDS FOR DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES. (a) In this section:

(1) "Caseload standards" means the minimum and maximum

number of cases that an employee can reasonably be expected to perform in a normal work month based on the number of cases handled by or the number of different job functions performed by the employee.

(2) "Professional caseload standards" means caseload standards for employees of health and human services agencies that are established or are recommended for establishment by:

(A) management studies conducted for health and human services agencies; or

(B) an authority or association, including:

(i) the Child Welfare League of America;

(ii) the National Eligibility Workers Association;

(iii) the National Association of Social Workers; and

(iv) associations of state health and human services agencies.

(b) Subject to Chapter 316 (H.B. 5), Acts of the 85th Legislature, Regular Session, 2017, the executive commissioner may establish caseload standards and other standards relating to caseloads for each category of caseworker the Department of Family and Protective Services employs.

(c) In establishing standards under this section, the executive commissioner shall:

(1) ensure that the standards are based on the caseworker's actual duties;

(2) ensure that the caseload standards are reasonable

and achievable;

(3) ensure that the standards are consistent with existing professional caseload standards;

(4) consider standards developed by other states for caseworkers in similar positions of employment; and

(5) ensure that the standards are consistent with existing caseload standards of other state agencies.

(d) Subject to the availability of funds the legislature appropriates:

(1) the commissioner of the Department of Family and Protective Services shall use the standards established under this section to determine the number of personnel to assign as caseworkers for the department; and

(2) the Department of Family and Protective Services shall use the standards established to assign caseloads to individual caseworkers the department employs.

(e) Nothing in this section may be construed to create a cause of action. (Gov. Code, Secs. 531.001(1), (5), 531.048; New.)

Sec. 526.0402. JOINT TRAINING FOR CERTAIN CASEWORKERS. (a) The executive commissioner shall provide for joint training for health and human services caseworkers whose clients are children, including caseworkers employed by:

(1) the commission;

(2) the Department of State Health Services;

(3) a local mental health authority; and

(4) a local intellectual and developmental disability authority.

(b) The joint training must be designed to increase a caseworker's knowledge and awareness of the services available to children at each health and human services agency or local mental health or intellectual and developmental disability authority, including long-term care programs and services available under a Section 1915(c) waiver program. (Gov. Code, Sec. 531.02491.)

Sec. 526.0403. COORDINATION AND APPROVAL OF CASELOAD ESTIMATES. (a) The commission shall coordinate and approve caseload estimates for programs health and human services agencies administer.

(b) To implement this section, the commission shall:

(1) adopt uniform guidelines for health and human services agencies to use in estimating each agency's caseload, with allowances given for those agencies for which exceptions from the guidelines may be necessary;

(2) assemble a single set of economic and demographic data and provide that data to each health and human services agency to use in estimating the agency's caseload; and

(3) seek advice from health and human services agencies, the Legislative Budget Board, the governor's budget office, the comptroller, and other relevant agencies as needed to coordinate the caseload estimating process. (Gov. Code, Sec. 531.0274.)

Sec. 526.0404. DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM: CAREER LADDER FOR INTERVENERS. (a) In this section:

(1) "Deaf-blind-related course work" means

educational courses designed to improve a student's:

(A) knowledge of deaf-blindness and its effect on learning;

(B) knowledge of the intervention role and ability to facilitate the intervention process;

(C) knowledge of communication areas relevant to deaf-blindness, including methods, adaptations, and use of assistive technology, and ability to facilitate development and use of communication skills for an individual who is deaf-blind;

(D) knowledge of the effect deaf-blindness has on an individual's psychological, social, and emotional development and ability to facilitate the emotional well-being of an individual who is deaf-blind;

(E) knowledge of and issues related to sensory systems and ability to facilitate the use of the senses;

(F) knowledge of motor skills, movement, orientation, and mobility strategies and ability to facilitate orientation and mobility skills;

(G) knowledge of the effect additional disabilities have on an individual who is deaf-blind and ability to provide appropriate support; or

(H) professionalism and knowledge of ethical issues relevant to the intervener role.

(2) "Program" means the deaf-blind with multiple disabilities (DBMD) waiver program.

(b) The executive commissioner by rule shall adopt a career ladder for individuals who provide intervener services under the

program. The rules must provide a system under which each individual may be classified based on the individual's level of training, education, and experience, as one of the following:

(1) Intervener;

(2) Intervener I;

(3) Intervener II; or

(4) Intervener III.

(c) The rules must require that:

(1) an Intervener:

(A) complete any orientation or training course required to be completed by any individual who provides direct care services to recipients of services under the program;

(B) hold a high school diploma or a high school equivalency certificate;

(C) have at least two years of experience working with individuals with developmental disabilities;

(D) have the ability to proficiently communicate in the functional language of the individual who is deaf-blind; and

(E) meet all direct-care worker qualifications as determined by the program;

(2) an Intervener I:

(A) meet the requirements of an Intervener under Subdivision (1);

(B) have at least six months of experience working with individuals who are deaf-blind; and

(C) have completed at least eight semester credit hours, plus a one-hour practicum in deaf-blind-related course work,

at an accredited college or university;

(3) an Intervener II:

(A) meet the requirements of an Intervener I;

(B) have at least nine months of experience working with individuals who are deaf-blind; and

(C) have completed an additional 10 semester credit hours in deaf-blind-related course work at an accredited college or university; and

(4) an Intervener III:

(A) meet the requirements of an Intervener II;

(B) have at least one year of experience working with individuals who are deaf-blind; and

(C) hold an associate's or bachelor's degree from an accredited college or university in a course of study with a focus on deaf-blind-related course work.

(d) Notwithstanding Subsections (b) and (c), the executive commissioner may adopt a career ladder under this section based on credentialing standards for interveners developed by the Academy for Certification of Vision Rehabilitation and Education Professionals or any other private credentialing entity as the executive commissioner determines appropriate.

(e) The compensation an intervener receives for providing services under the program must be based on and commensurate with the intervener's career ladder classification. (Gov. Code, Sec. 531.0973; New.)

SUBCHAPTER J. LICENSING, LISTING, OR REGISTRATION OF CERTAIN ENTITIES

Sec. 526.0451. APPLICABILITY. (a) This subchapter applies only to the final licensing, listing, or registration decisions of a health and human services agency with respect to a person under the law authorizing the agency to regulate the following:

(1) a youth camp licensed under Chapter 141, Health and Safety Code;

(2) a home and community support services agency licensed under Chapter 142, Health and Safety Code;

(3) a hospital licensed under Chapter 241, Health and Safety Code;

(4) a facility licensed under Chapter 242, Health and Safety Code;

(5) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(6) a special care facility licensed under Chapter 248, Health and Safety Code;

(7) an intermediate care facility licensed under Chapter 252, Health and Safety Code;

(8) a chemical dependency treatment facility licensed under Chapter 464, Health and Safety Code;

(9) a mental hospital or mental health facility licensed under Chapter 577, Health and Safety Code;

(10) a child-care facility or child-placing agency licensed under or a family home listed or registered under Chapter 42, Human Resources Code; or

(11) a day activity and health services facility licensed under Chapter 103, Human Resources Code.

(b) This subchapter does not apply to an agency decision that did not result in a final order or that was reversed on appeal. (Gov. Code, Sec. 531.951.)

Sec. 526.0452. REQUIRED APPLICATION INFORMATION. An applicant submitting an initial or renewal application for a license, including a renewal license or a license that does not expire, a listing, or a registration described by Section 526.0451 must include with the application a written statement of:

(1) the name of any person who is or will be a controlling person, as the applicable agency regulating the person determines, of the entity for which the license, listing, or registration is sought; and

(2) any other relevant information required by rules the executive commissioner adopts. (Gov. Code, Sec. 531.954.)

Sec. 526.0453. APPLICATION DENIAL BASED ON ADVERSE AGENCY DECISION. A health and human services agency that regulates a person to whom this subchapter applies may deny an application for a license, including a renewal license or a license that does not expire, a listing, or a registration described by Section 526.0451, if:

(1) any of the following persons are listed in a record maintained under Section 526.0454:

(A) the applicant;

(B) a person listed on the application; or

(C) a person the applicable regulating agency

determines to be a controlling person of an entity for which the license, including a renewal license or a license that does not expire, the listing, or the registration is sought; and

(2) the agency's action resulting in the person being listed in a record maintained under Section 526.0454 is based on:

(A) an act or omission that resulted in physical or mental harm to an individual in the care of the applicant or person;

(B) a threat to the health, safety, or well-being of an individual in the care of the applicant or person;

(C) the physical, mental, or financial exploitation of an individual in the care of the applicant or person; or

(D) the agency's determination that the applicant or person has committed an act or omission that renders the applicant unqualified or unfit to fulfill the obligations of the license, listing, or registration. (Gov. Code, Sec. 531.953.)

Sec. 526.0454. RECORD OF FINAL DECISION. (a) Each health and human services agency that regulates a person to whom this subchapter applies shall, in accordance with this section and rules the executive commissioner adopts, maintain a record of:

(1) each application for a license, including a renewal license or a license that does not expire, a listing, or a registration that the agency denies under the law authorizing the agency to regulate the person; and

(2) each license, listing, or registration that the agency revokes, suspends, or terminates under the applicable law.

(b) The record of an application required by Subsection (a)(1) must be maintained until the 10th anniversary of the date the application is denied. The record of the license, listing, or registration required by Subsection (a)(2) must be maintained until the 10th anniversary of the date of the revocation, suspension, or termination.

(c) The record required under Subsection (a) must include:

(1) the name and address of the applicant for a license, listing, or registration that is denied as described by Subsection (a)(1);

(2) the name and address of each person listed in the application for a license, listing, or registration that is denied as described by Subsection (a)(1);

(3) the name of each person the applicable regulatory agency determines to be a controlling person of an entity for which an application, license, listing, or registration is denied, revoked, suspended, or terminated as described by Subsection (a);

(4) the specific type of license, listing, or registration the agency denied, revoked, suspended, or terminated;

(5) a summary of the terms of the denial, revocation, suspension, or termination; and

(6) the effective period of the denial, revocation, suspension, or termination.

(d) Each health and human services agency that regulates a person to whom this subchapter applies each month shall provide a copy of the records maintained under this section to any other health and human services agency that regulates the person. (Gov.

Code, Sec. 531.952.)

SUBCHAPTER K. CHILDREN AND FAMILIES

Sec. 526.0501. SUBSTITUTE CARE PROVIDER OUTCOME STANDARDS. (a) The executive commissioner, after consulting with representatives from the commission, the Department of Family and Protective Services, and the Texas Juvenile Justice Department, shall by rule adopt result-oriented standards that a provider of substitute care services for children under the care of this state must achieve.

(b) A health and human services agency that purchases substitute care services shall include the result-oriented standards as requirements in each substitute care service provider contract.

(c) A health and human services agency may provide information about a substitute care provider, including rates, contracts, outcomes, and client information, to another agency that purchases substitute care services. (Gov. Code, Sec. 531.047.)

Sec. 526.0502. REPORT ON DELIVERY OF HEALTH AND HUMAN SERVICES TO YOUNG TEXANS. (a) The commission shall publish on the commission's Internet website a biennial report that addresses the efforts of the health and human services agencies to provide health and human services to children younger than six years of age.

(b) The report may:

(1) contain the commission's recommendations to better coordinate state agency programs relating to the delivery of health and human services to children younger than six years of age; and

(2) propose joint agency collaborative programs.

(c) On or before the date the report is due, the commission shall notify the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, and the appropriate legislative committees that the report is available on the commission's Internet website. (Gov. Code, Sec. 531.02492.)

Sec. 526.0503. POOLED FUNDING FOR FOSTER CARE PREVENTIVE SERVICES. (a) The commission and the Department of Family and Protective Services shall develop and implement a plan to combine, to the extent and in the manner allowed by Section 51, Article III, Texas Constitution, and other applicable law, funds held by those agencies with funds held by other appropriate state agencies and local governmental entities to provide services designed to prevent children from being placed in foster care. The preventive services may include:

(1) child and family counseling;

(2) instruction in parenting and homemaking skills;

(3) parental support services;

(4) temporary respite care; and

(5) crisis services.

(b) The plan must provide for:

(1) state funding to be distributed to other state agencies, local governmental entities, or private entities only as specifically directed by the terms of a grant or contract to provide preventive services;

(2) procedures to ensure that funds the commission receives by gift, grant, or interagency or interlocal contract from another state agency, a local governmental entity, the federal

government, or any other public or private source for purposes of this section are disbursed in accordance with the terms under which the commission received the funds; and

(3) a reporting mechanism to ensure appropriate use of funds.

(c) For the purposes of this section, the commission may request and accept gifts and grants under the terms of a gift, grant, or contract from a local governmental entity, a private entity, or any other public or private source for use in providing services designed to prevent children from being placed in foster care. If required by the terms of a gift, grant, or contract or by applicable law, the commission shall use the amounts received:

(1) from a local governmental entity to provide the services in the geographic area of this state in which the entity is located; and

(2) from the federal government or a private entity to provide the services statewide or in a particular geographic area of this state. (Gov. Code, Sec. 531.088.)

Sec. 526.0504. PARTICIPATION BY FATHERS. (a) The commission and each health and human services agency shall periodically examine commission or agency policies and procedures to determine if the policies and procedures deter or encourage participation of fathers in commission or agency programs and services relating to children.

(b) Based on the examination required under Subsection (a), the commission and each health and human services agency shall modify policies and procedures as necessary to permit full

participation of fathers in commission or agency programs and services relating to children in all appropriate circumstances. (Gov. Code, Sec. 531.061.)

Sec. 526.0505. PROHIBITED PUNITIVE ACTION FOR FAILURE TO IMMUNIZE. (a) In this section:

(1) "Person responsible for a child's care, custody, or welfare" has the meaning assigned by Section 261.001, Family Code.

(2) "Punitive action" includes initiating an investigation of a person responsible for a child's care, custody, or welfare for alleged or suspected abuse or neglect of a child.

(b) The executive commissioner by rule shall prohibit a health and human services agency from taking a punitive action against a person responsible for a child's care, custody, or welfare for the person's failure to ensure that the child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

(c) This section does not affect a law, including Chapter 31, Human Resources Code, that specifically provides a punitive action for failure to ensure that a child receives the immunization series prescribed by Section 161.004, Health and Safety Code. (Gov. Code, Sec. 531.0335.)

Sec. 526.0506. INVESTIGATION UNIT FOR CHILD-CARE FACILITIES OPERATING ILLEGALLY. The executive commissioner shall maintain a unit within the commission's child-care licensing division consisting of investigators whose primary responsibility is to:

(1) identify child-care facilities that are operating without a license, certification, registration, or listing required by Chapter 42, Human Resources Code; and

(2) initiate appropriate enforcement actions against those facilities. (Gov. Code, Sec. 531.0084.)

SUBCHAPTER L. TEXAS HOME VISITING PROGRAM

Sec. 526.0551. DEFINITIONS. In this subchapter:

(1) "Home visiting program" means a voluntary-enrollment program in which early childhood and health professionals such as nurses, social workers, or trained and supervised paraprofessionals repeatedly visit over a period of at least six months the homes of pregnant women or families with children younger than six years of age who are born with or exposed to one or more risk factors.

(2) "Risk factors" means factors that make a child more likely to experience adverse experiences leading to negative consequences, including preterm birth, poverty, low parental education, having a teenaged mother or father, poor maternal health, and parental underemployment or unemployment. (Gov. Code, Sec. 531.981.)

Sec. 526.0552. RULES. The executive commissioner may adopt rules as necessary to implement this subchapter. (Gov. Code, Sec. 531.988.)

Sec. 526.0553. STRATEGIC PLAN; ELIGIBILITY. (a) The commission shall maintain a strategic plan to serve at-risk pregnant women and families with children younger than six years of age through home visiting programs that improve outcomes for

parents and families.

(b) A pregnant woman or family is considered at-risk for purposes of this section and may be eligible for voluntary enrollment in a home visiting program if the woman or family is exposed to one or more risk factors.

(c) The commission may determine if a risk factor or combination of risk factors an at-risk pregnant woman or family experiences qualifies the woman or family for enrollment in a home visiting program. (Gov. Code, Sec. 531.982.)

Sec. 526.0554. TYPES OF HOME VISITING PROGRAMS. (a) A home visiting program is classified as either an evidence-based program or a promising practice program.

(b) An evidence-based program is a home visiting program that:

(1) is research-based and grounded in relevant, empirically based knowledge and program-determined outcomes;

(2) is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive standards that ensure high-quality service delivery and continuously improving quality;

(4) has demonstrated significant positive short-term and long-term outcomes;

(5) has been evaluated by at least one rigorous randomized controlled research trial across heterogeneous populations or communities, the results of at least one of which have been published in a peer-reviewed journal;

(6) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(7) employs well-trained and competent staff and provides continual relevant professional development opportunities;

(8) demonstrates strong links to other community-based services; and

(9) ensures compliance with home visiting standards.

(c) A promising practice program is a home visiting program that:

(1) has an active impact evaluation program or can demonstrate a timeline for implementing an active impact evaluation program;

(2) has been evaluated by at least one outcome-based study demonstrating effectiveness or a randomized controlled trial in a homogeneous sample;

(3) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(4) employs well-trained and competent staff and provides continual relevant professional development opportunities;

(5) demonstrates strong links to other community-based services; and

(6) ensures compliance with home visiting standards. (Gov. Code, Sec. 531.983.)

Sec. 526.0555. OUTCOMES. The commission shall ensure that a home visiting program achieves favorable outcomes in at least two of the following areas:

(1) improved maternal or child health outcomes;

(2) improved cognitive development of children;

(3) increased school readiness of children;

(4) reduced child abuse, neglect, and injury;

(5) improved child safety;

(6) improved social-emotional development of children;

(7) improved parenting skills, including nurturing and bonding;

(8) improved family economic self-sufficiency;

(9) reduced parental involvement with the criminal justice system; and

(10) increased father involvement and support. (Gov. Code, Sec. 531.985.)

Sec. 526.0556. EVALUATION OF HOME VISITING PROGRAM. (a) The commission shall adopt outcome indicators to measure the effectiveness of a home visiting program in achieving desired outcomes.

(b) The commission may work directly with the model developer of a home visiting program to identify appropriate outcome indicators for the program and to ensure that the program demonstrates fidelity to its research model.

(c) The commission shall develop internal processes to work with home visiting programs in sharing data and information to aid

in relevant analysis of a home visiting program's performance.

(d) The commission shall use data gathered under this section to monitor, conduct ongoing quality improvement on, and evaluate the effectiveness of home visiting programs. (Gov. Code, Sec. 531.986.)

Sec. 526.0557. FUNDING. (a) The commission shall ensure that at least 75 percent of the funds appropriated for home visiting programs is used in evidence-based programs described by Section 526.0554(b), with any remaining funds dedicated to promising practice programs described by Section 526.0554(c).

(b) The commission shall actively seek and apply for any available federal funds to support home visiting programs, including federal funds from the Temporary Assistance for Needy Families program.

(c) The commission may accept gifts, donations, and grants to support home visiting programs. (Gov. Code, Sec. 531.984; New.)

Sec. 526.0558. REPORTS TO LEGISLATURE. (a) Not later than December 1 of each even-numbered year, the commission shall prepare and submit a report on state-funded home visiting programs to the Senate Committee on Health and Human Services and the House Human Services Committee or their successors.

(b) A report submitted under this section must include:

(1) a description of home visiting programs being implemented and the associated models;

(2) data on the number of families being served and their demographic information;

(3) the goals and achieved outcomes of home visiting

programs;

(4) data on cost per family served, including third-party return-on-investment analysis, if available; and

(5) data explaining the percentage of funding that has been used on evidence-based programs and the percentage of funding that has been used on promising practice programs. (Gov. Code, Sec. 531.9871.)

SUBCHAPTER M. SERVICE MEMBERS, DEPENDENTS, AND VETERANS

Sec. 526.0601. SERVICES FOR SERVICE MEMBERS. (a) In this section, "service member" means a member or former member of the state military forces or a component of the United States armed forces, including a reserve component.

(b) The executive commissioner shall ensure that each health and human services agency adopts policies and procedures that require the agency to:

(1) identify service members who are seeking services from the agency during the agency's intake and eligibility determination process; and

(2) direct service members seeking services to appropriate service providers, including:

(A) the United States Veterans Health Administration;

(B) National Guard Bureau facilities; and

(C) other federal, state, and local service providers.

(c) The executive commissioner shall make the directory of resources established under Section 161.552, Health and Safety

Code, accessible to each health and human services agency. (Gov. Code, Sec. 531.093.)

Sec. 526.0602. INTEREST OR OTHER WAITING LIST FOR CERTAIN SERVICE MEMBERS AND DEPENDENTS. (a) In this section, "service member" means a member of the United States military serving in the army, navy, air force, marine corps, or coast guard on active duty.

(b) This section applies only to:

(1) a service member who has declared and maintains this state as the member's state of legal residence in the manner provided by the applicable military branch;

(2) a spouse or dependent child of a member described by Subdivision (1); or

(3) the spouse or dependent child of a former service member who had declared and maintained this state as the member's state of legal residence in the manner provided by the applicable military branch and who:

(A) was killed in action; or

(B) died while in service.

(c) The executive commissioner by rule shall require the commission or another health and human services agency to:

(1) maintain the position of an individual to whom this section applies in the queue of an interest list or other waiting list for any assistance program the commission or other health and human services agency provides, including a Section 1915(c) waiver program, if the individual cannot receive benefits under the assistance program because the individual temporarily resides out of state as the result of military service; and

(2) subject to Subsection (e), offer benefits to the individual according to the individual's position on the interest list or other waiting list that was attained while the individual resided out of state if the individual returns to reside in this state.

(d) If an individual to whom this section applies reaches a position on an interest list or other waiting list that would allow the individual to receive benefits under an assistance program but the individual cannot receive the benefits because the individual temporarily resides out of state as the result of military service, the commission or agency providing the benefits shall maintain the individual's position on the list relative to other individuals on the list but continue to offer benefits to other individuals on the interest list or other waiting list in accordance with those individuals' respective positions on the list.

(e) In adopting rules under Subsection (c), the executive commissioner must limit the amount of time an individual to whom this section applies may maintain the individual's position on an interest list or other waiting list under Subsection (c) to not more than one year after the date on which, as applicable:

(1) the service member's active duty ends;

(2) the member was killed if the member was killed in action; or

(3) the member died if the member died while in service. (Gov. Code, Sec. 531.0931.)

Sec. 526.0603. MEMORANDUM OF UNDERSTANDING REGARDING PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM; MAXIMIZATION OF

BENEFITS. (a) In this section, "system" means the Public Assistance Reporting Information System (PARIS) operated by the Administration for Children and Families of the United States Department of Health and Human Services.

(b) The commission, the Texas Veterans Commission, and the Veterans' Land Board shall enter into a memorandum of understanding for the purposes of:

(1) coordinating and collecting information about state agencies' use and analysis of data received from the system; and

(2) developing new strategies for state agencies to use system data in ways that:

(A) generate fiscal savings for this state; and

(B) maximize the availability of and access to benefits for veterans.

(c) The commission and the Texas Veterans Commission:

(1) shall coordinate to assist veterans in maximizing the benefits available to each veteran by using the system; and

(2) together may determine the geographic scope of the efforts described by Subdivision (1).

(d) Not later than October 1 of each year, the commission, the Texas Veterans Commission, and the Veterans' Land Board collectively shall submit to the legislature, the governor, and the Legislative Budget Board a report describing:

(1) interagency progress in identifying and obtaining United States Department of Veterans Affairs benefits for veterans receiving Medicaid and other public benefits;

(2) the number of veterans benefits claims awarded, the total dollar amount of veterans benefits claims awarded, and the costs to this state that were avoided as a result of state agencies' use of the system;

(3) efforts to expand the use of the system and improve the effectiveness of shifting veterans from Medicaid and other public benefits to United States Department of Veterans Affairs benefits, including any barriers and the manner in which state agencies have addressed those barriers; and

(4) the extent to which the Texas Veterans Commission has targeted specific veteran populations, including populations in rural counties and in specific age and service-connected disability categories, in order to maximize benefits for veterans and savings to this state.

(e) The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law. (Gov. Code, Sec. 531.0998.)

SUBCHAPTER N. PLAN TO SUPPORT GUARDIANSHIPS

Sec. 526.0651. DEFINITIONS. In this subchapter:

(1) "Guardian" has the meaning assigned by Section 1002.012, Estates Code.

(2) "Guardianship program" has the meaning assigned by Section 155.001.

(3) "Incapacitated individual" means an incapacitated person as defined by Section 1002.017, Estates Code. (Gov. Code, Sec. 531.121.)

Sec. 526.0652. PLAN ESTABLISHMENT. The commission shall

develop and, subject to appropriations, implement a plan to:

(1) ensure that each incapacitated individual in this state who needs a guardianship or another less restrictive type of assistance to make decisions concerning the incapacitated individual's own welfare and financial affairs receives that assistance; and

(2) foster the establishment and growth of local volunteer guardianship programs. (Gov. Code, Sec. 531.124.)

Sec. 526.0653. GUARDIANSHIP PROGRAM GRANT REQUIREMENTS. (a) The commission in accordance with commission rules may award grants to:

(1) a local guardianship program; and

(2) a local legal guardianship program to enable the family members and friends with low incomes of a proposed ward who is indigent to have legal representation in court if the individuals are willing and able to be appointed guardians of the proposed ward.

(b) To receive a grant under Subsection (a)(1), a local guardianship program operating in a county with a population of at least 150,000 must offer or submit a plan acceptable to the commission to offer, among the program's services, a money management service for appropriate clients, as determined by the program. The program may provide the money management service directly or by referring a client to a money management service that satisfies the requirements under Subsection (c).

(c) A money management service to which a local guardianship program may refer a client must:

(1) use employees or volunteers to provide bill payment or representative payee services;

(2) provide the service's employees and volunteers with training, technical support, monitoring, and supervision;

(3) match employees or volunteers with clients in a manner that ensures that the match is agreeable to both the employee or volunteer and the client;

(4) insure each employee and volunteer and hold the employee or volunteer harmless from liability for damages proximately caused by acts or omissions of the employee or volunteer while acting in the course and scope of the employee's or volunteer's duties or functions within the organization;

(5) have an advisory council that meets regularly and is composed of individuals who are knowledgeable with respect to issues related to guardianship, alternatives to guardianship, and related social services programs;

(6) be administered by a nonprofit corporation:

(A) formed under the Texas Nonprofit Corporation Law, as described by Section 1.008, Business Organizations Code; and

(B) exempt from taxation under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt entity under Section 501(c)(3) of that code; and

(7) refer clients who are in need of other services from an area agency on aging to the appropriate area agency on aging.

(d) A local guardianship program operating in a county with

a population of less than 150,000 may, at the program's option, offer, either directly or by referral, a money management service among the program's services. If the program elects to offer a money management service by referral, the service must satisfy the requirements under Subsection (c), except as provided by Subsection (e).

(e) On request by a local guardianship program, the commission may waive a requirement under Subsection (c) if the commission determines the waiver is appropriate to strengthen the continuum of local guardianship programs in a geographic area. (Gov. Code, Sec. 531.125.)

SUBCHAPTER O. ASSISTANCE PROGRAM FOR DOMESTIC VICTIMS OF TRAFFICKING

Sec. 526.0701. DEFINITIONS. In this subchapter:

(1) "Domestic victim" means a victim of trafficking who is a permanent legal resident or citizen of the United States.

(2) "Victim of trafficking" has the meaning assigned by 22 U.S.C. Section 7102. (Gov. Code, Sec. 531.381.)

Sec. 526.0702. VICTIM ASSISTANCE PROGRAM. The commission shall develop and implement a program designed to assist domestic victims, including victims who are children, in accessing necessary services. The program must include:

(1) a searchable database of assistance programs for domestic victims that may be used to match victims with appropriate resources, including:

(A) programs that provide mental health services;

(B) other health services;

(C) services to meet victims' basic needs;

(D) case management services; and

(E) any other services the commission considers appropriate;

(2) the grant program described by Section 526.0703;

(3) recommended training programs for judges, prosecutors, and law enforcement personnel; and

(4) an outreach initiative to ensure that victims, judges, prosecutors, and law enforcement personnel are aware of the availability of services through the program. (Gov. Code, Sec. 531.382.)

Sec. 526.0703. GRANT PROGRAM. (a) Subject to available funds, the commission shall establish a grant program to award grants to public and nonprofit organizations that provide assistance to domestic victims, including organizations that provide public awareness activities, community outreach and training, victim identification services, and legal services.

(b) To apply for a grant under this section, an applicant must submit an application in the form and manner the commission prescribes. An applicant must describe in the application the services the applicant intends to provide to domestic victims if the grant is awarded.

(c) In awarding grants under this section, the commission shall give preference to organizations that have experience in successfully providing the types of services for which the grants are awarded.

(d) A grant recipient shall provide the reports the commission requires regarding the use of grant funds.

(e) Not later than December 1 of each even-numbered year, the commission shall submit a report to the legislature:

(1) summarizing the activities, funding, and outcomes of programs awarded a grant under this section; and

(2) providing recommendations regarding the grant program.

(f) For purposes of Subchapter I, Chapter 659:

(1) the commission, for the sole purpose of administering the grant program under this section, is considered an eligible charitable organization entitled to participate in the state employee charitable campaign; and

(2) a state employee is entitled to authorize a deduction for contributions to the commission for the purposes of administering the grant program under this section as a charitable contribution under Section 659.132, and the commission may use the contributions as provided by Subsection (a). (Gov. Code, Sec. 531.383.)

Sec. 526.0704. TRAINING PROGRAMS. The commission, with assistance from the Office of Court Administration of the Texas Judicial System, the Department of Public Safety, and local law enforcement agencies, shall create training programs designed to increase the awareness of judges, prosecutors, and law enforcement personnel on:

(1) the needs of domestic victims;

(2) the availability of services under this

subchapter;

(3) the database of services described by Section 526.0702; and

(4) potential funding sources for those services. (Gov. Code, Sec. 531.384.)

Sec. 526.0705. FUNDING. The commission may use appropriated funds and may accept gifts, grants, and donations from any sources for purposes of the victim assistance program established under this subchapter. (Gov. Code, Sec. 531.385.)

SUBCHAPTER P. AGING ADULTS WITH VISUAL IMPAIRMENTS

Sec. 526.0751. OUTREACH CAMPAIGNS FOR AGING ADULTS WITH VISUAL IMPAIRMENTS. (a) The commission, in collaboration with the Texas State Library and Archives Commission and other appropriate state agencies, shall conduct public awareness and education outreach campaigns designed to provide information relating to the programs and resources available to aging adults who are blind or visually impaired in this state.

(b) The campaigns must be:

(1) tailored to targeted populations, including:

(A) aging adults with or at risk of blindness or visual impairment and the families and caregivers of those adults;

(B) health care providers, including home and community-based services providers, health care facilities, and emergency medical services providers;

(C) community and faith-based organizations; and

(D) the public; and

(2) disseminated through methods appropriate for each

targeted population, including by:

(A) attending health fairs; and

(B) working with organizations or groups that serve aging adults, including community clinics, libraries, support groups for aging adults, veterans organizations, for-profit providers of vision services, and the state and local chapters of the National Federation of the Blind. (Gov. Code, Sec. 531.0319(a).)

Sec. 526.0752. RULES. The executive commissioner may adopt rules necessary to implement this subchapter. (Gov. Code, Sec. 531.0319(c).)

Sec. 526.0753. COMMISSION SUPPORT. To support campaigns conducted under this subchapter, the commission shall:

(1) establish a toll-free telephone number for providing counseling and referrals to appropriate services for aging adults who are blind or visually impaired;

(2) post on the commission's Internet website information and training resources for aging adults, community stakeholders, and health care and other service providers that generally serve aging adults, including:

(A) links to Internet websites that contain resources for individuals who are blind or visually impaired;

(B) existing videos that provide awareness of blindness and visual impairments among aging adults and the importance of early intervention;

(C) best practices for referring aging adults at risk of blindness or visual impairment for appropriate services;

and

(D) training about resources available for aging adults who are blind or visually impaired for the staff of aging and disability resource centers established under the Aging and Disability Resource Center initiative funded partly by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(3) designate a commission contact to assist aging adults who are diagnosed with a visual impairment and are losing vision and the families of those adults with locating and obtaining appropriate services; and

(4) encourage awareness of the reading services the Texas State Library and Archives Commission offers for individuals who are blind or visually impaired. (Gov. Code, Sec. 531.0319(b).)

CHAPTER 532. MEDICAID ADMINISTRATION AND OPERATION IN GENERAL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 532.0001. DEFINITION

SUBCHAPTER B. ADMINISTRATION

Sec. 532.0051. COMMISSION ADMINISTRATION OF MEDICAID

Sec. 532.0052. STREAMLINING ADMINISTRATIVE PROCESSES

Sec. 532.0053. GRIEVANCES

Sec. 532.0054. OFFICE OF COMMUNITY ACCESS AND SERVICES

Sec. 532.0055. SERVICE DELIVERY AUDIT MECHANISMS

Sec. 532.0056. FEDERAL AUTHORIZATION FOR REFORM

Sec. 532.0057. FEES, CHARGES, AND RATES

Sec. 532.0058. ACUTE CARE BILLING COORDINATION SYSTEM; PENALTIES

CHAPTER 532. MEDICAID ADMINISTRATION AND OPERATION IN GENERAL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 532.0001. DEFINITION. In this chapter, "recipient" means a Medicaid recipient. (New.)

SUBCHAPTER B. ADMINISTRATION

Sec. 532.0051. COMMISSION ADMINISTRATION OF MEDICAID. (a) The commission is the state agency designated to administer federal Medicaid funds.

(b) The commission shall:

(1) in each agency that operates a portion of Medicaid, plan and direct Medicaid, including the management of the Medicaid managed care system and the development, procurement, management, and monitoring of contracts necessary to implement that system; and

(2) establish requirements for and define the scope of the ongoing evaluation of the Medicaid managed care system conducted in conjunction with the Department of State Health Services under Section 108.0065, Health and Safety Code. (Gov. Code, Secs. 531.021(a), (b).)

Sec. 532.0052. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort:

(1) using the commission's existing resources, to reduce the paperwork and other administrative burdens placed on recipients, Medicaid providers, and other Medicaid participants, and shall use technology and efficient business practices to reduce those burdens; and

(2) to improve the business practices associated with Medicaid administration by any method the commission determines is cost-effective, including:

(A) expanding electronic claims payment system use;

(B) developing an Internet portal system for prior authorization requests;

(C) encouraging Medicaid providers to submit program participation applications electronically;

(D) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers can conveniently apply to the program;

(E) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in Medicaid; and

(F) encouraging providers' increased use of medical technology, including increasing providers' use of:

(i) electronic communications between patients and their physicians or other health care providers;

(ii) electronic prescribing tools that

provide current payer formulary information at the time the physician or other health care provider writes a prescription and that support the electronic transmission of a prescription;

(iii) ambulatory computerized order entry systems that facilitate at the point of care physician and other health care provider orders for medications and laboratory and radiological tests;

(iv) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting;

(v) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and

(vi) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely. (Gov. Code, Sec. 531.02411.)

Sec. 532.0053. GRIEVANCES. (a) The commission shall:

(1) adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within the commission to ensure all grievances are managed consistently;

(2) standardize Medicaid grievance data reporting and tracking among divisions within the commission;

(3) implement a no-wrong-door system for Medicaid grievances reported to the commission; and

(4) verify grievance data a Medicaid managed care organization reports.

(b) The commission shall establish a procedure for expedited resolution of a grievance related to Medicaid that allows the commission to:

(1) identify a grievance related to a Medicaid access-to-care issue that is urgent and requires an expedited resolution; and

(2) resolve the grievance within a specified period.

(c) The commission shall:

(1) aggregate recipient and Medicaid provider grievance data to provide a comprehensive data set of grievances; and

(2) make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider. (Gov. Code, Sec. 531.02131.)

Sec. 532.0054. OFFICE OF COMMUNITY ACCESS AND SERVICES. The executive commissioner shall establish within the commission an office of community access and services. The office is responsible for:

(1) collaborating with community, state, and federal stakeholders to improve the elements of the health care system that are involved in delivering Medicaid services; and

(2) sharing with Medicaid providers, including hospitals, any best practices, resources, or other information regarding improvements to the health care system. (Gov. Code, Sec. 531.020.)

Sec. 532.0055. SERVICE DELIVERY AUDIT MECHANISMS. The

commission shall make every effort to ensure the integrity of Medicaid. To ensure that integrity, the commission shall:

(1) perform risk assessments of every element of the program and audit the program elements determined to present the greatest risks;

(2) ensure that sufficient oversight is in place for the Medicaid medical transportation program and that a quality review assessment of that program occurs; and

(3) evaluate Medicaid with respect to use of the metrics developed through the Texas Health Steps performance improvement plan to guide changes and improvements to the program. (Gov. Code, Sec. 531.02412.)

Sec. 532.0056. FEDERAL AUTHORIZATION FOR REFORM. The executive commissioner shall seek a waiver under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan that is designed to achieve the following objectives regarding Medicaid and alternatives to Medicaid:

(1) provide flexibility to determine Medicaid eligibility categories and income levels;

(2) provide flexibility to design Medicaid benefits that meet the demographic, public health, clinical, and cultural needs of this state or regions within this state;

(3) encourage use of the private health benefits coverage market rather than public benefits systems;

(4) encourage individuals who have access to private employer-based health benefits to obtain or maintain those benefits;

(5) create a culture of shared financial responsibility, accountability, and participation in Medicaid by:

(A) establishing and enforcing copayment requirements similar to private sector principles for all eligibility groups;

(B) promoting the use of health savings accounts to influence a culture of individual responsibility; and

(C) promoting the use of vouchers for consumer-directed services in which consumers manage and pay for health-related services provided to them using program vouchers;

(6) consolidate federal funding streams, including funds from the disproportionate share hospitals and upper payment limit supplemental payment programs and other federal Medicaid funds, to ensure the most effective and efficient use of those funding streams;

(7) allow flexibility in the use of state funds used to obtain federal matching funds, including allowing the use of intergovernmental transfers, certified public expenditures, costs not otherwise matchable, or other funds and funding mechanisms to obtain federal matching funds;

(8) empower individuals who are uninsured to acquire health benefits coverage through the promotion of cost-effective coverage models that provide access to affordable primary, preventive, and other health care on a sliding scale, with fees paid at the point of service; and

(9) allow for the redesign of long-term care services and supports to increase access to patient-centered care in the

most cost-effective manner. (Gov. Code, Sec. 537.002.)

Sec. 532.0057. FEES, CHARGES, AND RATES. (a) The executive commissioner shall adopt reasonable rules and standards governing the determination of fees, charges, and rates for Medicaid payments.

(b) In adopting rules and standards required by Subsection (a), the executive commissioner:

(1) may provide for payment of fees, charges, and rates in accordance with:

(A) formulas, procedures, or methodologies commission rules prescribe;

(B) state or federal law, policies, rules, regulations, or guidelines;

(C) economic conditions that substantially and materially affect provider participation in Medicaid, as the executive commissioner determines; or

(D) available levels of appropriated state and federal funds; and

(2) shall include financial performance standards that, in the event of a proposed rate reduction, provide private ICF-IID facilities and home and community-based services providers with flexibility in determining how to use Medicaid payments to provide services in the most cost-effective manner while continuing to meet state and federal Medicaid requirements.

(c) Notwithstanding any other provision of Chapter 32, Human Resources Code, Chapter 531 or revised provisions of Chapter 531, as that chapter existed on March 31, 2025, or Chapter 540 or

540A, the commission may adjust the fees, charges, and rates paid to Medicaid providers as necessary to achieve the objectives of Medicaid in a manner consistent with the considerations described by Subsection (b)(1).

(d) In adopting rates for Medicaid payments under Subsection (a), the executive commissioner may adopt reimbursement rates for appropriate nursing services provided to recipients with certain health conditions if those services are determined to provide a cost-effective alternative to hospitalization. A physician must certify that the nursing services are medically appropriate for the recipient for those services to qualify for reimbursement under this subsection.

(e) In adopting rates for Medicaid payments under Subsection (a), the executive commissioner may adopt cost-effective reimbursement rates for group appointments with Medicaid providers for certain diseases and medical conditions commission rules specify. (Gov. Code, Secs. 531.021(b-1), (c), (d), (e), (f), (g).)

Sec. 532.0058. ACUTE CARE BILLING COORDINATION SYSTEM; PENALTIES. (a) The acute care Medicaid billing coordination system for the fee-for-service and primary care case management delivery models for which the commission contracts must, on entry of a claim in the claims system:

(1) identify within 24 hours whether another entity has primary responsibility for paying the claim; and

(2) submit the claim to the entity the system determines is the primary payor.

(b) The billing coordination system may not increase Medicaid claims payment error rates.

(c) If cost-effective and feasible, the commission shall contract to expand the acute care Medicaid billing coordination system to process claims for all other Medicaid health care services in the manner the system processes claims for acute care services. This subsection does not apply to claims for Medicaid health care services if, before September 1, 2009, those claims were being processed by an alternative billing coordination system.

(d) If cost-effective, the executive commissioner shall adopt rules to enable the acute care Medicaid billing coordination system to identify an entity with primary responsibility for paying a claim that is processed by the system and establish reporting requirements for an entity that may have a contractual responsibility to pay for the types of services that are provided under Medicaid and the claims for which are processed by the system.

(e) An entity that holds a permit, license, or certificate of authority issued by a regulatory agency of this state:

(1) must allow a contractor under this section access to databases to allow the contractor to carry out the purposes of this section, subject to the contractor's contract with the commission and rules the executive commissioner adopts under this section; and

(2) is subject to an administrative penalty or other sanction as provided by the law applicable to the permit, license, or certificate of authority for the entity's violation of a rule the executive commissioner adopts under this section.

(f) Public funds may not be spent on an entity that is not in compliance with this section unless the executive commissioner and the entity enter into a memorandum of understanding.

(g) Information obtained under this section is confidential. The contractor may use the information only for the purposes authorized under this section. A person commits an offense if the person knowingly uses information obtained under this section for any purpose not authorized under this section. An offense under this subsection is a Class B misdemeanor and all other penalties may apply. (Gov. Code, Secs. 531.02413(a) (part), (a-1), (b), (c), (d), (e).)

Sec. 532.0059. RECOVERY OF CERTAIN THIRD-PARTY REIMBURSEMENTS. The commission shall obtain Medicaid reimbursement from each fiscal intermediary who makes a payment to a service provider on behalf of the Medicare program, including a reimbursement for a payment made to a home health services provider or nursing facility for services provided to an individual who is eligible to receive health care benefits under both Medicaid and the Medicare program. (Gov. Code, Sec. 531.0392.)

Sec. 532.0060. DENTAL DIRECTOR. The executive commissioner shall appoint a Medicaid dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and rules the State Board of Dental Examiners adopts under that subtitle. (Gov. Code, Sec. 531.02114.)

Sec. 532.0061. ALIGNMENT OF MEDICAID AND MEDICARE DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES. (a) The commission shall review Medicaid forms and requirements regarding

written orders for diabetic equipment and supplies to identify variations between permissible Medicaid ordering procedures and ordering procedures available to Medicare providers.

(b) To the extent practicable and in conformity with Chapter 157, Occupations Code, and Chapter 483, Health and Safety Code, after the commission conducts a review under Subsection (a), the commission or executive commissioner, as appropriate, shall modify only Medicaid forms, rules, and procedures applicable to orders for diabetic equipment and supplies to provide for an ordering system that is comparable to the Medicare ordering system for diabetic equipment and supplies. The ordering system must permit a diabetic equipment or supplies supplier to complete forms by hand or enter medical information or supply orders electronically into a form as necessary to provide the information required to dispense diabetic equipment or supplies.

(c) A diabetic equipment and supplies provider may bill and collect payment for the provider's services if the provider has a copy of the form that meets the requirements of Subsection (b) and is signed by a medical provider licensed in this state to treat diabetic patients. Additional documentation may not be required. (Gov. Code, Sec. 531.099.)

SUBCHAPTER C. FINANCING

Sec. 532.0101. FINANCING OPTIMIZATION. The commission shall ensure that the Medicaid finance system is optimized to:

(1) maximize this state's receipt of federal funds;

(2) create incentives for providers to use preventive care;

(3) increase and retain providers in the system to maintain an adequate provider network;

(4) more accurately reflect the costs borne by providers; and

(5) encourage improvement of the quality of care. (Gov. Code, Sec. 531.02113.)

Sec. 532.0102. RETENTION OF CERTAIN MONEY TO ADMINISTER CERTAIN PROGRAMS; ANNUAL REPORT REQUIRED. (a) In this section, "directed payment program" means a delivery system and provider patient initiative implemented by this state under 42 C.F.R. Section 438.6(c).

(b) This section applies only to money the commission receives from a source other than the general revenue fund to operate a waiver program established under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) or a directed payment program or successor program as the commission determines.

(c) Subject to Subsection (d), the commission may retain from money to which this section applies an amount equal to the estimated costs necessary to administer the program for which the commission receives the money, but not to exceed $8 million for a state fiscal year.

(d) If the commission determines that the commission needs additional money to administer a program described by Subsection (b), the commission may retain an additional amount with the governor's and the Legislative Budget Board's approval, but not to exceed a total retained amount equal to 0.25 percent of the total estimated amount the commission receives for the program.

(e) The commission shall spend the retained money to assist in paying the costs necessary to administer the program for which the commission receives the money, except that the commission may not use the money to pay any type of administrative cost that, before June 1, 2019, was funded with general revenue.

(f) The commission shall submit an annual report to the governor and the Legislative Budget Board that:

(1) details the amount of money the commission retained and spent under this section during the preceding state fiscal year, including a separate detail of any increase in the amount of money the commission retained for a program under Subsection (d);

(2) contains a transparent description of how the commission used the money described by Subdivision (1); and

(3) assesses the extent to which the retained money covered the estimated costs to administer the applicable program and states whether, based on that assessment, the commission adjusted or considered adjustments to the amount retained.

(g) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 531.021135.)

Sec. 532.0103. BIENNIAL FINANCIAL REPORT. (a) The commission shall prepare a biennial Medicaid financial report covering each state agency that operates a part of Medicaid and each component of Medicaid those agencies operate.

(b) The report must include:

(1) for each state agency that operates a part of Medicaid:

(A) a description of each of the Medicaid components the agency operates; and

(B) an accounting of all funds related to Medicaid the agency received and disbursed during the period the report covers, including:

(i) the amount of any federal Medicaid funds allocated to the agency for the support of each of the Medicaid components the agency operates;

(ii) the amount of any funds the legislature appropriated to the agency for each of those components; and

(iii) the amount of Medicaid payments and related expenditures made by or in connection with each of those components; and

(2) for each Medicaid component identified in the report:

(A) the amount and source of funds or other revenue received by or made available to the agency for the component;

(B) the amount spent on each type of service or benefit provided by or under the component;

(C) the amount spent on component operations, including eligibility determination, claims processing, and case management; and

(D) the amount spent on any other administrative costs.

(c) The report must cover the three-year period ending on

the last day of the previous fiscal year.

(d) The commission may request from any appropriate state agency information necessary to complete the report. Each agency shall cooperate with the commission in providing information for the report.

(e) Not later than December 1 of each even-numbered year, the commission shall submit the report to the governor, the lieutenant governor, the speaker of the house of representatives, the presiding officer of each standing committee of the senate and house of representatives having jurisdiction over health and human services issues, and the state auditor. (Gov. Code, Sec. 531.02111.)

SUBCHAPTER D. PROVIDERS

Sec. 532.0151. STREAMLINING PROVIDER ENROLLMENT AND CREDENTIALING PROCESSES. (a) The commission shall streamline Medicaid provider enrollment and credentialing processes.

(b) In streamlining the Medicaid provider enrollment process, the commission shall establish a centralized Internet portal through which providers may enroll in Medicaid.

(c) In streamlining the Medicaid provider credentialing process, the commission may:

(1) designate a centralized credentialing entity;

(2) share information in the database established under Subchapter C, Chapter 32, Human Resources Code, with the centralized credentialing entity; and

(3) require all Medicaid managed care organizations to use the centralized credentialing entity as a hub for collecting

and sharing information.

(d) The commission may:

(1) use the Internet portal created under Subsection (b) to create a single, consolidated Medicaid provider enrollment and credentialing process; and

(2) if cost-effective, contract with a third party to develop the single, consolidated process. (Gov. Code, Sec. 531.02118.)

Sec. 532.0152. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER. (a) In this section, "national provider identifier number" means the national provider identifier number required under Section 1128J(e) of the Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The commission shall transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.

(c) The commission shall implement a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid.

(d) The commission shall implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services. (Gov. Code, Sec. 531.021182.)

Sec. 532.0153. ENROLLMENT OF CERTAIN EYE HEALTH CARE PROVIDERS. (a) This section applies only to:

(1) an optometrist who is licensed by the Texas

Optometry Board;

(2) a therapeutic optometrist who is licensed by the Texas Optometry Board;

(3) an ophthalmologist who is licensed by the Texas Medical Board; and

(4) an institution of higher education that provides an accredited program for:

(A) training as a doctor of optometry or an optometrist residency; or

(B) training as an ophthalmologist or an ophthalmologist residency.

(b) The commission may not prevent a provider to whom this section applies from enrolling as a Medicaid provider if the provider:

(1) either:

(A) joins an established practice of a health care provider or provider group that has a contract with a Medicaid managed care organization to provide health care services to recipients under Chapter 540 or 540A; or

(B) is employed by or otherwise compensated for providing training at an institution of higher education described by Subsection (a)(4);

(2) applies to be an enrolled Medicaid provider;

(3) if applicable, complies with the requirements of the contract described by Subdivision (1)(A); and

(4) complies with all other applicable requirements related to being a Medicaid provider.

(c) The commission may not prevent an institution of higher education from enrolling as a Medicaid provider if the institution:

(1) has a contract with a managed care organization to provide health care services to recipients under Chapter 540 or 540A;

(2) applies to be an enrolled Medicaid provider;

(3) complies with the requirements of the contract described by Subdivision (1); and

(4) complies with all other applicable requirements related to being a Medicaid provider. (Gov. Code, Sec. 531.021191.)

Sec. 532.0154. RURAL HEALTH CLINIC REIMBURSEMENT. The commission may not impose any condition on the reimbursement of a rural health clinic under Medicaid if the condition is more stringent than the conditions imposed by:

(1) the Rural Health Clinic Services Act of 1977 (Pub. L. No. 95-210); or

(2) the laws of this state regulating the practice of medicine, pharmacy, or professional nursing. (Gov. Code, Sec. 531.02193.)

Sec. 532.0155. RURAL HOSPITAL REIMBURSEMENT. (a) In this section, "rural hospital" has the meaning assigned by commission rules for purposes of reimbursing hospitals for providing Medicaid inpatient or outpatient services.

(b) To the extent allowed by federal law and subject to limitations on appropriations, the executive commissioner by rule shall adopt a prospective reimbursement methodology for the payment of rural hospitals participating in Medicaid that ensures the rural

hospitals are reimbursed on an individual basis for providing inpatient and general outpatient services to recipients by using the hospitals' most recent cost information concerning the costs incurred for providing the services. The commission shall calculate the prospective cost-based reimbursement rates once every two years.

(c) In adopting rules under Subsection (b), the executive commissioner may:

(1) adopt a methodology that requires:

(A) a Medicaid managed care organization to reimburse rural hospitals for services delivered through the Medicaid managed care program using a minimum fee schedule or other method for which federal matching money is available; or

(B) both the commission and a Medicaid managed care organization to share in the total amount of reimbursement paid to rural hospitals; and

(2) require that the reimbursement amount paid to a rural hospital is subject to any applicable adjustments the commission makes for payments to or penalties imposed on the rural hospital that are based on a quality-based or performance-based requirement under the Medicaid managed care program.

(d) Not later than September 1 of each even-numbered year, the commission shall, for purposes of Subsection (b), determine the allowable costs incurred by a rural hospital participating in the Medicaid managed care program based on the rural hospital's cost reports submitted to the Centers for Medicare and Medicaid Services and other available information that the commission considers

relevant in determining the hospital's allowable costs.

(e) Notwithstanding Subsection (b) and subject to Subsection (f), the executive commissioner shall adopt and the commission shall implement, beginning with the state fiscal year ending August 31, 2022, a true cost-based reimbursement methodology for inpatient and general outpatient services provided to recipients at rural hospitals that provides:

(1) prospective payments during a state fiscal year to the hospitals using the reimbursement methodology adopted under Subsection (b); and

(2) to the extent allowed by federal law, in the subsequent state fiscal year a cost settlement to provide additional reimbursement as necessary to reimburse the hospitals for the true costs incurred in providing inpatient and general outpatient services to recipients during the previous state fiscal year.

(f) If federal law does not permit the use of a true cost-based reimbursement methodology described by Subsection (e), the commission shall continue to use the prospective cost-based reimbursement methodology the executive commissioner adopts under Subsection (b) for the payment of rural hospitals for providing inpatient and general outpatient services to recipients. (Gov. Code, Sec. 531.02194.)

Sec. 532.0156. REIMBURSEMENT SYSTEM FOR ELECTRONIC HEALTH INFORMATION REVIEW AND TRANSMISSION. If feasible and cost-effective, the executive commissioner by rule may develop and the commission may implement a system to provide Medicaid

reimbursement to a health care provider, including a physician, for reviewing and transmitting electronic health information. (Gov. Code, Secs. 531.0162(g), (h) (part).)

SUBCHAPTER E. DATA AND TECHNOLOGY

Sec. 532.0201. DATA COLLECTION SYSTEM. (a) The commission and each health and human services agency that administers a part of Medicaid shall jointly develop a system to coordinate and integrate state Medicaid databases to:

(1) facilitate the comprehensive analysis of Medicaid data; and

(2) detect fraud a program provider or recipient perpetrates.

(b) To minimize cost and duplication of activities, the commission shall assist and coordinate:

(1) the efforts of the agencies that are participating in developing the system; and

(2) the efforts of those agencies with the efforts of other agencies involved in a statewide health care data collection system provided for by Section 108.006, Health and Safety Code, including avoiding duplication of expenditure of state funds for computer hardware, staff, or services.

(c) On the executive commissioner's request, a state agency that administers any part of Medicaid shall assist the commission in developing the system.

(d) The commission shall develop the system in a manner that will enable a complete analysis of the use of prescription medications, including information relating to:

(1) recipients for whom more than three medications have been prescribed; and

(2) the medical effect denial of Medicaid coverage for more than three medications has had on recipients.

(e) The commission shall ensure that the system is used each month to match vital statistics unit death records with a list of individuals eligible for Medicaid, and that each individual who is deceased is promptly removed from the list of individuals eligible for Medicaid. (Gov. Code, Sec. 531.0214.)

Sec. 532.0202. INFORMATION COLLECTION AND ANALYSIS. (a) The commission shall:

(1) make every effort to improve data analysis and integrate available information associated with Medicaid;

(2) use the decision support system in the commission's center for analytics and decision support for the purpose described by Subdivision (1);

(3) modify or redesign the decision support system to allow for the data collected by Medicaid to be used more systematically and effectively for Medicaid evaluation and policy development; and

(4) develop or redesign the decision support system as necessary to ensure that the system:

(A) incorporates currently collected Medicaid enrollment, utilization, and provider data;

(B) allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within Medicaid;

(C) is able to obtain consistent and accurate answers to questions;

(D) allows for analysis of multiple issues within Medicaid to determine whether any programmatic or policy issues overlap or are in conflict;

(E) includes predefined data reports on utilization of high-cost services that allow Medicaid management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate;

(F) includes any encounter data with respect to recipients that a Medicaid managed care organization receives from a health care provider in the organization's provider network; and

(G) links Medicaid and non-Medicaid data sets, including data sets related to:

(i) Medicaid;

(ii) the financial assistance program under Chapter 31, Human Resources Code;

(iii) the special supplemental nutrition program for women, infants, and children authorized by 42 U.S.C. Section 1786;

(iv) vital statistics; and

(v) other public health programs.

(b) The commission shall ensure that all Medicaid data sets the decision support system creates or identifies are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy

concerns exist or arise with respect to making the data sets available on the Internet, the system and the commission shall make every effort to make the data available on the Internet either by:

(1) removing individually identifiable information; or

(2) aggregating the data in a manner to prevent the association of individual records with particular individuals.

(c) The commission shall regularly evaluate data submitted by Medicaid managed care organizations to determine whether:

(1) the data continues to serve a useful purpose; and

(2) additional data is needed to oversee contracts or evaluate the effectiveness of Medicaid.

(d) The commission shall collect Medicaid managed care data that effectively captures the quality of services recipients receive.

(e) The commission shall develop a dashboard for agency leadership that is designed to assist leadership with overseeing Medicaid and comparing the performance of Medicaid managed care organizations. The dashboard must identify a concise number of important Medicaid indicators, including key data, performance measures, trends, and problems. (Gov. Code, Sec. 531.02141.)

Sec. 532.0203. PUBLIC ACCESS TO CERTAIN DATA. (a) To the extent permitted by federal law, the commission, in collaboration with the appropriate advisory committees related to Medicaid, shall make available to the public on the commission's Internet website in an easy-to-read format data relating to the quality of health care recipients received and the health outcomes of those

recipients. Data the commission makes available to the public must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing duties under this section, the commission may collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data. (Gov. Code, Sec. 531.02142.)

Sec. 532.0204. DATA REGARDING TREATMENT FOR PRENATAL ALCOHOL OR CONTROLLED SUBSTANCE EXPOSURE. (a) The commission shall collect hospital discharge data for recipients regarding treatment of a newborn child for prenatal exposure to alcohol or a controlled substance.

(b) The commission shall provide the collected data to the Department of Family and Protective Services. (Gov. Code, Sec. 531.02143.)

Sec. 532.0205. MEDICAL TECHNOLOGY. The commission shall explore and evaluate new developments in medical technology and propose implementing the technology in Medicaid, if appropriate and cost-effective. Commission staff implementing this section must have skills and experience in research regarding health care technology. (Gov. Code, Sec. 531.0081.)

Sec. 532.0206. PILOT PROJECTS RELATING TO TECHNOLOGY APPLICATIONS. (a) Notwithstanding any other law, the commission may establish one or more pilot projects through which Medicaid reimbursement is made to demonstrate the applications of technology in providing Medicaid services.

(b) A pilot project under this section may relate to

providing rehabilitation services, services for the aging or individuals with disabilities, or long-term care services, including community care services and supports.

(c) Notwithstanding an eligibility requirement prescribed by any other law or rule, the commission may establish requirements for an individual to receive services provided through a pilot project under this section.

(d) An individual's receipt of services provided through a pilot project under this section does not entitle the individual to other services under a government-funded health program.

(e) The commission may set a maximum enrollment limit for a pilot project under this section. (Gov. Code, Sec. 531.062.)

SUBCHAPTER F. ELECTRONIC VISIT VERIFICATION SYSTEM

Sec. 532.0251. DEFINITION. In this subchapter, "electronic visit verification system" means the electronic visit verification system implemented under Section 532.0253. (New.)

Sec. 532.0252. IMPLEMENTATION OF CERTAIN PROVISIONS. Notwithstanding any other provision of this subchapter, the commission is required to implement a change in law made to former Section 531.024172 by Chapter 909 (S.B. 894), Acts of the 85th Legislature, Regular Session, 2017, only if the commission determines the implementation is appropriate based on the findings of the electronic visit verification system review conducted before April 1, 2018, under Section 531.024172(a) as that section existed before that date. (Gov. Code, Sec. 531.024172(a) (part).)

Sec. 532.0253. ELECTRONIC VISIT VERIFICATION SYSTEM IMPLEMENTATION. (a) Subject to Section 532.0258(a), the

commission shall, in accordance with federal law, implement an electronic visit verification system to electronically verify that personal care services, attendant care services, or other services the commission identifies that are provided under Medicaid to recipients, including personal care services or attendant care services provided under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) or any other Medicaid waiver program, are provided to recipients in accordance with a prior authorization or plan of care.

(b) The verification must be made through a telephone, global positioning, or computer-based system. (Gov. Code, Sec. 531.024172(b) (part).)

Sec. 532.0254. INFORMATION TO BE VERIFIED. The electronic visit verification system must allow for verification of only the following information relating to the delivery of Medicaid services:

(1) the type of service provided;

(2) the name of the recipient to whom the service was provided;

(3) the date and times the provider began and ended the service delivery visit;

(4) the location, including the address, at which the service was provided;

(5) the name of the individual who provided the service; and

(6) other information the commission determines is

necessary to ensure the accurate adjudication of Medicaid claims. (Gov. Code, Sec. 531.024172(b) (part).)

Sec. 532.0255. COMPLIANCE STANDARDS AND STANDARDIZED PROCESSES. (a) In implementing the electronic visit verification system:

(1) subject to Subsection (b), the executive commissioner shall adopt compliance standards for health care providers; and

(2) the commission shall ensure that:

(A) the information required to be reported by health care providers is standardized across Medicaid managed care organizations and commission programs;

(B) processes Medicaid managed care organizations require to retrospectively correct data are standardized and publicly accessible to health care providers;

(C) standardized processes are established for addressing the failure of a Medicaid managed care organization to provide a timely authorization for delivering services necessary to ensure continuity of care; and

(D) a health care provider is allowed to enter a variable schedule into the system.

(b) In establishing compliance standards for health care providers under Subsection (a), the executive commissioner shall consider:

(1) the administrative burdens placed on health care providers required to comply with the standards; and

(2) the benefits of using emerging technologies for

ensuring compliance, including Internet-based, mobile telephone-based, and global positioning-based technologies. (Gov. Code, Secs. 531.024172(d), (e).)

Sec. 532.0256. RECIPIENT COMPLIANCE. The commission shall inform each recipient who receives personal care services, attendant care services, or other services the commission identifies that the health care provider providing the services and the recipient are each required to comply with the electronic visit verification system. A Medicaid managed care organization shall also inform recipients described by this section who are enrolled in a managed care plan offered by the organization of those requirements. (Gov. Code, Sec. 531.024172(c).)

Sec. 532.0257. HEALTH CARE PROVIDER COMPLIANCE. A health care provider that provides to recipients personal care services, attendant care services, or other services the commission identifies shall:

(1) use the electronic visit verification system or a proprietary system the commission allows as provided by Section 532.0258 to document the provision of those services;

(2) comply with all documentation requirements the commission establishes;

(3) comply with federal and state laws regarding confidentiality of recipients' information;

(4) ensure that the commission or the Medicaid managed care organization with which a claim for reimbursement for a service is filed may review electronic visit verification system documentation related to the claim or obtain a copy of that

documentation at no charge to the commission or the organization; and

(5) at any time, allow the commission or a Medicaid managed care organization with which a health care provider contracts to provide health care services to recipients enrolled in the organization's managed care plan to have direct, on-site access to the electronic visit verification system in use by the health care provider. (Gov. Code, Sec. 531.024172(f).)

Sec. 532.0258. HEALTH CARE PROVIDER: USE OF PROPRIETARY SYSTEM. (a) The commission may recognize a health care provider's proprietary electronic visit verification system, whether purchased or developed by the provider, as complying with this subchapter and allow the health care provider to use that system for a period the commission determines if the commission determines that the system:

(1) complies with all necessary data submission, exchange, and reporting requirements established under this subchapter; and

(2) meets all other standards and requirements established under this subchapter.

(b) If feasible, the executive commissioner shall ensure a health care provider is reimbursed for the use of the provider's proprietary electronic visit verification system the commission recognizes.

(c) For purposes of facilitating the use of proprietary electronic visit verification systems by health care providers and in consultation with industry stakeholders and the work group

established under Section 532.0259, the commission or the executive commissioner, as appropriate, shall:

(1) develop an open model system that mitigates the administrative burdens providers required to use electronic visit verification identify;

(2) allow providers to use emerging technologies, including Internet-based, mobile telephone-based, and global positioning-based technologies, in the providers' proprietary electronic visit verification systems; and

(3) adopt rules governing data submission and provider reimbursement. (Gov. Code, Secs. 531.024172(g), (g-1), (g-2).)

Sec. 532.0259. STAKEHOLDER INPUT. The commission shall create a stakeholder work group composed of representatives of affected health care providers, Medicaid managed care organizations, and recipients. The commission shall periodically solicit from the work group input regarding the ongoing operation of the electronic visit verification system. (Gov. Code, Sec. 531.024172(h).)

Sec. 532.0260. RULES. The executive commissioner may adopt rules necessary to implement this subchapter. (Gov. Code, Sec. 531.024172(i).)

SUBCHAPTER G. APPLICANTS AND RECIPIENTS

Sec. 532.0301. BILL OF RIGHTS AND BILL OF RESPONSIBILITIES. (a) The executive commissioner by rule shall adopt a bill of rights and a bill of responsibilities for each recipient.

(b) The bill of rights must address a recipient's right to:

(1) respect, dignity, privacy, confidentiality, and

nondiscrimination;

(2) a reasonable opportunity to choose a health benefits plan and primary care provider and to change to another plan or provider in a reasonable manner;

(3) consent to or refuse treatment and actively participate in treatment decisions;

(4) ask questions and receive complete information relating to the recipient's medical condition and treatment options, including specialty care;

(5) access each available complaint process, receive a timely response to a complaint, and receive a fair hearing; and

(6) timely access to care that does not have any communication or physical access barriers.

(c) The bill of responsibilities must address a recipient's responsibility to:

(1) learn and understand each right the recipient has under Medicaid;

(2) abide by the health plan and Medicaid policies and procedures;

(3) share information relating to the recipient's health status with the primary care provider and become fully informed about service and treatment options; and

(4) actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain the recipient's health. (Gov. Code, Sec. 531.0212.)

Sec. 532.0302. UNIFORM FAIR HEARING RULES. (a) The

executive commissioner shall adopt uniform fair hearing rules for Medicaid-funded services. The rules must provide:

(1) due process to a Medicaid applicant and to a recipient who seeks a Medicaid service, including a service that requires prior authorization; and

(2) the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:

(A) the written notice to an individual of the individual's right to a hearing must:

(i) contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and

(ii) be delivered by mail, and postmarked at least 10 business days, before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by 42 C.F.R. Section 431.213 or 431.214; and

(B) if a hearing is requested before the date a recipient's service, including a service that requires prior authorization, is scheduled to be terminated, suspended, or reduced, the agency may not take that proposed action before a decision is rendered after the hearing unless:

(i) it is determined at the hearing that the sole issue is one of federal or state law or policy; and

(ii) the agency promptly informs the recipient in writing that services are to be terminated, suspended,

or reduced pending the hearing decision.

(b) The commission shall develop a process to address a situation in which:

(1) an individual does not receive adequate notice as required by Subsection (a)(2)(A); or

(2) the notice required by Subsection (a)(2)(A) is delivered without a postmark. (Gov. Code, Secs. 531.024(a) (part), (b), (c).)

Sec. 532.0303. SUPPORT AND INFORMATION SERVICES FOR RECIPIENTS. (a) The commission shall provide support and information services to a recipient or applicant for Medicaid who experiences barriers to receiving health care services. The commission shall give emphasis to assisting an individual with an urgent or immediate medical or support need.

(b) The commission shall provide the support and information services through a network of entities that are:

(1) coordinated by the commission's office of the ombudsman or other commission division the executive commissioner designates; and

(2) composed of:

(A) the commission's office of the ombudsman or other commission division the executive commissioner designates to coordinate the network;

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

(C) the commission division responsible for

oversight of Medicaid managed care contracts;

(D) area agencies on aging;

(E) aging and disability resource centers established under the aging and disability resource center initiative funded in part by the Administration on Aging and the Centers for Medicare and Medicaid Services; and

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

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

(d) As a part of the support and information services, the commission shall:

(1) operate a statewide toll-free assistance telephone number that includes relay services for individuals with speech or hearing disabilities and assistance for individuals who speak Spanish;

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

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

(4) educate individuals 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 the assistance lines receive 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 identified problems with Medicaid managed care;

(6) assist the state Medicaid office and Medicaid 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 managed care recipients, including children receiving dental benefits and other recipients receiving benefits, under:

(A) the STAR Medicaid managed care program;

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

(C) the STAR Kids managed care program established under Subchapter R, Chapter 540; and

(D) the STAR Health program;

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

(9) ensure that staff providing support and information services receive sufficient training, including training in the Medicare program for the purpose of assisting recipients who are dually eligible for Medicare and Medicaid, and have 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 commission division the executive commissioner designates to coordinate the network of entities responsible for providing the support and information services must be sufficiently independent from other aspects of Medicaid managed care to represent the best interests of recipients in problem resolution. (Gov. Code, Sec. 531.0213.)

Sec. 532.0304. NURSING SERVICES ASSESSMENTS. (a) In this section, "acute nursing services" means home health skilled nursing services, home health aide services, and private duty nursing services.

(b) If cost-effective, the commission shall develop an objective assessment process for use in assessing a recipient's need for acute nursing services. If the commission develops the objective assessment process, the commission shall require that:

(1) the assessment be conducted:

(A) by a state employee or contractor who is a

registered nurse licensed to practice in this state, and who is not:

(i) the individual who will deliver any necessary services to the recipient; or

(ii) affiliated with the person who will deliver those services; and

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

(2) the process include:

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

(B) an assessment of whether the recipient should be referred for additional assessments regarding the recipient's need for therapy services, as described by Section 532.0305, attendant care services, and durable medical equipment; and

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

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

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

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

(d) Unless the commission determines that the assessment is feasible and beneficial, an assessment under Subsection (b)(2)(B) of whether a recipient should be referred for additional therapy services assessments shall be waived if the recipient's need for therapy services has been established by a recommendation from a therapist providing care before the recipient is discharged from a licensed hospital or nursing facility. The assessment may not be waived if the recommendation is made by a therapist who:

(1) will deliver any services to the recipient; or

(2) is affiliated with a person who will deliver those services after the recipient is discharged from the licensed hospital or nursing facility.

(e) The executive commissioner shall adopt rules providing for a process by which a provider of acute nursing services who disagrees with the results of the assessment conducted under Subsection (b) may request and obtain a review of those results. (Gov. Code, Sec. 531.02417.)

Sec. 532.0305. THERAPY SERVICES ASSESSMENTS. (a) In this section, "therapy services" includes occupational, physical, and speech therapy services.

(b) After implementing the objective assessment process for acute nursing services in accordance with Section 532.0304, the commission shall consider whether implementing age- and diagnosis-appropriate objective assessment processes for use in assessing a recipient's need for therapy services would be feasible and beneficial.

(c) If the commission determines that implementing age- and

diagnosis-appropriate processes with respect to one or more types of therapy services is feasible and would be beneficial, the commission may implement the processes within:

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

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

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

(d) An objective assessment process implemented under this section must include a process that allows a therapy services provider to request and obtain a review of the results of an assessment conducted as provided by this section. The review process must be comparable to the review process implemented under Section 532.0304(e). (Gov. Code, Sec. 531.024171.)

Sec. 532.0306. WELLNESS SCREENING PROGRAM. If cost-effective, the commission may implement a wellness screening program for recipients that is designed to evaluate a recipient's risk for having certain diseases and medical conditions to establish:

(1) a health baseline for each recipient that may be used to tailor the recipient's treatment plan; or

(2) the recipient's health goals. (Gov. Code, Sec. 531.0981.)

Sec. 532.0307. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES. (a) In this section:

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

(2) "Rural health clinic services" has the meaning assigned by 42 U.S.C. Section 1396d(l)(1).

(b) Notwithstanding any provision of this chapter, Chapter 32, Human Resources Code, or any other law, the commission shall:

(1) promote recipient access to federally qualified health center services or rural health clinic services; and

(2) ensure that payment for federally qualified health center services or rural health clinic services is in accordance with 42 U.S.C. Section 1396a(bb). (Gov. Code, Sec. 531.02192(a) (part), (b).)

SUBCHAPTER H. PROGRAMS AND SERVICES FOR CERTAIN CATEGORIES OF MEDICAID POPULATION

Sec. 532.0351. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF MEDICAID POPULATION. (a) The executive commissioner may seek a waiver under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to develop and, subject to Subsection (c), implement tailored benefit packages designed to:

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

(2) improve health outcomes and access to services for those recipients;

(3) achieve cost containment and efficiency; and

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

(b) The commission:

(1) shall develop a tailored benefit package that is

customized to meet the health care needs of recipients who are children with special health care needs, subject to approval of the waiver described by Subsection (a); and

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

(c) If the commission develops tailored benefit packages under Subsection (b)(2), the commission shall submit to the standing committees of the senate and house of representatives having primary jurisdiction over Medicaid a report that specifies in detail the categories of recipients to which each of those packages will apply and the services available under each package.

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

(e) Each tailored benefit package must include:

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

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

(A) a set of benefits customized to meet the

health care needs of recipients in that category; and

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

(3) if the package applies to recipients who are children, at least the services required by federal law under the early and periodic screening, diagnosis, and treatment program.

(f) A tailored benefit package may include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventive health or wellness service.

(g) A tailored benefit package must increase this state's flexibility with respect to the state's use of Medicaid funding and may not reduce the benefits available under the Medicaid state plan to any recipient population.

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

(1) individuals with disabilities or special health care needs;

(2) elderly individuals;

(3) children without special health care needs; and

(4) working-age parents and caretaker relatives. (Gov. Code, Sec. 531.097.)

Sec. 532.0352. WAIVER PROGRAM FOR CERTAIN INDIVIDUALS WITH

CHRONIC HEALTH CONDITIONS. (a) If feasible and cost-effective, the commission may apply for a waiver from the Centers for Medicare and Medicaid Services or another appropriate federal agency to more efficiently leverage the use of state and local funds to maximize the receipt of federal Medicaid matching funds by providing Medicaid benefits to individuals who:

(1) meet established income and other eligibility criteria; and

(2) are eligible to receive services through the county for chronic health conditions.

(b) In establishing the waiver program, the commission shall:

(1) ensure that this state is a prudent purchaser of the health care services that are needed for the individuals described by Subsection (a);

(2) solicit broad-based input from interested persons;

(3) ensure that the benefits an individual receives through the county are not reduced once the individual is enrolled in the waiver program; and

(4) employ the use of intergovernmental transfers and other procedures to maximize the receipt of federal Medicaid matching funds. (Gov. Code, Sec. 531.0226.)

Sec. 532.0353. BUY-IN PROGRAMS FOR CERTAIN INDIVIDUALS WITH DISABILITIES. (a) The executive commissioner shall develop and implement:

(1) a Medicaid buy-in program for individuals with

disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (Pub. L. No. 105-33); and

(2) a Medicaid buy-in program for children with disabilities described by 42 U.S.C. Section 1396a(cc)(1) whose family incomes do not exceed 300 percent of the applicable federal poverty level, as authorized by the Deficit Reduction Act of 2005 (Pub. L. No. 109-171).

(b) The executive commissioner shall adopt rules in accordance with federal law that provide for:

(1) eligibility requirements for each program described by Subsection (a); and

(2) requirements for program participants to pay premiums or cost-sharing payments, subject to Subsection (c).

(c) Rules the executive commissioner adopts under Subsection (b) with respect to the program for children with disabilities described by Subsection (a)(2) must require a participant to pay monthly premiums according to a sliding scale that is based on family income, subject to the requirements of 42 U.S.C. Sections 1396o(i)(2) and (3). (Gov. Code, Sec. 531.02444.)

SUBCHAPTER I. UTILIZATION REVIEW, PRIOR AUTHORIZATION, AND COVERAGE PROCESSES AND DETERMINATIONS

Sec. 532.0401. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. The commission shall:

(1) in accordance with an established schedule, periodically review the prior authorization and utilization review processes within the Medicaid fee-for-service delivery model to

determine whether those processes need modification to reduce authorizations of unnecessary services and inappropriate use of services;

(2) monitor the prior authorization and utilization review processes within the Medicaid fee-for-service delivery model for anomalies and, on identification of an anomaly in a process, review the process for modification earlier than scheduled; and

(3) monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services. (Gov. Code, Sec. 531.076.)

Sec. 532.0402. ACCESSIBILITY OF INFORMATION REGARDING PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's Internet website in an easily searchable and accessible format:

(1) the applicable timelines for prior authorization requirements, including:

(A) the time within which the organization or entity must make a determination on a prior authorization request;

(B) a description of the notice the organization or entity provides to a provider and recipient on whose behalf the request was submitted regarding the documentation required to

complete a determination on a prior authorization request; and

(C) the deadline by which the organization or entity is required to submit the notice described by Paragraph (B); and

(2) an accurate and current catalog of coverage criteria and prior authorization requirements, including:

(A) for a prior authorization requirement first imposed on or after September 1, 2019, the effective date of the requirement;

(B) a list or description of any supporting or other documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each review of a prior authorization requirement conducted under Section 540.0304, if applicable.

(b) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to:

(1) adopt and maintain a process for a provider or recipient to contact the organization or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request; and

(2) ensure that the process described by Subdivision (1) is not arduous or overly burdensome to a provider or recipient. (Gov. Code, Sec. 531.024163.)

Sec. 532.0403. NOTICE REQUIREMENTS REGARDING COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (a) The

commission shall ensure that a notice the commission or a Medicaid managed care organization sends to a recipient or Medicaid provider regarding the denial, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

(1) information required by federal and state law and regulations;

(2) for the recipient:

(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;

(B) a copy of the information the commission or organization sent to the provider; and

(C) an educational component that includes:

(i) a description of the recipient's rights;

(ii) an explanation of the process related to appeals and Medicaid fair hearings; and

(iii) a description of the role of an external medical review; and

(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as applicable, information required under Subsection (b).

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the

recipient on whose behalf the request was submitted. The notice must:

(1) include a section specifically for the provider that contains:

(A) a clear and specific list and description of the documentation necessary for the commission or organization to make a final determination on the request;

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process described by Section 540.0306, if applicable; and

(C) information on the manner through which a provider may contact a Medicaid managed care organization or other entity as required by Section 532.0402; and

(2) be sent:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the extent practicable using existing resources. (Gov. Code, Sec. 531.024162.)

Sec. 532.0404. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" means a third-party medical review organization that provides objective, unbiased medical

necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with state law and rules.

(b) The commission shall contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) the commission's denial of eligibility for a Medicaid program in which eligibility is based on a recipient's medical and functional needs.

(c) A Medicaid managed care organization may not have a financial relationship with or ownership interest in the external medical reviewer with which the commission contracts.

(d) The external medical reviewer with which the commission contracts must:

(1) be overseen by a medical director who is a physician licensed in this state; and

(2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.

(e) The commission shall establish:

(1) a common procedure for external medical reviews that:

(A) to the greatest extent possible, reduces:

(i) administrative burdens on providers; and

(ii) the submission of duplicative information or documents; and

(B) bases a medical necessity determination on clinical criteria that is:

(i) publicly available;

(ii) current;

(iii) evidence-based; and

(iv) peer-reviewed; and

(2) a procedure and time frame for expedited reviews that allow the external medical reviewer to:

(A) identify an appeal that requires an expedited resolution; and

(B) resolve the review of the appeal within a specified period.

(f) The external medical reviewer shall conduct an external medical review within a period the commission specifies.

(g) A recipient or Medicaid applicant, or the recipient's or applicant's parent or legally authorized representative, must affirmatively request an external medical review. If requested:

(1) an external medical review described by Subsection (b)(1):

(A) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing; and

(B) is granted when a recipient contests the internal appeal decision of the Medicaid managed care organization;

and

(2) an external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing.

(h) The external medical reviewer's determination of medical necessity establishes the minimum level of services a recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

(i) The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

(j) To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations the external medical reviewer reviewed, including the rate of prior authorization denials the external medical reviewer overturned and additional information the commission and the external medical reviewer determine appropriate. (Gov. Code, Sec. 531.024164.)

SUBCHAPTER J. COST-SAVING INITIATIVES

Sec. 532.0451. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES. (a) The commission shall develop and implement a comprehensive plan to reduce recipients' use of hospital emergency room services. The plan may include:

(1) a pilot program that is designed to assist a program participant in accessing an appropriate level of health care and that may include as components:

(A) providing a program participant access to bilingual health services providers; and

(B) giving a program participant information on how to access primary care physicians, advanced practice registered nurses, and local health clinics;

(2) a pilot program under which a health care provider other than a hospital is given a financial incentive for treating a recipient outside of normal business hours to divert the recipient from a hospital emergency room;

(3) payment of a nominal referral fee to a hospital emergency room that performs an initial medical evaluation of a recipient and subsequently refers the recipient, if medically stable, to an appropriate level of health care, such as care provided by a primary care physician, advanced practice registered nurse, or local clinic;

(4) a program under which the commission or a Medicaid managed care organization contacts, by telephone or mail, a recipient who accesses a hospital emergency room three times during a six-month period and provides the recipient with information on ways the recipient may secure a medical home to avoid unnecessary treatment at a hospital emergency room;

(5) a health care literacy program under which the commission develops partnerships with other state agencies and private entities to:

(A) assist the commission in developing materials that:

(i) contain basic health care information

for parents of young children who are recipients and who are participating in public or private child-care or prekindergarten programs, including federal Head Start programs; and

(ii) are written in a language understandable to those parents and specifically tailored to be applicable to the needs of those parents;

(B) distribute the materials developed under Paragraph (A) to those parents; and

(C) otherwise teach those parents about their children's health care needs and ways to address those needs; and

(6) other initiatives developed and implemented in other states that have shown success in reducing the incidence of unnecessary treatment in a hospital emergency room.

(b) The commission shall coordinate with hospitals and other providers that receive supplemental payments under the uncompensated care payment program operated under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315) to identify and implement initiatives based on best practices and models that are designed to reduce recipients' use of hospital emergency room services as a primary means of receiving health care benefits, including initiatives designed to improve recipients' access to and use of primary care providers. (Gov. Code, Sec. 531.085.)

Sec. 532.0452. PHYSICIAN INCENTIVE PROGRAM TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) If cost-effective, the executive commissioner by rule shall establish

a physician incentive program designed to reduce recipients' use of hospital emergency room services for non-emergent conditions.

(b) In establishing the physician incentive program, the executive commissioner may include only the program components identified as cost-effective in the study conducted under former Section 531.086 before that section expired September 1, 2014.

(c) If the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, the executive commissioner shall implement controls to ensure that the after-hours services billed are actually provided outside of normal business hours. (Gov. Code, Sec. 531.0861.)

Sec. 532.0453. CONTINUED IMPLEMENTATION OF CERTAIN INTERVENTIONS AND BEST PRACTICES BY PROVIDERS; SEMIANNUAL REPORT. (a) The commission shall encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of recipients that were developed and achieved under the Delivery System Reform Incentive Payment (DSRIP) program previously operated under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315), through:

(1) existing provider incentive programs and the creation of new provider incentive programs;

(2) the terms included in contracts with Medicaid managed care organizations;

(3) implementation of alternative payment models; or

(4) adoption of other cost-effective measures.

(b) The commission shall semiannually prepare and submit to the legislature a report that contains a summary of the commission's efforts under this section and Section 532.0451(b). (Gov. Code, Sec. 531.0862.)

Sec. 532.0454. HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a) If the commission determines that it is cost-effective and feasible, the commission shall develop and implement a Medicaid health savings account pilot program that is consistent with federal law to:

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

(2) promote adult recipients' appropriate use of Medicaid services.

(b) If the commission implements the pilot program, the commission:

(1) may include only adult recipients as program participants; and

(2) shall ensure that:

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

(B) a recipient who participates in the pilot program may, at the recipient's option and subject to Subsection (c), discontinue participating and resume receiving benefits and services under the traditional Medicaid delivery model.

(c) A recipient who chooses to discontinue participating in the pilot program and resume receiving benefits and services under

the traditional Medicaid delivery model before completion of the health savings account enrollment period forfeits any funds remaining in the recipient's health savings account. (Gov. Code, Sec. 531.0941.)

Sec. 532.0455. DURABLE MEDICAL EQUIPMENT REUSE PROGRAM. (a) In this section:

(1) "Complex rehabilitation technology equipment":

(A) means equipment that is:

(i) classified as durable medical equipment under the Medicare program on January 1, 2013;

(ii) configured specifically for an individual to meet the individual's unique medical, physical, and functional needs and capabilities for basic and instrumental daily living activities; and

(iii) medically necessary to prevent the individual's hospitalization or institutionalization; and

(B) includes a complex rehabilitation power wheelchair, highly configurable manual wheelchair, adaptive seating and positioning system, standing frame, and gait trainer.

(2) "Durable medical equipment" means equipment, including repair and replacement parts for the equipment, but excluding complex rehabilitation technology equipment, that:

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to an individual in the absence of illness or injury; and

(D) is appropriate and safe for use in the home.

(b) If the commission determines that it is cost-effective, the executive commissioner by rule shall establish a program to facilitate the reuse of durable medical equipment provided to recipients.

(c) The program must include provisions for ensuring that:

(1) reused equipment meets applicable standards of functionality and sanitation; and

(2) a recipient's participation in the reuse program is voluntary.

(d) The program does not:

(1) waive any immunity from liability of the commission or a commission employee; or

(2) create a cause of action against the commission or a commission employee arising from the provision of reused durable medical equipment under the program. (Gov. Code, Secs. 531.0843(a), (b), (c), (d).)

CHAPTER 540. MEDICAID MANAGED CARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

SUBCHAPTER B. ADMINISTRATION OF MEDICAID MANAGED CARE PROGRAM

SUBCHAPTER F. REQUIRED CONTRACT PROVISIONS

Sec. 540.0251. APPLICABILITY

Sec. 540.0252. ACCOUNTABILITY TO STATE

Sec. 540.0253. CAPITATION RATES

Sec. 540.0254. COST INFORMATION

Sec. 540.0255. FRAUD CONTROL

Sec. 540.0256. RECIPIENT OUTREACH AND EDUCATION

Sec. 540.0257. NOTICE OF MEDICAID CERTIFICATION DATE

Sec. 540.0258. PRIMARY CARE PROVIDER ASSIGNMENT

Sec. 540.0259. COMPLIANCE WITH PROVIDER NETWORK REQUIREMENTS

Sec. 540.0260. COMPLIANCE WITH PROVIDER ACCESS STANDARDS; REPORT

Sec. 540.0261. PROVIDER NETWORK SUFFICIENCY

Sec. 540.0262. QUALITY MONITORING PROGRAM FOR HEALTH CARE SERVICES

Sec. 540.0263. OUT-OF-NETWORK PROVIDER USAGE AND REIMBURSEMENT

Sec. 540.0264. PROVIDER REIMBURSEMENT RATE REDUCTION

Sec. 540.0265. PROMPT PAYMENT OF CLAIMS

Sec. 540.0266. REIMBURSEMENT FOR CERTAIN SERVICES PROVIDED OUTSIDE REGULAR BUSINESS HOURS

Sec. 540.0267. PROVIDER APPEALS PROCESS

Sec. 540.0268. ASSISTANCE RESOLVING RECIPIENT AND PROVIDER ISSUES

CHAPTER 540. MEDICAID MANAGED CARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 540.0001. DEFINITIONS. In this chapter:

(1) Notwithstanding Section 521.0001(2), "commission" means the Health and Human Services Commission or an agency operating part of the Medicaid managed care program, as appropriate.

(2) "Health care service region" or "region" means a Medicaid managed care service area the commission delineates.

(3) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or provide a

managed care plan.

(4) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(5) "Potentially preventable event" has the meaning assigned by Section 543A.0001.

(6) "Recipient" means a Medicaid recipient. (Gov. Code, Secs. 533.001(1), (4), (5), (6), (7), 533.00251(a)(4), 533.00253(a)(3), 533.00256(a)(1) (part), 533.00511(a).)

SUBCHAPTER B. ADMINISTRATION OF MEDICAID MANAGED CARE PROGRAM

Sec. 540.0051. PURPOSE AND IMPLEMENTATION. The commission shall implement the Medicaid managed care program by contracting with managed care organizations in a manner that, to the extent possible:

(1) improves the health of Texans by:

(A) emphasizing prevention;

(B) promoting continuity of care; and

(C) providing a medical home for recipients;

(2) ensures each recipient receives high quality, comprehensive health care services in the recipient's local community;

(3) encourages training of and access to primary care physicians and providers;

(4) maximizes cooperation with existing public health entities, including local health departments;

(5) provides incentives to managed care organizations to improve the quality of health care services for recipients by providing value-added services; and

(6) reduces administrative and other nonfinancial barriers for recipients in obtaining health care services. (Gov. Code, Sec. 533.002.)

Sec. 540.0052. RECIPIENT DIRECTORY. The commission shall, in accordance with a single source of truth design:

(1) maintain an accurate electronic directory of contact information for each recipient enrolled in a Medicaid managed care plan offered by a managed care organization, including, to the extent feasible, each recipient's:

(A) home, work, and mobile telephone numbers;

(B) e-mail address; and

(C) home and work addresses; and

(2) ensure that each Medicaid managed care organization and enrollment broker participating in the Medicaid managed care program update the electronic directory in real time. (Gov. Code, Sec. 533.00751.)

Sec. 540.0053. STATEWIDE EFFORT TO PROMOTE MEDICAID ELIGIBILITY MAINTENANCE. (a) The commission shall develop and implement a statewide effort to assist recipients who satisfy Medicaid eligibility requirements and who receive Medicaid

services through a Medicaid managed care organization with:

(1) maintaining eligibility; and

(2) avoiding lapses in Medicaid coverage.

(b) As part of the commission's effort under Subsection (a), the commission shall:

(1) require each Medicaid managed care organization to assist the organization's recipients with maintaining eligibility;

(2) if the commission determines it is cost-effective, develop specific strategies for assisting recipients who receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq. with maintaining eligibility; and

(3) ensure information relevant to a recipient's eligibility status is provided to the recipient's Medicaid managed care organization. (Gov. Code, Sec. 533.0077.)

Sec. 540.0054. PROVIDER AND RECIPIENT EDUCATION PROGRAMS. (a) In adopting rules to implement a Medicaid managed care program, the executive commissioner shall establish guidelines for, and require Medicaid managed care organizations to provide, education programs for providers and recipients using a variety of techniques and media.

(b) A provider education program must include information on:

(1) Medicaid policies, procedures, eligibility standards, and benefits;

(2) recipients' specific problems and needs; and

(3) recipients' rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by

Section 532.0301.

(c) A recipient education program must present information in a manner that is easy to understand. A program must include information on:

(1) a recipient's rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section 532.0301;

(2) how to access health care services;

(3) how to access complaint procedures and the recipient's right to bypass the Medicaid managed care organization's internal complaint system and use the notice and appeal procedures otherwise required by Medicaid;

(4) Medicaid policies, procedures, eligibility standards, and benefits;

(5) the Medicaid managed care organization's policies and procedures; and

(6) the importance of prevention, early intervention, and appropriate use of services. (Gov. Code, Sec. 531.0211.)

Sec. 540.0055. MARKETING GUIDELINES. (a) The commission shall establish marketing guidelines for Medicaid managed care organizations, including guidelines that prohibit:

(1) door-to-door marketing to a recipient by a Medicaid managed care organization or the organization's agent;

(2) using marketing materials with inaccurate or misleading information;

(3) making a misrepresentation to a recipient or provider;

(4) offering a recipient a material or financial incentive to choose a Medicaid managed care plan, other than a nominal gift or free health screening the commission approves that the Medicaid managed care organization offers to all recipients regardless of whether the recipients enroll in the plan;

(5) using a marketing agent who is paid solely by commission; and

(6) face-to-face marketing at a public assistance office by a Medicaid managed care organization or the organization's agent.

(b) This section does not prohibit:

(1) distributing approved marketing materials at a public assistance office; or

(2) providing information directly to a recipient under marketing guidelines the commission establishes. (Gov. Code, Secs. 533.008(a), (b).)

Sec. 540.0056. GUIDELINES FOR COMMUNICATIONS WITH RECIPIENTS. The executive commissioner shall adopt and publish guidelines for Medicaid managed care organizations regarding how an organization may communicate by text message or e-mail with a recipient enrolled in the organization's Medicaid managed care plan using the contact information provided in the recipient's application for Medicaid benefits under Section 32.025(g)(2), Human Resources Code, including updated information provided to the organization in accordance with Section 32.025(h), Human Resources Code. (Gov. Code, Sec. 533.008(c).)

Sec. 540.0057. COORDINATION OF EXTERNAL OVERSIGHT

ACTIVITIES. (a) To the extent possible, the commission shall coordinate all external oversight activities to minimize duplicating oversight of Medicaid managed care plans and disrupting operations under those plans.

(b) The executive commissioner, after consulting with the commission's office of inspector general, shall by rule define the commission's and office's roles in, jurisdiction over, and frequency of audits of Medicaid managed care organizations that are conducted by the commission and the office.

(c) In accordance with Section 544.0109, the commission shall share with the commission's office of inspector general, at the office's request, the results of any informal audit or on-site visit that could inform the office's risk assessment when determining:

(1) whether to conduct an audit of a Medicaid managed care organization; or

(2) the scope of the audit. (Gov. Code, Sec. 533.015.)

Sec. 540.0058. INFORMATION FOR FRAUD CONTROL. (a) Each Medicaid managed care organization shall submit at no cost to the commission and, on request, the office of the attorney general:

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

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

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

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

(b) The information under this section must be:

(1) submitted in the form the commission or the office of the attorney general, as applicable, requires; and

(2) updated as the commission or the office of the attorney general, as applicable, requires.

(c) The commission's office of inspector general or the office of the attorney general, as applicable, shall review the information a Medicaid managed care organization submits under this section as appropriate in investigating fraud in the Medicaid managed care program.

(d) Information a Medicaid managed care organization submits to the commission or the office of the attorney general under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552. (Gov. Code, Sec. 533.012.)

Sec. 540.0059. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:

(1) establish a clinical improvement program to identify goals designed to:

(A) improve quality of care and care management; and

(B) reduce potentially preventable events; and

(2) require Medicaid managed care organizations to develop and implement collaborative program improvement strategies to address the goals.

(b) Goals established under this section may be set by geographic region and program type. (Gov. Code, Secs. 533.00256(a) (part), (b).)

Sec. 540.0060. COMPLAINT SYSTEM GUIDELINES. (a) The Texas Department of Insurance, in conjunction with the commission, shall establish complaint system guidelines for Medicaid managed care organizations.

(b) The guidelines must require that information regarding a Medicaid managed care organization's complaint process be made available to a recipient in an appropriate communication format when the recipient enrolls in the Medicaid managed care program. (Gov. Code, Secs. 533.020(a) (part), (b).)

SUBCHAPTER C. FISCAL PROVISIONS

Sec. 540.0101. FISCAL SOLVENCY STANDARDS. The Texas Department of Insurance, in conjunction with the commission, shall establish fiscal solvency standards for Medicaid managed care organizations. (Gov. Code, Sec. 533.020(a) (part).)

Sec. 540.0102. PROFIT SHARING. (a) The executive commissioner shall adopt rules regarding the sharing of profits

earned by a Medicaid managed care organization through a Medicaid managed care plan.

(b) Except as provided by Subsection (c), any amount this state receives under this section shall be deposited in the general revenue fund.

(c) If cost-effective, the commission may use amounts this state receives under this section to provide incentives to specific Medicaid managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization. (Gov. Code, Sec. 533.014.)

Sec. 540.0103. TREATMENT OF STATE TAXES IN CALCULATING EXPERIENCE REBATE OR PROFIT SHARING. The commission shall ensure that any experience rebate or profit sharing for Medicaid managed care organizations is calculated by treating premium, maintenance, and other taxes under the Insurance Code and any other taxes payable to this state as allowable expenses to determine the amount of the experience rebate or profit sharing. (Gov. Code, Sec. 533.0132.)

SUBCHAPTER D. STRATEGY FOR MANAGING AUDIT RESOURCES

Sec. 540.0151. DEFINITIONS. In this subchapter:

(1) "Accounts receivable tracking system" means the system the commission uses to track experience rebates and other payments collected from managed care organizations.

(2) "Agreed-upon procedures engagement" means an evaluation of a managed care organization's financial statistical reports or other data conducted by an independent auditing firm the commission engages as agreed in the managed care organization's

contract with the commission.

(3) "Experience rebate" means the amount a managed care organization is required to pay this state according to the graduated rebate method described in the organization's contract with the commission.

(4) "External quality review organization" means an organization that performs an external quality review of a managed care organization in accordance with 42 C.F.R. Section 438.350. (Gov. Code, Sec. 533.051.)

Sec. 540.0152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission's office of inspector general under the authority provided by Subchapter C, Chapter 544, including an audit of a managed care organization the office conducts after coordinating the office's audit and oversight activities with the commission as required by Section 544.0109(c). (Gov. Code, Sec. 533.052.)

Sec. 540.0153. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES. The commission shall develop and implement an overall strategy for planning, managing, and coordinating audit resources that the commission uses to verify the accuracy and reliability of program and financial information managed care organizations report. (Gov. Code, Sec. 533.053.)

Sec. 540.0154. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP. (a) To improve the commission's processes for performance audits of managed care organizations, the commission shall:

(1) document the process by which the commission selects organizations to audit;

(2) include previous audit coverage as a risk factor in selecting organizations to audit; and

(3) prioritize the highest risk organizations to audit.

(b) To verify that managed care organizations correct negative performance audit findings, the commission shall:

(1) establish a process to:

(A) document how the commission follows up on those findings; and

(B) verify that organizations implement performance audit recommendations; and

(2) establish and implement policies and procedures to:

(A) determine under what circumstances the commission must issue a corrective action plan to an organization based on a performance audit; and

(B) follow up on the organization's implementation of the plan. (Gov. Code, Sec. 533.054.)

Sec. 540.0155. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:

(1) ensure that financial risks identified in agreed-upon procedures engagements are adequately and consistently

addressed; and

(2) establish policies and procedures to determine under what circumstances the commission must issue a corrective action plan based on an agreed-upon procedures engagement. (Gov. Code, Sec. 533.055.)

Sec. 540.0156. AUDITS OF PHARMACY BENEFIT MANAGERS. To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:

(1) periodically audit each pharmacy benefit manager that contracts with a managed care organization; and

(2) develop, document, and implement a monitoring process to ensure that managed care organizations correct and resolve negative findings reported in performance audits or agreed-upon procedures engagements of pharmacy benefit managers. (Gov. Code, Sec. 533.056.)

Sec. 540.0157. COLLECTING COSTS FOR AUDIT-RELATED SERVICES. The commission shall develop, document, and implement billing processes in the commission's Medicaid and CHIP services department to ensure that managed care organizations reimburse the commission for audit-related services as required by contract. (Gov. Code, Sec. 533.057.)

Sec. 540.0158. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING. To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the commission's Medicaid and CHIP services department to ensure that

the commission:

(1) identifies experience rebates deposited in the commission's suspense account and timely transfers those rebates to the appropriate accounts; and

(2) timely follows up on and resolves disputes over experience rebates managed care organizations claim. (Gov. Code, Sec. 533.058.)

Sec. 540.0159. USING INFORMATION FROM EXTERNAL QUALITY REVIEWS. (a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:

(1) detailed data from results of surveys of:

(A) recipients and, if applicable, child health plan program enrollees;

(B) caregivers of those recipients and enrollees; and

(C) Medicaid and, as applicable, child health plan program providers; and

(2) the validation results of matching paid claims data with medical records.

(b) The commission shall document how the commission uses the information described by Subsection (a) to monitor managed care organizations. (Gov. Code, Sec. 533.059.)

Sec. 540.0160. SECURITY OF AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS. The commission shall:

(1) strengthen user access controls for the commission's accounts receivable tracking system and network

folders that the commission uses to manage the collection of experience rebates;

(2) document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in:

(A) the commission's cost accounting system for all health and human services agencies; and

(B) the uniform statewide accounting system; and

(3) develop, document, and implement a process to ensure that the commission formally documents:

(A) all programming changes made to the accounts receivable tracking system; and

(B) the authorization and testing of the changes described by Paragraph (A). (Gov. Code, Sec. 533.060.)

SUBCHAPTER E. CONTRACT ADMINISTRATION

Sec. 540.0201. CONTRACT ADMINISTRATION IMPROVEMENT EFFORTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve contract administration, the commission shall:

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

(2) evaluate options for Medicaid payment recovery from a managed care organization if an enrolled recipient:

(A) dies;

(B) is incarcerated;

(C) is enrolled in more than one state program;

or

(D) is covered by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in recovering capitation payments, payments from other liable third parties, and other payments made to a managed care organization with respect to an enrolled recipient who leaves the managed care program;

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

(A) where possible, decreasing duplicate administrative reporting and process requirements for managed care organizations and providers, such as requirements for submitting:

(i) encounter data;

(ii) quality reports;

(iii) historically underutilized business reports; and

(iv) claims payment summary reports;

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

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to:

(i) the preauthorization process;

(ii) lengths of hospital stays;

(iii) filing deadlines;

(iv) levels of care; and

(v) case management services;

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to:

(i) including a separate cover sheet for all communications;

(ii) submitting handwritten communications instead of electronic or typed review processes; and

(iii) admitting patients listed on separate notices; and

(E) providing a portal through which a provider in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

(5) reserve the right to amend a managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process the commission establishes for final determination of these disputes. (Gov. Code, Sec. 533.0071.)

Sec. 540.0202. PUBLIC NOTICE OF REQUEST FOR CONTRACT APPLICATIONS. Not later than the 30th day before the date the commission plans to issue a request for applications to enter into a contract with the commission to provide health care services to recipients in a region, the commission shall publish notice of and

make available for public review the request for applications and all related nonproprietary documents, including the proposed contract. (Gov. Code, Sec. 533.011.)

Sec. 540.0203. CERTIFICATION BY COMMISSION. (a) Before the commission may award a contract under this chapter to a managed care organization, the commission shall evaluate and certify that the organization is reasonably able to fulfill the contract terms, including all federal and state law requirements. Notwithstanding any other law, the commission may not award a contract under this chapter to an organization that does not receive the required certification.

(b) A managed care organization may appeal the commission's denial of certification. (Gov. Code, Sec. 533.0035.)

Sec. 540.0204. CONTRACT CONSIDERATIONS RELATING TO MANAGED CARE ORGANIZATIONS. In awarding contracts to managed care organizations, the commission shall:

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

(2) give extra consideration to an organization that agrees to assure continuity of care for at least three months beyond a recipient's Medicaid eligibility period;

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

(4) consider the ability of an organization to process Medicaid claims electronically. (Gov. Code, Sec. 533.003(a)

(part).)

Sec. 540.0205. CONTRACT CONSIDERATIONS RELATING TO PHARMACY BENEFIT MANAGERS. In considering approval of a subcontract between a managed care organization and a pharmacy benefit manager to provide Medicaid prescription drug benefits, the commission shall review and consider whether in the preceding three years the pharmacy benefit manager has been:

(1) convicted of:

(A) an offense involving a material misrepresentation or an act of fraud; or

(B) another violation of state or federal criminal law;

(2) adjudicated to have committed a breach of contract; or

(3) assessed a penalty or fine of $500,000 or more in a state or federal administrative proceeding. (Gov. Code, Sec. 533.003(b).)

Sec. 540.0206. MANDATORY CONTRACTS. (a) Subject to the certification required under Section 540.0203 and the considerations required under Section 540.0204, in providing health care services through Medicaid managed care to recipients in a health care service region, the commission shall contract with a managed care organization in that region that holds a certificate of authority issued under Chapter 843, Insurance Code, to provide health care in that region and that is:

(1) wholly owned and operated by a hospital district in that region;

(2) created by a nonprofit corporation that:

(A) has a contract, agreement, or other arrangement with a hospital district in that region or with a municipality in that region that owns a hospital licensed under Chapter 241, Health and Safety Code, and has an obligation to provide health care to indigent patients; and

(B) under the contract, agreement, or other arrangement, assumes the obligation to provide health care to indigent patients and leases, manages, or operates a hospital facility the hospital district or municipality owns; or

(3) created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to arrange for services under the Medicaid expansion for children as authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995.

(b) A managed care organization described by Subsection (a) is subject to all terms to which other managed care organizations are subject, including all contractual, regulatory, and statutory provisions relating to participation in the Medicaid managed care program.

(c) The commission shall make the awarding and renewal of a mandatory contract under this section to a managed care organization affiliated with a hospital district or municipality contingent on the district or municipality entering into a matching funds agreement to expand Medicaid for children as authorized by

Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995. The commission shall make compliance with the matching funds agreement a condition of the continuation of the contract with the managed care organization to provide health care services to recipients.

(d) Subsection (c) does not apply if:

(1) the commission does not expand Medicaid for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995; or

(2) a waiver from a federal agency necessary for the expansion is not granted.

(e) In providing health care services through Medicaid managed care to recipients in a health care service region, with the exception of the Harris service area for the STAR Medicaid managed care program, as the commission defined as of September 1, 1999, the commission shall also contract with a managed care organization in that region that holds a certificate of authority as a health maintenance organization issued under Chapter 843, Insurance Code, and that:

(1) is certified under Section 162.001, Occupations Code;

(2) is created by The University of Texas Medical Branch at Galveston; and

(3) has obtained a certificate of authority as a health maintenance organization to serve one or more counties in that region from the Texas Department of Insurance before September 2, 1999. (Gov. Code, Sec. 533.004.)

Sec. 540.0207. CONTRACTUAL OBLIGATIONS REVIEW. The commission shall review each Medicaid managed care organization to determine whether the organization is prepared to meet the organization's contractual obligations. (Gov. Code, Sec. 533.007(a).)

Sec. 540.0208. CONTRACT IMPLEMENTATION PLAN. (a) Each Medicaid managed care organization that contracts to provide health care services to recipients in a health care service region shall submit an implementation plan not later than the 90th day before the date the organization plans to begin providing those services in that region through managed care. The implementation plan must include:

(1) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training; and

(2) specific time frames for demonstrating preparedness for implementation before the date the organization plans to begin providing those services in that region through managed care.

(b) The commission shall respond to an implementation plan not later than the 10th day after the date a Medicaid managed care organization submits the plan if the plan does not adequately meet preparedness guidelines.

(c) Each Medicaid managed care organization that contracts to provide health care services to recipients in a health care service region shall submit status reports on the implementation

plan:

(1) not later than the 60th day and the 30th day before the date the organization plans to begin providing those services in that region through managed care; and

(2) every 30th day after that date until the 180th day after that date. (Gov. Code, Secs. 533.007(b), (c), (d).)

Sec. 540.0209. COMPLIANCE AND READINESS REVIEW. (a) The commission shall conduct a compliance and readiness review of each Medicaid managed care organization:

(1) not later than the 15th day before the date the process of enrolling recipients in a managed care plan the organization issues is to begin in a region; and

(2) not later than the 15th day before the date the organization plans to begin providing health care services to recipients in that region through managed care.

(b) The compliance and readiness review must include an on-site inspection and tests of service authorization and claims payment systems, including:

(1) the Medicaid managed care organization's ability to process claims electronically;

(2) the Medicaid managed care organization's complaint processing systems; and

(3) any other process or system the contract between the Medicaid managed care organization and the commission requires.

(c) The commission may delay recipient enrollment in a managed care plan a Medicaid managed care organization issues if the compliance and readiness review reveals that the organization

is not prepared to meet the organization's contractual obligations. The commission shall notify the organization of a decision to delay enrollment in a plan the organization issues. (Gov. Code, Secs. 533.007(e), (f).)

Sec. 540.0210. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and maintain a record of each enforcement action the commission initiates that results in a sanction, including a penalty, being imposed against a managed care organization for failure to comply with the terms of a contract to provide health care services to recipients through a Medicaid managed care plan the organization issues.

(b) The record must include:

(1) the managed care organization's name and address;

(2) a description of the contractual obligation the organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed;

(5) the maximum sanction that may be imposed under the contract for the violation; and

(6) the actual sanction imposed against the organization.

(c) The commission shall:

(1) post and maintain on the commission's Internet website the records required by this section:

(A) in English and Spanish; and

(B) in a format that is readily accessible to and

understandable by the public; and

(2) update the list of records on the website at least quarterly.

(d) The commission may not post information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) A record prepared under this section may not include information that is excepted from disclosure under Chapter 552.

(f) The executive commissioner shall adopt rules as necessary to implement this section. (Gov. Code, Sec. 533.0072.)

Sec. 540.0211. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS. (a) The commission shall establish outcome-based performance measures and incentives to include in each contract between the commission and a health maintenance organization to provide health care services to recipients that is procured and managed under a value-based purchasing model. The performance measures and incentives must:

(1) be designed to facilitate and increase recipient access to appropriate health care services; and

(2) to the extent possible, align with other state and regional quality care improvement initiatives.

(b) Subject to Subsection (c), the commission shall include the performance measures and incentives in each contract described by Subsection (a) in addition to all other contract provisions required by this chapter and Chapter 540A.

(c) The commission may use a graduated approach to including the performance measures and incentives in contracts described by

Subsection (a) to ensure incremental and continued improvements over time.

(d) Subject to Subsection (e), the commission shall assess the feasibility and cost-effectiveness of including provisions in a contract described by Subsection (a) that require the health maintenance organization to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in recipient care. Pay-for-performance opportunities may include incentives for providers to:

(1) provide care after normal business hours;

(2) participate in the early and periodic screening, diagnosis, and treatment program; and

(3) participate in other activities that improve recipient access to care.

(e) The commission shall, to the extent possible, base an assessment of feasibility and cost-effectiveness under Subsection (d) on publicly available, scientifically valid, evidence-based criteria appropriate for assessing the Medicaid population.

(f) In assessing feasibility and cost-effectiveness under Subsection (d), the commission may consult with participating Medicaid providers, including providers with expertise in quality improvement and performance measurement.

(g) If the commission determines that the provisions described by Subsection (d) are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission

will include the provisions in contracts with health maintenance organizations offering Medicaid managed care plans in the region.

(h) The commission shall post the financial statistical report on the commission's Internet website in a comprehensive and understandable format. (Gov. Code, Sec. 533.0051.)

Sec. 540.0212. MONITORING COMPLIANCE WITH BEHAVIORAL HEALTH INTEGRATION. (a) In this section, "behavioral health services" has the meaning assigned by Section 540.0703.

(b) In monitoring contracts the commission enters into with Medicaid managed care organizations under this chapter, the commission shall:

(1) ensure the organizations fully integrate behavioral health services into a recipient's primary care coordination;

(2) use performance audits and other oversight tools to improve monitoring of the provision and coordination of behavioral health services; and

(3) establish performance measures that may be used to determine the effectiveness of the behavioral health services integration.

(c) In monitoring a Medicaid managed care organization's compliance with behavioral health services integration requirements under this section, the commission shall give particular attention to an organization that provides behavioral health services through a contract with a third party. (Gov. Code, Sec. 533.002551.)

SUBCHAPTER F. REQUIRED CONTRACT PROVISIONS

Sec. 540.0251. APPLICABILITY. This subchapter applies to a contract between a Medicaid managed care organization and the commission to provide health care services to recipients. (Gov. Code, Sec. 533.005(a) (part).)

Sec. 540.0252. ACCOUNTABILITY TO STATE. A contract to which this subchapter applies must contain procedures to ensure accountability to this state for providing health care services, including procedures for:

(1) financial reporting;

(2) quality assurance;

(3) utilization review; and

(4) assurance of contract and subcontract compliance. (Gov. Code, Sec. 533.005(a)(1).)

Sec. 540.0253. CAPITATION RATES. A contract to which this subchapter applies must contain capitation rates that:

(1) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the Medicaid managed care plan; and

(2) ensure the cost-effective provision of quality health care. (Gov. Code, Sec. 533.005(a)(2).)

Sec. 540.0254. COST INFORMATION. A contract to which this subchapter applies must require the contracting Medicaid managed care organization and any entity with which the organization contracts to perform services under a Medicaid managed care plan to disclose at no cost to the commission and, on request, the office of

the attorney general all agreements affecting the net cost of goods or services provided under the plan, including:

(1) discounts;

(2) incentives;

(3) rebates;

(4) fees;

(5) free goods; and

(6) bundling arrangements. (Gov. Code, Sec. 533.005(a)(24).)

Sec. 540.0255. FRAUD CONTROL. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to:

(1) provide the information required by Section 540.0058; and

(2) otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general. (Gov. Code, Sec. 533.005(a)(10).)

Sec. 540.0256. RECIPIENT OUTREACH AND EDUCATION. A contract to which this subchapter applies must:

(1) require the contracting Medicaid managed care organization to provide:

(A) information about the availability of and referral to educational, social, and other community services that could benefit a recipient; and

(B) special programs and materials for recipients with limited English proficiency or low literacy skills; and

(2) contain procedures for recipient outreach and education. (Gov. Code, Secs. 533.005(a)(5), (6), (18).)

Sec. 540.0257. NOTICE OF MEDICAID CERTIFICATION DATE. A contract to which this subchapter applies must require the commission to inform the contracting Medicaid managed care organization, on the date of a recipient's enrollment in a Medicaid managed care plan the organization issues, of the recipient's Medicaid certification date. (Gov. Code, Sec. 533.005(a)(8).)

Sec. 540.0258. PRIMARY CARE PROVIDER ASSIGNMENT. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to make initial and subsequent primary care provider assignments and changes. (Gov. Code, Sec. 533.005(a)(26).)

Sec. 540.0259. COMPLIANCE WITH PROVIDER NETWORK REQUIREMENTS. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to comply with Sections 540.0651(a)(1) and (2) and (b) as a condition of contract retention and renewal. (Gov. Code, Sec. 533.005(a)(9).)

Sec. 540.0260. COMPLIANCE WITH PROVIDER ACCESS STANDARDS; REPORT. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to:

(1) develop and submit to the commission, before the organization begins providing health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards the commission establishes under Section 540.0652;

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

(A) continue to comply with the provider access standards; and

(B) make substantial efforts, as the commission determines, to mitigate or remedy any noncompliance with the provider access standards;

(3) pay liquidated damages for each failure, as the commission determines, to comply with the provider access standards in amounts that are reasonably related to the noncompliance; and

(4) regularly, as the commission determines, submit to the commission and make available to the public a report containing:

(A) data on the organization's provider network sufficiency with regard to providing the care and services described by Section 540.0652(a); and

(B) specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

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

(ii) the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated. (Gov. Code, Sec. 533.005(a)(20).)

Sec. 540.0261. PROVIDER NETWORK SUFFICIENCY. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to demonstrate to the commission, before

the organization begins providing health care services to recipients, that, subject to the provider access standards the commission establishes under Section 540.0652:

(1) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a Medicaid managed care plan the organization offers;

(2) the organization's provider network includes:

(A) a sufficient number of primary care providers;

(B) a sufficient variety of provider types;

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

(D) providers located throughout the region in which the organization will provide health care services; and

(3) 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 model or primary care case management Medicaid managed care model. (Gov. Code, Sec. 533.005(a)(21).)

Sec. 540.0262. QUALITY MONITORING PROGRAM FOR HEALTH CARE SERVICES. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(1) incorporates the National Committee for Quality

Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(2) focuses on measuring outcomes; and

(3) includes collecting and analyzing clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance use disorder. (Gov. Code, Sec. 533.005(a)(22).)

Sec. 540.0263. OUT-OF-NETWORK PROVIDER USAGE AND REIMBURSEMENT. (a) A contract to which this subchapter applies must require that:

(1) the contracting Medicaid managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits the commission determines for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions; and

(2) the 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, if the commission finds that the organization violated Subdivision (1).

(b) In accordance with Subsection (a)(2), a Medicaid managed care organization must reimburse an out-of-network provider of poststabilization services for providing the services at the allowable rate for those services until the organization

arranges for the recipient's timely transfer, as the recipient's attending physician determines, to a provider in the organization's provider network. The organization may not refuse to reimburse an out-of-network provider for emergency or poststabilization services provided as a result of the organization's failure to arrange for and authorize a recipient's timely transfer. (Gov. Code, Secs. 533.005(a)(11), (12), (b).)

Sec. 540.0264. PROVIDER REIMBURSEMENT RATE REDUCTION. (a) A contract to which this subchapter applies must require that the contracting Medicaid managed care organization not implement a significant, nonnegotiated, across-the-board provider reimbursement rate reduction unless:

(1) subject to Subsection (b), the organization has the commission's prior approval to implement the reduction; or

(2) the rate reduction is based on changes to the Medicaid fee schedule or cost containment initiatives the commission implements.

(b) A provider reimbursement rate reduction a Medicaid managed care organization proposes is considered to have received the commission's prior approval unless the commission issues a written statement of disapproval not later than the 45th day after the date the commission receives notice of the proposed rate reduction from the organization. (Gov. Code, Secs. 533.005(a)(25), (a-3).)

Sec. 540.0265. PROMPT PAYMENT OF CLAIMS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to pay a physician or provider for health

care services provided to a recipient under a Medicaid managed care plan on any claim for payment the organization receives with documentation reasonably necessary for the organization to process the claim:

(1) not later than:

(A) the 10th day after the date the organization receives the claim if the claim relates to services a nursing facility, intermediate care facility, or group home provided;

(B) the 30th day after the date the organization receives the claim if the claim relates to the provision of long-term services and supports not subject to Paragraph (A); and

(C) the 45th day after the date the organization receives the claim if the claim is not subject to Paragraph (A) or (B); or

(2) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the organization.

(b) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to demonstrate to the commission that the organization pays claims described by Subsection (a)(1)(B) on average not later than the 21st day after the date the organization receives the claim. (Gov. Code, Secs. 533.005(a)(7), (7-a).)

Sec. 540.0266. REIMBURSEMENT FOR CERTAIN SERVICES PROVIDED OUTSIDE REGULAR BUSINESS HOURS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to 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 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.

(b) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (a). (Gov. Code, Secs. 533.005(a)(14), (c).)

Sec. 540.0267. PROVIDER APPEALS PROCESS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop, implement, and maintain a system for tracking and resolving provider appeals related to claims payment. The system must include a process that requires:

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

(2) 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 that:

(A) relate to denial on the basis of medical necessity; and

(B) remain unresolved after a provider appeal;

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

(4) the organization to allow a provider to initiate an appeal of a claim that has not been paid before the time

prescribed by Section 540.0265(a)(1)(B).

(b) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop and establish a process for responding to provider appeals in the region in which the organization provides health care services. (Gov. Code, Secs. 533.005(a)(15), (19).)

Sec. 540.0268. ASSISTANCE RESOLVING RECIPIENT AND PROVIDER ISSUES. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to provide ready access to a person who assists:

(1) a recipient in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures; and

(2) a provider in resolving issues relating to payment, plan administration, education and training, and grievance procedures. (Gov. Code, Secs. 533.005(a)(3), (4).)

Sec. 540.0269. USE OF ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, to:

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

(2) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians

with regard to:

(A) selection and assignment as primary care providers;

(B) inclusion as primary care providers in the organization's provider network; and

(C) inclusion as primary care providers in any provider network directory the organization maintains.

(b) For purposes of this section, an advanced practice registered nurse may be included as a primary care provider in a Medicaid managed care organization's provider network regardless of whether the physician supervising the advanced practice registered nurse is in the provider network. This subsection may not be construed as authorizing a Medicaid managed care organization to supervise or control the practice of medicine as prohibited by Subtitle B, Title 3, Occupations Code. (Gov. Code, Secs. 533.005(a)(13), (d).)

Sec. 540.0270. MEDICAL DIRECTOR AVAILABILITY. A contract to which this subchapter applies must require that a medical director who is authorized to make medical necessity determinations be available to the region in which the contracting Medicaid managed care organization provides health care services. (Gov. Code, Sec. 533.005(a)(16).)

Sec. 540.0271. PERSONNEL REQUIRED IN CERTAIN SERVICE REGIONS. A contract to which this subchapter applies must require a contracting Medicaid managed care organization that provides a Medicaid managed care plan in the South Texas service region to ensure the following personnel are located in that region:

(1) a medical director;

(2) patient care coordinators; and

(3) provider and recipient support services personnel. (Gov. Code, Sec. 533.005(a)(17).)

Sec. 540.0272. CERTAIN SERVICES PERMITTED IN LIEU OF OTHER MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES; ANNUAL REPORT. A contract to which this subchapter applies must contain language permitting the contracting Medicaid managed care organization to offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee and included in the contract in lieu of mental health or substance use disorder services specified in the state Medicaid plan. A recipient is not required to use a service from the list included in the contract in lieu of another mental health or substance use disorder service specified in the state Medicaid plan. The commission shall:

(1) prepare and submit to the legislature an annual report on the number of times during the preceding year a service from the list included in the contract is used; and

(2) consider the actual cost and use of any services from the list included in the contract that are offered by a Medicaid managed care organization when setting the capitation rates for that organization under the contract. (Gov. Code, Sec. 533.005(h).)

Sec. 540.0273. OUTPATIENT PHARMACY BENEFIT PLAN. (a) Subject to Subsection (b), a contract to which this subchapter applies must require the contracting Medicaid managed care

organization to develop, implement, and maintain an outpatient pharmacy benefit plan for the organization's enrolled recipients that:

(1) except as provided by Section 540.0280(2), exclusively employs the vendor drug program formulary and preserves this state's ability to reduce Medicaid fraud, waste, and abuse;

(2) adheres to the applicable preferred drug list the commission adopts under Subchapter E, Chapter 549;

(3) except as provided by Section 540.0280(1), includes the prior authorization procedures and requirements prescribed by or implemented under Sections 549.0257(a) and (c) and 549.0259 for the vendor drug program;

(4) does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, as defined by Section 549.0252, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse; and

(5) does not require prior authorization for a nonpreferred antipsychotic drug prescribed to an adult recipient if the requirements of Section 549.0253(a) are met.

(b) The requirements imposed by Subsections (a)(1)-(3) do not apply, and may not be enforced, on and after August 31, 2023. (Gov. Code, Secs. 533.005(a)(23)(A), (B), (C), (C-1), (C-2), (a-1).)

Sec. 540.0274. PHARMACY BENEFIT PLAN: REBATES AND RECEIPT OF CONFIDENTIAL INFORMATION PROHIBITED. A Medicaid managed care organization, for purposes of the organization's outpatient

pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, may not:

(1) negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; or

(2) receive drug rebate or pricing information that is confidential under Subchapter D, Chapter 549. (Gov. Code, Sec. 533.005(a)(23)(D).)

Sec. 540.0275. PHARMACY BENEFIT PLAN: CERTAIN PHARMACY BENEFITS FOR SEX OFFENDERS PROHIBITED. A Medicaid managed care organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies must comply with the prohibition under Section 549.0004. (Gov. Code, Sec. 533.005(a)(23)(E).)

Sec. 540.0276. PHARMACY BENEFIT PLAN: RECIPIENT SELECTION OF PHARMACEUTICAL SERVICES PROVIDER. A Medicaid managed care organization, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice to provide pharmaceutical services under the plan by imposing different copayments. (Gov. Code, Sec. 533.005(a)(23)(F).)

Sec. 540.0277. PHARMACY BENEFIT PLAN: PHARMACY BENEFIT PROVIDERS. (a) A Medicaid managed care organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies must allow the organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy

services, except that:

(1) the 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 administering the pharmacy benefit program; and

(2) the organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs that:

(A) are consistent with rules the executive commissioner adopts; and

(B) include notice to network pharmacy providers from the organization.

(b) A Medicaid managed care organization, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies:

(1) may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms, as well as other reasonable administrative and professional terms, of the contract;

(2) may include mail-order pharmacies in the organization's networks, but may not require enrolled recipients to use those pharmacies; and

(3) may not charge an enrolled recipient who opts to use a mail-order pharmacy a fee, including a postage or handling fee. (Gov. Code, Secs. 533.005(a)(23)(G), (H), (I).)

Sec. 540.0278. PHARMACY BENEFIT PLAN: PROMPT PAYMENT OF PHARMACY BENEFIT CLAIMS. A Medicaid managed care organization or

pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must pay claims in accordance with Section 843.339, Insurance Code. (Gov. Code, Sec. 533.005(a)(23)(J).)

Sec. 540.0279. PHARMACY BENEFIT PLAN: MAXIMUM ALLOWABLE COST PRICE AND LIST FOR PHARMACY BENEFITS. (a) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must:

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

(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 this state from national or regional wholesalers and is not obsolete;

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

(3) in formulating a drug's maximum allowable cost price, 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;

(4) 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; and

(5) 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.

(b) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must:

(1) provide a procedure for a network pharmacy provider to challenge a drug's listed maximum allowable cost price;

(2) respond to a challenge not later than the 15th day after the date the provider makes the challenge;

(3) if the challenge is successful, adjust the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as the Medicaid managed care organization or pharmacy benefit manager, as appropriate, determines;

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

(5) 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.

(c) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must provide:

(1) to a network pharmacy provider, at the time the organization or pharmacy benefit manager enters into or renews a contract with the provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider; and

(2) a process for each network pharmacy provider to readily access the maximum allowable cost list specific to that provider.

(d) Except as provided by Subsection (c)(2), a maximum allowable cost list specific to a provider that a Medicaid managed care organization or pharmacy benefit manager maintains is confidential. (Gov. Code, Secs. 533.005(a)(23)(K), (a-2).)

Sec. 540.0280. PHARMACY BENEFIT PLAN: PHARMACY BENEFITS FOR CHILD ENROLLED IN STAR KIDS MANAGED CARE PROGRAM. A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies:

(1) may not require a prior authorization, other than a clinical prior authorization or a prior authorization the commission imposes to minimize the opportunity for fraud, waste, or abuse, for or impose any other barriers to a drug that is prescribed

to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list the commission adopts under Subchapter E, Chapter 549;

(2) must provide continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the organization's formulary;

(3) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug the child's physician recommends for the child's treatment before the organization will cover the recommended drug; and

(4) must pay liquidated damages to the commission for each failure, as the commission determines, to comply with this section in an amount that is a reasonable forecast of the damages caused by the noncompliance. (Gov. Code, Sec. 533.005(a)(23)(L).)

SUBCHAPTER G. PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCEDURES

Sec. 540.0301. INAPPLICABILITY OF CERTAIN OTHER LAW TO MEDICAID MANAGED CARE UTILIZATION REVIEWS. Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization. (Gov. Code, Sec. 533.00282(a).)

Sec. 540.0302. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. (a) This section applies only to a prior authorization request submitted with respect to a recipient who is hospitalized at the time of the request.

(b) In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that, notwithstanding any other law, the organization review and issue a determination on a prior authorization request to which this section applies according to the following time frames:

(1) within one business day after the organization receives the request, except as provided by Subdivisions (2) and (3);

(2) within 72 hours after the organization receives the request if a provider of acute care inpatient services submits the request and the request is for services or equipment necessary to discharge the recipient from an inpatient facility; or

(3) within one hour after the organization receives the request if the request is related to poststabilization care or a life-threatening condition. (Gov. Code, Sec. 533.002821.)

Sec. 540.0303. PRIOR AUTHORIZATION PROCEDURES FOR NONHOSPITALIZED RECIPIENT. (a) This section applies only to a prior authorization request submitted with respect to a recipient who is not hospitalized at the time of the request.

(b) In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that the

organization review and issue a determination on a prior authorization request to which this section applies according to the following time frames:

(1) within three business days after the organization receives the request; or

(2) within the time frame and following the process the commission establishes if the organization receives a prior authorization request that does not include sufficient or adequate documentation.

(c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request to which this section applies that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(1). (Gov. Code, Secs. 533.00282(b) (part), (c).)

Sec. 540.0304. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by contract, shall develop and implement a process for conducting an annual review of the organization's prior authorization requirements. The annual review process does not apply to a prior authorization requirement prescribed by or implemented under Subchapter F, Chapter 549, for the vendor drug program.

(b) In conducting an annual review, a Medicaid managed care organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that, as appropriate, distinguish between categories of recipients for whom prior authorization requests are submitted, including age categories.

(c) A Medicaid managed care organization may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Subchapter F, Chapter 549, for the vendor drug program, unless the organization reviewed the requirement during the most recent annual review.

(d) The commission shall periodically review each Medicaid managed care organization to ensure the organization's compliance with this section. (Gov. Code, Sec. 533.00283.)

Sec. 540.0305. PHYSICIAN CONSULTATION BEFORE ADVERSE PRIOR AUTHORIZATION DETERMINATION. In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that, before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who:

(1) practices in the same or a similar specialty, but not necessarily the same subspecialty; and

(2) has experience in treating the same category of population as the recipient on whose behalf the physician submitted the request. (Gov. Code, Sec. 533.00282(b) (part).)

Sec. 540.0306. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and timeline for a Medicaid managed care organization to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must include a requirement that the organization implement the process and timeline.

(b) The process and timeline must:

(1) allow a provider to submit any documentation identified as insufficient or inadequate in the notice provided under Section 532.0403;

(2) allow the provider requesting the prior authorization to discuss the request with another provider who:

(A) practices in the same or a similar specialty, but not necessarily the same subspecialty; and

(B) has experience in treating the same category of population as the recipient on whose behalf the provider submitted the request; and

(3) require the Medicaid managed care organization to

amend the determination on the prior authorization request as necessary, considering the additional documentation.

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3) to approve the request.

(d) The process and timeline for reconsidering an adverse determination on a prior authorization request under this section do not affect:

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; or

(2) any rights of a recipient to appeal a determination on a prior authorization request. (Gov. Code, Sec. 533.00284.)

Sec. 540.0307. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The combined amount of time provided for the time frames prescribed by the utilization review and prior authorization procedures described by Sections 540.0301, 540.0303, and 540.0305 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 540.0306 may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care. (Gov. Code, Sec. 533.002841.)

SUBCHAPTER H. PREMIUM PAYMENT RATES

Sec. 540.0351. PREMIUM PAYMENT RATE DETERMINATION. (a) In determining premium payment rates paid to a managed care organization under a managed care plan, the commission shall consider:

(1) the regional variation in health care service costs;

(2) the range and type of health care services that premium payment rates are to cover;

(3) the number of managed care plans in a region;

(4) the current and projected number of recipients in each region, including the current and projected number for each category of recipient;

(5) the managed care plan's ability to meet operating costs under the proposed premium payment rates;

(6) the requirements of the Balanced Budget Act of 1997 (Pub. L. No. 105-33) and implementing regulations that require adequacy of premium payments to Medicaid managed care organizations;

(7) the adequacy of the management fee paid for assisting enrollees of Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) who are voluntarily enrolled in the managed care plan;

(8) the impact of reducing premium payment rates for the category of pregnant recipients; and

(9) the managed care plan's ability under the proposed premium payment rates to pay inpatient and outpatient hospital

provider payment rates that are comparable to the inpatient and outpatient hospital provider payment rates the commission pays under a primary care case management model or a partially capitated model.

(b) The premium payment rates paid to a managed care organization that holds a certificate of authority issued under Chapter 843, Insurance Code, must be established by a competitive bid process but may not exceed the maximum premium payment rates the commission establishes under Section 540.0352(b).

(c) The commission shall pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practices. In pursuing the strategies, the commission shall review and consider strategies employed or under consideration by other states. If necessary, the commission may request a waiver or other authorization from a federal agency to implement strategies the commission identifies under this subsection. (Gov. Code, Secs. 533.013(a), (c), (e).)

Sec. 540.0352. MAXIMUM PREMIUM PAYMENT RATES FOR CERTAIN PROGRAMS. (a) This section applies only to a Medicaid managed care organization that holds a certificate of authority issued under Chapter 843, Insurance Code, and with respect to Medicaid managed care pilot programs, Medicaid behavioral health pilot programs, and Medicaid STAR+PLUS pilot programs implemented in a health care service region after June 1, 1999.

(b) In determining the maximum premium payment rates paid to a Medicaid managed care organization to which this section applies,

the commission shall consider and adjust for the regional variation in costs of services under the traditional fee-for-service component of Medicaid, utilization patterns, and other factors that influence the potential for cost savings. For a service area with a service area factor of .93 or less, or another appropriate service area factor, as the commission determines, the commission may not discount premium payment rates in an amount that is more than the amount necessary to meet federal budget neutrality requirements for projected fee-for-service costs unless:

(1) a historical review of managed care financial results among managed care organizations in the service area the organization serves demonstrates that additional savings are warranted; or

(2) a review of Medicaid fee-for-service delivery in the service area the organization serves has historically shown:

(A) significant recipient overutilization of certain services covered by the premium payment rates in comparison to utilization patterns throughout the rest of this state; or

(B) an above-market cost for services for which there is substantial evidence that Medicaid managed care delivery will reduce the cost of those services. (Gov. Code, Secs. 533.013(b), (d).)

Sec. 540.0353. USE OF ENCOUNTER DATA IN DETERMINING PREMIUM PAYMENT RATES AND OTHER PAYMENT AMOUNTS. (a) In determining premium payment rates and other amounts paid to managed care organizations under a managed care plan, the commission may not base or derive the rates or amounts on or from encounter data, or

incorporate in the determination an analysis of encounter data, unless a certifier of encounter data certifies that:

(1) the encounter data for the most recent state fiscal year is complete, accurate, and reliable; and

(2) there is no statistically significant variability in the encounter data attributable to incompleteness, inaccuracy, or another deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.

(b) In determining whether data is equivalent data for similar populations under Subsection (a)(2), a certifier of encounter data shall, at a minimum, consider:

(1) the regional variation in recipient utilization patterns and health care service costs;

(2) the range and type of health care services premium payment rates are to cover;

(3) the number of managed care plans in the region; and

(4) the current number of recipients in each region, including the number for each recipient category. (Gov. Code, Sec. 533.0131.)

SUBCHAPTER I. ENCOUNTER DATA

Sec. 540.0401. PROVIDER REPORTING OF ENCOUNTER DATA. The commission shall collaborate with Medicaid managed care organizations and health care providers in the organizations' provider networks to develop incentives and mechanisms to encourage providers to report complete and accurate encounter data to the organizations in a timely manner. (Gov. Code, Sec. 533.016.)

Sec. 540.0402. CERTIFIER OF ENCOUNTER DATA QUALIFICATIONS. (a) The state Medicaid director shall appoint a person as the certifier of encounter data.

(b) The certifier of encounter data must have:

(1) demonstrated expertise in estimating premium payment rates paid to a managed care organization under a managed care plan; and

(2) access to actuarial expertise, including expertise in estimating premium payment rates paid to a managed care organization under a managed care plan.

(c) A person may not be appointed as the certifier of encounter data if the person participated with the commission in developing premium payment rates for managed care organizations under managed care plans in this state during the three-year period before the date the certifier is appointed. (Gov. Code, Sec. 533.017.)

Sec. 540.0403. ENCOUNTER DATA CERTIFICATION. (a) The certifier of encounter data shall certify the completeness, accuracy, and reliability of encounter data for each state fiscal year.

(b) The commission shall make available to the certifier of encounter data all records and data the certifier considers appropriate for evaluating whether to certify the encounter data. The commission shall provide to the certifier selected resources and assistance in obtaining, compiling, and interpreting the records and data. (Gov. Code, Sec. 533.018.)

SUBCHAPTER J. MANAGED CARE PLAN REQUIREMENTS

Sec. 540.0451. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A Medicaid managed care plan must be accredited by a nationally recognized accreditation organization. The commission may:

(1) require all Medicaid managed care plans to be accredited by the same organization; or

(2) allow for accreditation by different organizations.

(b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight process. (Gov. Code, Sec. 533.0031.)

Sec. 540.0452. MEDICAL DIRECTOR QUALIFICATIONS. An individual who serves as a medical director for a managed care plan must be a physician licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec. 533.0073.)

SUBCHAPTER K. MEDICAID MANAGED CARE PLAN ENROLLMENT AND DISENROLLMENT

Sec. 540.0501. RECIPIENT ENROLLMENT IN AND DISENROLLMENT FROM MEDICAID MANAGED CARE PLAN. The commission shall:

(1) encourage recipients to choose appropriate Medicaid managed care plans and primary health care providers by:

(A) providing initial information to recipients and providers in a region about the need for recipients to choose plans and providers not later than the 90th day before the date a Medicaid managed care organization plans to begin providing health

care services to recipients in that region through managed care;

(B) providing follow-up information before assignment of plans and providers and after assignment, if necessary, to recipients who delay in choosing plans and providers; and

(C) allowing plans and providers to provide information to recipients or engage in marketing activities under marketing guidelines the commission establishes under Section 540.0055(a) after the commission approves the information or activities;

(2) in assigning plans and providers to recipients who fail to choose plans and providers, consider:

(A) the importance of maintaining existing provider-patient and physician-patient relationships, including relationships with specialists, public health clinics, and community health centers;

(B) to the extent possible, the need to assign family members to the same providers and plans; and

(C) geographic convenience of plans and providers for recipients;

(3) retain responsibility for enrolling recipients in and disenrolling recipients from plans, except that the commission may delegate the responsibility to an independent contractor who receives no form of payment from, and has no financial ties to, any managed care organization;

(4) develop and implement an expedited process for determining eligibility for and enrolling pregnant women and

newborn infants in plans; and

(5) ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in plans, including ensuring that a pregnant woman may obtain an appointment with an obstetrical care provider for an initial maternity evaluation not later than the 30th day after the date the woman applies for Medicaid. (Gov. Code, Sec. 533.0075.)

Sec. 540.0502. AUTOMATIC ENROLLMENT IN MEDICAID MANAGED CARE PLAN. (a) If the commission determines that it is feasible and notwithstanding any other law, the commission may implement an automatic enrollment process under which an applicant determined eligible for Medicaid is automatically enrolled in a Medicaid managed care plan the applicant chooses.

(b) The commission may elect to implement the automatic enrollment process for certain recipient populations. (Gov. Code, Sec. 533.0025(h).)

Sec. 540.0503. ENROLLMENT OF CERTAIN RECIPIENTS IN SAME MEDICAID MANAGED CARE PLAN. The commission shall ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same Medicaid managed care plan. (Gov. Code, Sec. 533.0027.)

Sec. 540.0504. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MEDICAID MANAGED CARE ORGANIZATIONS. The commission shall create an incentive program that automatically enrolls in a Medicaid managed care plan a greater percentage of recipients who did not actively choose a plan, based on:

(1) the quality of care provided through the Medicaid

managed care organization offering the plan;

(2) the organization's ability to efficiently and effectively provide services, considering the acuity of populations the organization primarily serves; and

(3) the organization's performance with respect to exceeding or failing to achieve appropriate outcome and process measures the commission develops, including measures based on potentially preventable events. (Gov. Code, Sec. 533.00511(b).)

Sec. 540.0505. LIMITATIONS ON RECIPIENT DISENROLLMENT FROM MEDICAID MANAGED CARE PLAN. (a) Except as provided by Subsections (b) and (c) and to the extent permitted by federal law, a recipient enrolled in a Medicaid managed care plan may not disenroll from that plan and enroll in another Medicaid managed care plan during the 12-month period after the date the recipient initially enrolls in a plan.

(b) At any time before the 91st day after the date of a recipient's initial enrollment in a Medicaid managed care plan, the recipient may disenroll from that plan for any reason and enroll in another Medicaid managed care plan.

(c) The commission shall allow a recipient who is enrolled in a Medicaid managed care plan to disenroll from that plan and enroll in another Medicaid managed care plan:

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

(2) once for any reason after the periods described by Subsections (a) and (b). (Gov. Code, Sec. 533.0076.)

SUBCHAPTER L. CONTINUITY OF CARE AND COORDINATION OF BENEFITS

Sec. 540.0551. GUIDANCE REGARDING CONTINUATION OF SERVICES UNDER CERTAIN CIRCUMSTANCES. The commission shall provide guidance and additional education to Medicaid managed care organizations regarding federal law requirements to continue providing services during an internal appeal, a Medicaid fair hearing, or any other review. (Gov. Code, Sec. 533.005(g).)

Sec. 540.0552. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS. (a) In this section, "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient who has primary health benefit plan coverage in addition to Medicaid coverage when:

(1) the recipient has exceeded the primary health benefit plan coverage limit; or

(2) the service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations and in consultation with the STAR Kids Managed Care Advisory Committee, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients who have primary health benefit plan coverage in addition to Medicaid coverage. In developing the policy, the commission shall consider requiring a Medicaid managed care organization to allow, notwithstanding Subchapter F, Chapter 549, Section 540.0273, and Section 540.0280 or any other law, a recipient using a prescription

drug for which the recipient's primary health benefit plan issuer previously provided coverage to continue receiving the prescription drug without requiring additional prior authorization.

(c) If the commission determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the Medicaid managed care organization that paid the claim shall:

(1) work with the commission on the recovery process; and

(2) make every attempt to reduce health care provider and recipient abrasion.

(d) The executive commissioner may seek a waiver from the federal government as needed to:

(1) address federal policies related to coordination of benefits and third-party liability; and

(2) maximize federal financial participation for recipients who have primary health benefit plan coverage in addition to Medicaid coverage.

(e) The commission may include in the Medicaid managed care eligibility files an indication of whether a recipient has primary health benefit plan coverage or is enrolled in a group health benefit plan for which the commission provides premium assistance under the health insurance premium payment program. For a recipient with that coverage or for whom that premium assistance is provided, the files may include the following up-to-date, accurate information related to primary health benefit plan coverage to the

extent the information is available to the commission:

(1) the primary health benefit plan issuer's name and address;

(2) the recipient's policy number;

(3) the primary health benefit plan coverage start and end dates; and

(4) the primary health benefit plan coverage benefits, limits, copayment, and coinsurance information.

(f) To the extent allowed by federal law, the commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed, regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider, regardless of whether the recipient has primary health benefit plan

coverage in addition to Medicaid coverage.

(h) If a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the Medicaid managed care plan in which the recipient is enrolled, the organization shall develop a simple, timely, and efficient process to, and shall make a good-faith effort to, negotiate a single-case agreement with the specialty provider. Until the organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rules, including 1 T.A.C. Section 353.4.

(i) A single-case agreement entered into under this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements. (Gov. Code, Sec. 533.038.)

SUBCHAPTER M. PROVIDER NETWORK ADEQUACY

Sec. 540.0601. MONITORING OF PROVIDER NETWORKS. The commission shall establish and implement a process for the direct monitoring of a Medicaid 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. (Gov. Code, Sec. 533.007(l).)

Sec. 540.0602. REPORT ON OUT-OF-NETWORK PROVIDER SERVICES. To ensure appropriate access to an adequate provider network, each Medicaid managed care organization providing health care services to recipients in a health care service region shall submit to the commission, in the format and manner the commission prescribes, a report detailing the number, type, and scope of services out-of-network providers provide to recipients enrolled in a Medicaid managed care plan the organization provides. (Gov. Code, Sec. 533.007(g) (part).)

Sec. 540.0603. REPORT ON COMMISSION INVESTIGATION OF PROVIDER COMPLAINT. Not later than the 60th day after the date a provider files a complaint with the commission regarding reimbursement for or overuse of out-of-network providers by a Medicaid managed care organization, the commission shall provide to the provider a report regarding the conclusions of the commission's investigation. The report must include:

(1) a description of any corrective action required of the organization that was the subject of the complaint; and

(2) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider. (Gov. Code,

Sec. 533.007(i).)

Sec. 540.0604. ADDITIONAL REIMBURSEMENT FOLLOWING PROVIDER COMPLAINT. (a) If, after an investigation, the commission determines that a Medicaid managed care organization owes additional reimbursement to a provider, the organization shall, not later than the 90th day after the date the provider filed the complaint, pay the additional reimbursement or provide to the provider a reimbursement payment plan under which the organization must pay the entire amount of the additional reimbursement not later than the 120th day after the date the provider filed the complaint.

(b) The commission may require a Medicaid managed care organization to pay interest on any amount of the additional reimbursement that is not paid on or before the 90th day after the date the provider to whom the amount is owed filed the complaint. If the commission requires the organization to pay interest, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount beginning on the 90th day after the date the provider to whom the amount is owed filed the complaint and accrues until the date the organization pays the entire reimbursement amount. (Gov. Code, Sec. 533.007(j).)

Sec. 540.0605. CORRECTIVE ACTION PLAN FOR INADEQUATE NETWORK AND PROVIDER REIMBURSEMENT. (a) The commission shall initiate a corrective action plan requiring a Medicaid managed care organization to maintain an adequate provider network, provide reimbursement to support that network, and educate recipients enrolled in Medicaid managed care plans provided by the

organization regarding the proper use of the plan's provider network, if:

(1) as the commission determines, the organization exceeds maximum limits the commission established for out-of-network access to health care services; or

(2) based on the commission's investigation of a provider complaint regarding reimbursement, the commission determines that the organization did not reimburse an out-of-network provider based on a reasonable reimbursement methodology.

(b) The corrective action plan required by Subsection (a) must include at least one of the following elements:

(1) a requirement that reimbursements the Medicaid managed care organization pays to out-of-network providers for a health care service provided to a recipient enrolled in a Medicaid managed care plan provided by the organization equal the allowable rate for the service, as determined under Sections 32.028 and 32.0281, Human Resources Code, for all health care services provided during the period the organization:

(A) is not in compliance with the utilization benchmarks the commission determines; or

(B) is not reimbursing out-of-network providers based on a reasonable methodology, as the commission determines;

(2) an immediate freeze on the enrollment of additional recipients in a Medicaid managed care plan the organization provides that continues until the commission determines that the provider network under the plan can adequately

meet the needs of additional recipients; and

(3) other actions the commission determines are necessary to ensure that recipients enrolled in a Medicaid managed care plan the organization provides have access to appropriate health care services and that providers are properly reimbursed for providing medically necessary health care services to those recipients. (Gov. Code, Secs. 533.007(g) (part), (h).)

Sec. 540.0606. REMEDIES FOR NONCOMPLIANCE WITH CORRECTIVE ACTION PLAN. The commission shall pursue any appropriate remedy authorized in the contract between the Medicaid managed care organization and the commission if the organization fails to comply with a corrective action plan under Section 540.0605(a). (Gov. Code, Sec. 533.007(k).)

SUBCHAPTER N. PROVIDERS

Sec. 540.0651. INCLUSION OF CERTAIN PROVIDERS IN MEDICAID MANAGED CARE ORGANIZATION PROVIDER NETWORK. (a) The commission shall require that each managed care organization that contracts with the commission under any managed care model or arrangement to provide health care services to recipients in a region:

(1) seek participation in the organization's provider network from:

(A) each health care provider in the region who has traditionally provided care to recipients;

(B) each hospital in the region that has been designated as a disproportionate share hospital under Medicaid; and

(C) each specialized pediatric laboratory in the region, including a laboratory located in a children's hospital;

(2) include in the organization's provider network for at least three years:

(A) each health care provider in the region who:

(i) previously provided care to Medicaid and charity care recipients at a significant level as the commission prescribes;

(ii) agrees to accept the organization's prevailing provider contract rate; and

(iii) has the credentials the organization requires, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network;

(B) each accredited primary care residency program in the region; and

(C) each disproportionate share hospital the commission designates as a statewide significant traditional provider; and

(3) subject to Section 32.047, Human Resources Code, and notwithstanding any other law, include in the organization's provider network each optometrist, therapeutic optometrist, and ophthalmologist described by Section 532.0153(b)(1)(A) or (B) who, and an institution of higher education described by Section 532.0153(a)(4) in the region that:

(A) agrees to comply with the organization's terms;

(B) agrees to accept the organization's prevailing provider contract rate;

(C) agrees to abide by the organization's required standards of care; and

(D) is an enrolled Medicaid provider.

(b) A contract between a Medicaid managed care organization and the commission for the organization to provide health care services to recipients in a health care service region that includes a rural area must require the organization to include in the organization's provider network rural hospitals, physicians, home and community support services agencies, and other rural health care providers who:

(1) are sole community providers;

(2) provide care to Medicaid and charity care recipients at a significant level as the commission prescribes;

(3) agree to accept the organization's prevailing provider contract rate; and

(4) have the credentials the organization requires, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network. (Gov. Code, Secs. 533.006, 533.0067.)

Sec. 540.0652. PROVIDER ACCESS STANDARDS; BIENNIAL REPORT. (a) The commission shall establish minimum provider access standards for a Medicaid managed care organization's provider network. The provider access standards must ensure that a Medicaid 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 the commission identifies.

(b) To the extent feasible, the provider access standards must:

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

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

(3) subject to Section 548.0054(a) and consistent with Section 111.007, Occupations Code, consider and include the availability of telehealth services and telemedicine medical services in a Medicaid managed care organization's provider network.

(c) The commission shall biennially submit to the legislature and make available to the public a report that contains:

(1) information and statistics on:

(A) recipient access to providers through Medicaid managed care organizations' provider networks; and

(B) Medicaid managed care organization

compliance with contractual obligations related to provider access standards;

(2) a compilation and analysis of information Medicaid managed care organizations submit to the commission under Section 540.0260(4);

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

(4) a description of, and analysis of the results from, the commission's monitoring process established under Section 540.0601. (Gov. Code, Sec. 533.0061.)

Sec. 540.0653. PENALTIES AND OTHER REMEDIES FOR FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS. If a Medicaid managed care organization fails to comply with one or more provider access standards the commission establishes under Section 540.0652 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 540.0260(3); and

(2) if the organization's noncompliance occurs in a given service delivery area for two consecutive calendar quarters, shall suspend default enrollment to the organization in that

service delivery area for at least one calendar quarter. (Gov. Code, Sec. 533.0062.)

Sec. 540.0654. PROVIDER NETWORK DIRECTORIES. (a) The commission shall ensure that a Medicaid managed care organization:

(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) A Medicaid 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. (Gov. Code, Sec. 533.0063.)

Sec. 540.0655. PROVIDER PROTECTION PLAN. (a) The commission shall develop and implement a provider protection plan designed to:

(1) reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement

implemented under this chapter or Chapter 540A; and

(2) ensure efficient provider enrollment and reimbursement.

(b) To the greatest extent possible, the commission shall incorporate the measures in the provider protection plan into each contract between a managed care organization and the commission to provide health care services to recipients.

(c) The provider protection plan must provide for:

(1) a Medicaid managed care organization's prompt payment to and proper reimbursement of providers;

(2) prompt and accurate claim adjudication through:

(A) educating providers on properly submitting clean claims and on appeals;

(B) accepting uniform forms, including HCFA Forms 1500 and UB-92 and subsequent versions of those forms, through an electronic portal; and

(C) establishing standards for claims payments in accordance with a provider's contract;

(3) adequate and clearly defined provider network standards that:

(A) are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards in effect on January 1, 2013; and

(B) ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for Medicaid managed care organizations for submitting and tracking preauthorization requests for Medicaid services;

(6) establishing an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:

(A) submit electronic claims, prior authorization requests, claims appeals and reconsiderations, clinical data, and other documents that the organization requests for prior authorization and claims processing; and

(B) obtain electronic remittance advice, explanation of benefits statements, and other standardized reports;

(7) measuring Medicaid managed care organization retention rates of significant traditional providers;

(8) creating a work group to review and make recommendations to the commission concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submitting and accepting attachments for claims processing and prior authorization requests through an electronic process under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected:

(A) fiscal impact of implementing the requirement; and

(B) timeline for implementing the requirement;

and

(9) any other provision the commission determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement. (Gov. Code, Sec. 533.0055.)

Sec. 540.0656. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a physician or other health care provider applying for expedited credentialing.

(b) Notwithstanding any other law and subject to Subsection (c), a Medicaid managed care organization shall establish and implement an expedited credentialing process that allows an applicant provider to provide services to recipients on a provisional basis.

(c) The commission shall identify the types of providers for which a Medicaid managed care organization must establish and implement an expedited credentialing process.

(d) To qualify for expedited credentialing 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 with a Medicaid managed care organization;

(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 the Medicaid managed care organization requires as necessary to enable

the organization to begin the credentialing process the organization requires to include a provider in the organization's provider network.

(e) On an applicant provider's submission of the information the Medicaid managed care organization requires 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), a Medicaid managed care organization that determines on completion of the credentialing process that an applicant provider does not meet the organization's credentialing requirements may recover from the provider the difference between payments for in-network benefits and out-of-network benefits.

(g) A Medicaid managed care organization that determines on completion of the credentialing process that an applicant provider does not meet the organization's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing may recover from the provider the entire amount the organization paid the provider. (Gov. Code, Sec. 533.0064.)

Sec. 540.0657. FREQUENCY OF PROVIDER RECREDENTIALING. (a) A Medicaid managed care organization shall formally recredential a physician or other provider with the frequency required by the single, consolidated Medicaid provider enrollment and credentialing process, if that process is created under Section

532.0151.

(b) Notwithstanding any other law, the required frequency of recredentialing may be less frequent than once in any three-year period. (Gov. Code, Sec. 533.0065.)

Sec. 540.0658. PROVIDER INCENTIVES FOR PROMOTING PREVENTIVE SERVICES. To the extent possible, the commission shall work to ensure that a Medicaid managed care organization provides payment incentives to a health care provider in the organization's provider network whose performance in promoting recipient use of preventive services exceeds minimum established standards. (Gov. Code, Sec. 533.0066.)

Sec. 540.0659. REIMBURSEMENT RATE FOR CERTAIN SERVICES PROVIDED BY CERTAIN HEALTH CENTERS AND CLINICS OUTSIDE REGULAR BUSINESS HOURS. (a) This section applies only to a recipient receiving benefits through a Medicaid managed care model or arrangement.

(b) The commission shall ensure that a federally qualified health center, rural health clinic, or municipal health department's public clinic is reimbursed for health care services provided to a recipient outside of regular business hours, including on a weekend or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, regardless of whether the recipient has a referral from the recipient's primary care provider.

(c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (b).

(Gov. Code, Sec. 533.01315.)

SUBCHAPTER O. DELIVERY OF SERVICES: GENERAL PROVISIONS

Sec. 540.0701. ACUTE CARE SERVICE DELIVERY THROUGH MOST COST-EFFECTIVE MODEL; MANAGED CARE SERVICE DELIVERY AREAS. (a) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care as the commission determines. The commission shall require mandatory participation in a Medicaid capitated managed care program for all individuals eligible for Medicaid acute care benefits, but may implement alternative models or arrangements, including a traditional fee-for-service arrangement, if the commission determines the alternative would be more cost-effective or efficient.

(b) In determining whether a model or arrangement described by Subsection (a) is more cost-effective, the executive commissioner must consider:

(1) the scope, duration, and types of health benefits or services to be provided in a certain part of this state or to a certain recipient population;

(2) administrative costs necessary to meet federal and state statutory and regulatory requirements;

(3) the anticipated effect of market competition associated with the configuration of Medicaid service delivery models the commission determines; and

(4) the gain or loss to this state of a tax collected under Chapter 222, Insurance Code.

(c) If the commission determines that it is not more cost-effective to use a Medicaid managed care model to provide certain types of Medicaid acute care in a certain area or to certain recipients as prescribed by this section, the commission shall provide Medicaid acute care through a traditional fee-for-service arrangement.

(d) The commission shall determine the most cost-effective alignment of managed care service delivery areas. The executive commissioner may consider:

(1) the number of lives impacted;

(2) the usual source of health care services for residents in an area; and

(3) other factors that impact health care service delivery in the area. (Gov. Code, Secs. 533.0025(b), (c), (d), (e).)

Sec. 540.0702. TRANSITION OF CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MEDICAID MANAGED CARE PROGRAM. (a) In this section, "children and pregnant women program" means the Medicaid benefits program administered by the Department of State Health Services that provides case management services to children who have a health condition or health risk and pregnant women who have a high-risk condition.

(b) The commission shall transition to a Medicaid managed care model all case management services provided to children and pregnant women program recipients. In transitioning the services, the commission shall ensure a recipient is provided case management services through the Medicaid managed care plan in which the

recipient is enrolled.

(c) In implementing this section, the commission shall ensure that:

(1) there is a seamless transition in case management services for children and pregnant women program recipients; and

(2) case management services provided under the program are not interrupted. (Gov. Code, Sec. 533.002555.)

Sec. 540.0703. BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES. (a) In this section, "behavioral health services" means mental health and substance use disorder services.

(b) To the greatest extent possible, the commission shall integrate the following services into the Medicaid managed care program:

(1) behavioral health services, including targeted case management and psychiatric rehabilitation services; and

(2) physical health services.

(c) A Medicaid managed care organization shall:

(1) develop a network of public and private behavioral health services providers; and

(2) ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.

(d) In implementing this section, the commission shall ensure that:

(1) an appropriate assessment tool is used to authorize services;

(2) providers are well-qualified and able to provide

an appropriate array of services;

(3) appropriate performance and quality outcomes are measured;

(4) two health home pilot programs are established in two health service areas, representing two distinct regions of this state, for individuals who are diagnosed with:

(A) a serious mental illness; and

(B) at least one other chronic health condition;

(5) a health home established under a pilot program under Subdivision (4) complies with the principles for patient-centered medical homes described in Section 540.0712; and

(6) all behavioral health services provided under this section are based on an approach to treatment in which the expected outcome of treatment is recovery.

(e) If the commission determines that it is cost-effective and beneficial to recipients, the commission shall include a peer specialist as a benefit to recipients or as a provider type.

(f) To the extent of any conflict between this section and any other law relating to behavioral health services, this section prevails.

(g) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 533.00255.)

Sec. 540.0704. TARGETED CASE MANAGEMENT AND PSYCHIATRIC REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES. (a) A provider in the provider network of a Medicaid managed care organization that contracts with the commission to provide behavioral health services under Section 540.0703 may contract with

the organization to provide targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(b) Commission rules and guidelines concerning contract and training requirements applicable to the provision of behavioral health services may apply to a provider that contracts with a Medicaid managed care organization under Subsection (a) only to the extent those contract and training requirements are specific to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(c) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization under Subsection (a) may not require the provider to provide a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week. This subsection does not prohibit a Medicaid managed care organization that contracts with the commission to provide behavioral health services under Section 540.0703 from specifically contracting with a provider for the provision of a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week.

(d) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization to provide targeted case management and psychiatric rehabilitative services specific to children and adolescents who are at risk of juvenile justice involvement, expulsion from school, displacement

from the home, hospitalization, residential treatment, or serious injury to self, others, or animals may not require the provider to also provide less intensive psychiatric rehabilitative services specified by commission rules and guidelines as applicable to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families, if that provider has a referral arrangement to provide access to those less intensive psychiatric rehabilitative services.

(e) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization under Subsection (a) may not require the provider to provide services not covered under Medicaid. (Gov. Code, Sec. 533.002552.)

Sec. 540.0705. BEHAVIORAL HEALTH SERVICES PROVIDED THROUGH THIRD PARTY OR SUBSIDIARY. (a) In this section, "behavioral health services" has the meaning assigned by Section 540.0703.

(b) For a Medicaid managed care organization that provides behavioral health services through a contract with a third party or an arrangement with a subsidiary of the organization, the commission shall:

(1) require the effective sharing and integration of care coordination, service authorization, and utilization management data between the organization and the third party or subsidiary;

(2) encourage the colocation of physical health and behavioral health care coordination staff, to the extent feasible;

(3) require warm call transfers between physical

health and behavioral health care coordination staff;

(4) require the organization and the third party or subsidiary to implement joint rounds for physical health and behavioral health services network providers or some other effective means for sharing clinical information; and

(5) ensure that the organization makes available a seamless provider portal for both physical health and behavioral health services network providers, to the extent allowed by federal law. (Gov. Code, Sec. 533.002553.)

Sec. 540.0706. PSYCHOTROPIC MEDICATION MONITORING SYSTEM FOR CERTAIN CHILDREN. (a) In this section, "psychotropic medication" has the meaning assigned by Section 266.001, Family Code.

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic medications for:

(1) children who are in the conservatorship of the Department of Family and Protective Services and enrolled in the STAR Health program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter 162, Family Code.

(c) The commission shall include as a component of the monitoring system a medical review of a prescription to which Subsection (b) applies when that review is appropriate. (Gov. Code, Sec. 533.0161.)

Sec. 540.0707. MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events. (Gov. Code, Sec. 533.00515.)

Sec. 540.0708. SPECIAL DISEASE MANAGEMENT. (a) The commission shall ensure that a Medicaid managed care organization develops and implements special disease management programs to manage a disease or other chronic health condition with respect to which disease management would be cost-effective for populations the commission identifies. The special disease management programs may manage a disease or other chronic health condition such as:

(1) heart disease;

(2) chronic kidney disease and related medical complications;

(3) respiratory illness, including asthma;

(4) diabetes;

(5) end-stage renal disease;

(6) HIV infection; or

(7) AIDS.

(b) A Medicaid managed care plan must provide, in the manner the commission requires, disease management services including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation

criteria; and

(5) physician-directed or physician-supervised care.

(c) The executive commissioner by rule shall prescribe the minimum requirements that a Medicaid managed care organization must meet in providing a special disease management program to be eligible to receive a contract under this section. The organization must at a minimum be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease management services under Section 32.057, Human Resources Code;

(2) show evidence of ability to manage complex diseases in the Medicaid population; and

(3) if a special disease management program the organization provides has low active participation rates, identify the reason for the low rates and develop an approach to increase active participation in special disease management programs for high-risk recipients.

(d) If a Medicaid managed care organization implements a special disease management program to manage chronic kidney disease and related medical complications as provided by Subsection (a) and the organization develops a program to provide screening for and diagnosis and treatment of chronic kidney disease and related medical complications to recipients under the organization's Medicaid managed care plan, the program for screening, diagnosis, and treatment must use generally recognized clinical practice

guidelines and laboratory assessments that identify chronic kidney disease on the basis of impaired kidney function or the presence of kidney damage. (Gov. Code, Sec. 533.009.)

Sec. 540.0709. SPECIAL PROTOCOLS FOR INDIGENT POPULATIONS. In conjunction with an academic center, the commission may study the treatment of indigent populations to develop special protocols for use by Medicaid managed care organizations in providing health care services to recipients. (Gov. Code, Sec. 533.010.)

Sec. 540.0710. DIRECT ACCESS TO EYE HEALTH CARE SERVICES. (a) Notwithstanding any other law, the commission shall ensure that a Medicaid managed care plan offered by a Medicaid managed care organization and any other Medicaid managed care model or arrangement implemented under this chapter allow a recipient receiving services through the plan or other model or arrangement to, in the manner and to the extent required by Section 32.072, Human Resources Code:

(1) select an in-network ophthalmologist or therapeutic optometrist in the managed care network to provide eye health care services other than surgery; and

(2) have direct access to the selected in-network ophthalmologist or therapeutic optometrist for the nonsurgical services.

(b) This section does not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms of the Medicaid managed care plan. (Gov. Code, Sec. 533.0026.)

Sec. 540.0711. DELIVERY OF BENEFITS USING

TELECOMMUNICATIONS OR INFORMATION TECHNOLOGY. (a) The commission shall establish policies and procedures to improve access to care under the Medicaid managed care program by encouraging the use under the program of:

(1) telehealth services;

(2) telemedicine medical services;

(3) home telemonitoring services; and

(4) other telecommunications or information technology.

(b) To the extent allowed by federal law, the executive commissioner by rule shall establish policies and procedures that allow a Medicaid managed care organization to conduct assessments and provide care coordination services using telecommunications or information technology. In establishing the policies and procedures, the executive commissioner shall consider:

(1) the extent to which a Medicaid managed care organization determines using the telecommunications or information technology is appropriate;

(2) whether the recipient requests that the assessment or service be provided using telecommunications or information technology;

(3) whether the recipient consents to receiving the assessment or service using telecommunications or information technology;

(4) whether conducting the assessment, including an assessment for an initial waiver eligibility determination, or providing the service in person is not feasible because of the

existence of an emergency or state of disaster, including a public health emergency or natural disaster; and

(5) whether the commission determines using the telecommunications or information technology is appropriate under the circumstances.

(c) If a Medicaid managed care organization conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the organization shall:

(1) monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse; and

(2) determine whether additional social services or supports are needed.

(d) To the extent allowed by federal law, the commission shall allow a recipient who is assessed or provided with care coordination services by a Medicaid managed care organization using telecommunications or information technology to provide consent or other authorizations to receive services verbally instead of in writing.

(e) The commission shall determine categories of recipients of home and community-based services who must receive in-person visits. Except during circumstances described by Subsection (b)(4), a Medicaid managed care organization shall, for a recipient of home and community-based services for which the commission requires in-person visits, conduct:

(1) at least one in-person visit with the recipient to make an initial waiver eligibility determination; and

(2) additional in-person visits with the recipient if necessary, as determined by the organization.

(f) Notwithstanding this section, the commission may, on a case-by-case basis, require a Medicaid managed care organization to discontinue the use of telecommunications or information technology for assessment or care coordination services if the commission determines that the discontinuation is in the recipient's best interest. (Gov. Code, Sec. 533.039.)

Sec. 540.0712. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOME. (a) In this section, "patient-centered medical home" means a medical relationship:

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

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

(B) facilitates partnerships between the physician, the patient, any acute care and other care providers, and, when appropriate, the patient's family; and

(2) that encompasses the following primary principles:

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

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

(C) the physician is responsible for providing

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

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

(E) quality and safe care is provided.

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

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

(2) provide payment incentives for providers that meet the requirements of a patient-centered medical home. (Gov. Code, Sec. 533.0029.)

Sec. 540.0713. VALUE-ADDED SERVICES. The commission shall actively encourage Medicaid managed care organizations to offer benefits, including health care services or benefits or other types of services, that:

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

(2) have the potential to improve the health status of recipients enrolled in the plan. (Gov. Code, Sec. 533.019.)

SUBCHAPTER P. DELIVERY OF SERVICES: STAR+PLUS MEDICAID MANAGED CARE PROGRAM

Sec. 540.0751. DELIVERY OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS. Subject to Sections 540.0701 and 540.0753, the commission shall expand the STAR+PLUS Medicaid managed care program to all areas of this state to serve individuals eligible for Medicaid acute care services and long-term services and supports. (Gov. Code, Sec. 533.00251(b).)

Sec. 540.0752. DELIVERY OF MEDICAID BENEFITS TO NURSING FACILITY RESIDENTS. (a) In this section:

(1) "Clean claim" means a claim that meets the same criteria the commission uses for a clean claim in reimbursing nursing facility claims.

(2) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to recipients.

(b) Subject to Section 540.0701 and notwithstanding any other law, the commission shall provide Medicaid benefits through the STAR+PLUS Medicaid managed care program to recipients who reside in nursing facilities. In implementing this subsection, the commission shall ensure that:

(1) a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;

(2) services are used appropriately, consistent with criteria the commission establishes;

(3) the incidence of potentially preventable events

and unnecessary institutionalizations is reduced;

(4) a Medicaid managed care organization providing services under the program:

(A) provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(B) assists in collecting applied income from recipients; and

(C) provides payment incentives to nursing facility providers that:

(i) reward reductions in preventable acute care costs; and

(ii) encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(5) a portal is established that complies with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the program may submit claims to any participating Medicaid managed care organization;

(6) rules and procedures relating to certifying and decertifying nursing facility beds under Medicaid are not affected;

(7) a Medicaid managed care organization providing services under the program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(8) the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the program.

(c) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A Medicaid managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards the commission establishes under this section.

(d) In addition to the minimum performance standards the commission establishes for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program, the executive commissioner shall adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards and requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

(e) A managed care organization may not require prior

authorization for a nursing facility resident in need of emergency hospital services. (Gov. Code, Secs. 533.00251(a)(2), (3), (c) as eff. Sept. 1, 2023, (e), (f), (h).)

Sec. 540.0753. DELIVERY OF BASIC ATTENDANT AND HABILITATION SERVICES. Subject to Section 542.0152, the commission shall:

(1) implement the option for the delivery of basic attendant and habilitation services to individuals with disabilities under the STAR+PLUS Medicaid managed care program that:

(A) is the most cost-effective; and

(B) maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR+PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss a personal attendant providing basic attendant and habilitation services under the program. (Gov. Code, Sec. 533.0025(i).)

Sec. 540.0754. EVALUATION OF CERTAIN PROGRAM SERVICES. The external quality review organization shall periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to recipients who are:

(1) enrolled in the STAR+PLUS Medicaid managed care program; and

(2) eligible to receive health care benefits under both Medicaid and the Medicare program. (Gov. Code, Sec. 533.0028.)

Sec. 540.0755. UTILIZATION REVIEW; ANNUAL REPORT. (a) The

commission's office of contract management shall establish an annual utilization review process for Medicaid managed care organizations participating in the STAR+PLUS Medicaid managed care program. The commission shall determine the topics to be examined in the review process. The review process must include a thorough investigation of each Medicaid managed care organization's procedures for determining whether a recipient should be enrolled in the STAR+PLUS home and community-based services (HCBS) waiver program, including the conduct of functional assessments for that purpose and records relating to those assessments.

(b) The office of contract management shall use the utilization review process to review each fiscal year:

(1) every Medicaid managed care organization participating in the STAR+PLUS Medicaid managed care program; or

(2) only the Medicaid managed care organizations that, using a risk-based assessment process, the office determines have a higher likelihood of inappropriate recipient placement in the STAR+PLUS home and community-based services (HCBS) waiver program.

(c) Not later than December 1 of each year and in conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over Medicaid. The report must:

(1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year;

(2) provide analysis of errors committed by each reviewed Medicaid managed care organization; and

(3) extrapolate those findings and make recommendations for improving the STAR+PLUS Medicaid managed care program's efficiency.

(d) If a utilization review conducted under this section results in a determination to recoup money from a Medicaid managed care organization, a service provider who contracts with the organization may not be held liable for providing services in good faith based on the organization's authorization. (Gov. Code, Sec. 533.00281.)

SUBCHAPTER Q. DELIVERY OF SERVICES: STAR HEALTH PROGRAM

Sec. 540.0801. TRAUMA-INFORMED CARE TRAINING. (a) A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require that trauma-informed care training be offered to each contracted physician or provider.

(b) The commission shall encourage each Medicaid managed care organization providing health care services to recipients under the STAR Health program to make training in post-traumatic stress disorder and attention-deficit/hyperactivity disorder available to a contracted physician or provider within a reasonable time after the date the physician or provider begins providing services under the Medicaid managed care plan the organization offers. (Gov. Code, Sec. 533.0052.)

Sec. 540.0802. MENTAL HEALTH PROVIDERS. A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require the organization to ensure that the organization maintains a network of mental and

behavioral health providers, including child psychiatrists and other appropriate providers, in all Department of Family and Protective Services regions in this state, regardless of whether community-based care has been implemented in any region. (Gov. Code, Sec. 533.00522.)

Sec. 540.0803. HEALTH SCREENING REQUIREMENTS AND COMPLIANCE WITH TEXAS HEALTH STEPS. (a) A Medicaid managed care organization providing health care services to a recipient under the STAR Health program must ensure that the recipient receives a complete early and periodic screening, diagnosis, and treatment checkup in accordance with the requirements specified in the managed care contract between the organization and the commission.

(b) The commission shall encourage each Medicaid managed care organization providing health care services to a recipient under the STAR Health program to ensure that the organization's network providers comply with the regimen of care prescribed by the Texas Health Steps program under Section 32.056, Human Resources Code, if applicable, including the requirement to provide a mental health screening during each of the recipient's Texas Health Steps medical exams a network provider conducts.

(c) The commission shall include a provision in a STAR Health program managed care contract between a Medicaid managed care organization and the commission specifying progressive monetary penalties for the organization's failure to comply with Subsection (a). (Gov. Code, Secs. 533.0053, 533.0054.)

Sec. 540.0804. HEALTH CARE AND OTHER SERVICES FOR CHILDREN IN SUBSTITUTE CARE. (a) The commission shall annually evaluate the

use of benefits offered to children in foster care under the STAR Health program and provide recommendations to the Department of Family and Protective Services and each single source continuum contractor in this state to better coordinate the provision of health care and use of those benefits for those children.

(b) In conducting the evaluation, the commission shall:

(1) collaborate with residential child-care providers regarding any unmet needs of children in foster care and the development of capacity for providing quality medical, behavioral health, and other services for those children; and

(2) identify options to obtain federal matching funds under Medicaid to pay for a safe home-like or community-based residential setting for a child in the conservatorship of the Department of Family and Protective Services:

(A) who is identified or diagnosed as having a serious behavioral or mental health condition that requires intensive treatment;

(B) who is identified as a victim of serious abuse or serious neglect;

(C) for whom a traditional substitute care placement contracted for or purchased by the department is not available or would further denigrate the child's behavioral or mental health condition; or

(D) for whom the department determines a safe home-like or community-based residential placement could stabilize the child's behavioral or mental health condition in order to return the child to a traditional substitute care placement.

(c) The commission shall report the commission's findings to the standing committees of the senate and house of representatives having jurisdiction over the Department of Family and Protective Services. (Gov. Code, Sec. 533.00521.)

Sec. 540.0805. PLACEMENT CHANGE NOTICE AND CARE COORDINATION. A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require the organization to ensure continuity of care for a child whose placement has changed by:

(1) notifying each specialist treating the child of the placement change; and

(2) coordinating the transition of care from the child's previous treating primary care physician and specialists to the child's new treating primary care physician and specialists, if any. (Gov. Code, Sec. 533.0056.)

Sec. 540.0806. MEDICAID BENEFITS FOR CERTAIN CHILDREN FORMERLY IN FOSTER CARE. (a) This section applies only with respect to a child who:

(1) resides in this state; and

(2) is eligible for assistance or services under:

(A) Subchapter D, Chapter 162, Family Code; or

(B) Subchapter K, Chapter 264, Family Code.

(b) Except as provided by Subsection (c), the commission shall ensure that each child to whom this section applies remains or is enrolled in the STAR Health program until the child is enrolled in another Medicaid managed care program.

(c) A child to whom this section applies who received

Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) or was receiving Supplemental Security Income before becoming eligible for assistance or services under Subchapter D, Chapter 162, Family Code, or Subchapter K, Chapter 264, Family Code, may receive Medicaid benefits in accordance with the program established under this subsection. To the extent allowed by federal law, the commission, in consultation with the Department of Family and Protective Services, shall develop and implement a program that allows the adoptive parent or permanent managing conservator of a child described by this subsection to elect on behalf of the child to receive or continue receiving Medicaid benefits under the:

(1) STAR Health program; or

(2) STAR Kids managed care program.

(d) The commission shall protect the continuity of care for each child to whom this section applies and ensure coordination between the STAR Health program and any other Medicaid managed care program for each child who is transitioning between Medicaid managed care programs.

(e) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 533.00531.)

SUBCHAPTER R. DELIVERY OF SERVICES: STAR KIDS MANAGED CARE PROGRAM

Sec. 540.0851. STAR KIDS MANAGED CARE PROGRAM. (a) In this section, "health home" means a primary care provider practice or specialty care provider practice that incorporates several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and

provider satisfaction under Medicaid.

(b) Subject to Sections 540.0701 and 540.0753, the commission shall establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. The program must:

(1) provide Medicaid benefits customized to meet the health care needs of program recipients through a defined system of care;

(2) better coordinate recipient care under the program;

(3) improve recipient:

(A) access to health care services; and

(B) health outcomes;

(4) achieve cost containment and cost efficiency;

(5) reduce:

(A) the administrative complexity of delivering Medicaid benefits; and

(B) the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(6) require a health home; and

(7) for recipients who receive long-term services and supports outside of the Medicaid managed care organization, coordinate and collaborate with long-term care service providers and long-term care management providers. (Gov. Code, Secs. 533.00253(a)(2), (b).)

Sec. 540.0852. CARE MANAGEMENT AND CARE NEEDS ASSESSMENT. (a) The commission may require that care management services made available as provided by Section 540.0851(b)(5)(B):

(1) incorporate best practices as the commission determines;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification methodology that identifies recipients who have the greatest need for services;

(4) include a care needs assessment for a recipient;

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transitioning care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics the commission determines appropriate; and

(8) use innovations in providing services.

(b) To improve the care needs assessment tool used for a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission, in consultation and collaboration with

the STAR Kids Managed Care Advisory Committee, shall consider changes that will:

(1) reduce the amount of time needed to complete the initial care needs assessment and a reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity. (Gov. Code, Secs. 533.00253(a)(1), (c), (c-1), (c-2).)

Sec. 540.0853. BENEFITS FOR CHILDREN IN MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM. The commission shall:

(1) provide Medicaid benefits through the STAR Kids managed care program to children receiving benefits under the medically dependent children (MDCP) waiver program; and

(2) ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this section. (Gov. Code, Sec. 533.00253(d).)

Sec. 540.0854. BENEFITS TRANSITION FROM STAR KIDS TO STAR+PLUS MEDICAID MANAGED CARE PROGRAM. The commission shall ensure that there is a plan for transitioning the provision of Medicaid benefits to recipients 21 years of age or older from the

STAR Kids managed care program to the STAR+PLUS Medicaid managed care program in a manner that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age. (Gov. Code, Sec. 533.00253(e).)

Sec. 540.0855. UTILIZATION REVIEW OF PRIOR AUTHORIZATIONS. At least once every two years, the commission shall conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care. (Gov. Code, Sec. 533.00253(n).)

CHAPTER 540A. MEDICAID MANAGED TRANSPORTATION SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 540A.0001. DEFINITIONS

SUBCHAPTER B. MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION DELIVERY MODEL

Sec. 540A.0051. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION ORGANIZATION

Sec. 540A.0052. MINIMUM QUALITY AND EFFICIENCY MEASURES

Sec. 540A.0053. MANAGED TRANSPORTATION ORGANIZATION: CONTRACT WITH MEDICAL TRANSPORTATION PROVIDER

Sec. 540A.0054. MANAGED TRANSPORTATION ORGANIZATION: SUBCONTRACT WITH TRANSPORTATION NETWORK COMPANY

CHAPTER 540A. MEDICAID MANAGED TRANSPORTATION SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 540A.0001. DEFINITIONS. In this chapter:

(1) Notwithstanding Section 521.0001(2), "commission" means the Health and Human Services Commission or an agency operating part of the Medicaid managed care program, as appropriate.

(2) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(3) "Managed transportation organization" means:

(A) a rural or urban transit district created under Chapter 458, Transportation Code;

(B) a public transportation provider as defined by Section 461.002, Transportation Code;

(C) a regional contracted broker as defined by Section 526.0351;

(D) a local private transportation provider the commission approves to provide Medicaid nonemergency medical transportation services; or

(E) any other entity the commission determines meets the requirements of Subchapter B.

(4) "Medical transportation program" has the meaning assigned by Section 526.0351.

(5) "Nonemergency transportation service" has the meaning assigned by Section 526.0351.

(6) "Nonmedical transportation service" means:

(A) curb-to-curb transportation to or from a medically necessary, nonemergency covered health care service in a standard passenger vehicle that is scheduled not more than 48 hours before the transportation occurs, that is provided to a recipient enrolled in a Medicaid managed care plan offered by a Medicaid managed care organization, and that the organization determines meets the level of care that is medically appropriate for the recipient, including transportation related to:

(i) discharging a recipient from a health care facility;

(ii) receiving urgent care; and

(iii) obtaining pharmacy services and prescription drugs; and

(B) any other transportation to or from a medically necessary, nonemergency covered health care service the commission considers appropriate to be provided by a transportation vendor, as determined by commission rule or policy.

(7) "Recipient" means a Medicaid recipient.

(8) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

(9) "Transportation vendor" means an entity, including a transportation network company, that contracts with a Medicaid managed care organization to provide nonmedical transportation services. (Gov. Code, Secs. 533.001(1), (5), (6),

533.00257(a)(1), (2), (2-a), 533.002571(a), 533.00258(a), 533.002581(a); New.)

SUBCHAPTER B. MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION DELIVERY MODEL

Sec. 540A.0051. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION ORGANIZATION. (a) The commission may provide medical transportation program services on a regional basis through a managed transportation delivery model using managed transportation organizations and providers, as appropriate, that:

(1) operate under a capitated rate system;

(2) assume financial responsibility under a full-risk model;

(3) operate a call center;

(4) use fixed routes when available and appropriate; and

(5) agree to provide data to the commission if the commission determines that the data is required to receive federal matching funds.

(b) The commission shall procure managed transportation organizations under the medical transportation program through a competitive bidding process for each managed transportation region as determined by the commission.

(c) The commission may not delay providing medical transportation program services through a managed transportation delivery model in:

(1) a county with a population of 750,000 or more:

(A) in which all or part of a municipality with a population of one million or more is located; and

(B) that is located adjacent to a county with a population of two million or more; or

(2) a county with a population of at least 55,000 but not more than 65,000 that is located adjacent to a county with a population of at least 500,000 but not more than 1.5 million. (Gov. Code, Secs. 533.00257(b), (c), (j).)

Sec. 540A.0052. MINIMUM QUALITY AND EFFICIENCY MEASURES. Except as provided by Sections 540A.0054, 540A.0057, and 540A.0058, the commission shall require that managed transportation organizations and providers participating in the medical transportation program meet minimum quality and efficiency measures the commission determines. (Gov. Code, Sec. 533.00257(g).)

Sec. 540A.0053. MANAGED TRANSPORTATION ORGANIZATION: CONTRACT WITH MEDICAL TRANSPORTATION PROVIDER. Except as provided by Sections 540A.0054, 540A.0057, and 540A.0058, a managed transportation organization that participates in the medical transportation program must attempt to contract with medical transportation providers that:

(1) are significant traditional providers, as the executive commissioner defines by rule;

(2) meet the minimum quality and efficiency measures required under Section 540A.0052 and other requirements that the managed transportation organization may impose; and

(3) agree to accept the managed transportation

organization's prevailing contract rate. (Gov. Code, Sec. 533.00257(d).)

Sec. 540A.0054. MANAGED TRANSPORTATION ORGANIZATION: SUBCONTRACT WITH TRANSPORTATION NETWORK COMPANY. A managed transportation organization may subcontract with a transportation network company to provide services under this subchapter. A rule or other requirement the executive commissioner adopts under this subchapter or Subchapter H, Chapter 526, does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. (Gov. Code, Sec. 533.00257(k) (part).)

Sec. 540A.0055. MANAGED TRANSPORTATION ORGANIZATION: VEHICLE FLEETS. (a) To the extent allowed under federal law, a managed transportation organization may own, operate, and maintain a fleet of vehicles or contract with an entity that owns, operates, and maintains a fleet of vehicles. The commission shall seek an appropriate federal waiver or other authorization to implement this subsection as necessary.

(b) The commission shall consider a managed transportation organization's ownership, operation, and maintenance of a fleet of vehicles to be a related-party transaction for purposes of applying experience rebates, administrative costs, and other administrative controls the commission determines. (Gov. Code, Secs. 533.00257(e), (f).)

Sec. 540A.0056. PERIODIC SCREENING OF TRANSPORTATION NETWORK COMPANY OR MOTOR VEHICLE OPERATOR AUTHORIZED. The commission or a managed transportation organization that

subcontracts with a transportation network company under Section 540A.0054 may require the transportation network company or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and entities the Office of Inspector General of the United States Department of Health and Human Services maintains. (Gov. Code, Sec. 533.00257(l).)

Sec. 540A.0057. ENROLLMENT AS MEDICAID PROVIDER BY CERTAIN MOTOR VEHICLE OPERATORS NOT REQUIRED. The commission or a managed transportation organization that subcontracts with a transportation network company under Section 540A.0054 may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this subchapter. (Gov. Code, Sec. 533.00257(k) (part).)

Sec. 540A.0058. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS. Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a managed transportation organization under Section 540A.0054 and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this subchapter. The commission and the managed transportation organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this subchapter. (Gov. Code, Sec. 533.00257(m).)

Sec. 540A.0059. MOTOR VEHICLE OPERATOR: VEHICLE

ACCESSIBILITY. For purposes of this subchapter and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides a service under this subchapter may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting a passenger using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code. (Gov. Code, Sec. 533.00257(n).)

SUBCHAPTER C. NONEMERGENCY TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION

Sec. 540A.0101. DELIVERY OF NONEMERGENCY TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION. (a) The commission shall require each Medicaid managed care organization to arrange and provide nonemergency transportation services to a recipient enrolled in a Medicaid managed care plan offered by the organization using the most cost-effective and cost-efficient method of delivery, including by delivering nonmedical transportation services through a transportation network company or other transportation vendor as provided by Section 540A.0151, if available and medically appropriate. The commission shall supervise the provision of the services.

(b) The commission may temporarily waive the applicability of Subsection (a) to a Medicaid managed care organization as necessary based on the results of a review conducted under Sections 540.0207 and 540.0209 and until enrollment of recipients in a Medicaid managed care plan offered by the organization is permitted under that section. (Gov. Code, Secs. 533.002571(b), (h).)

Sec. 540A.0102. RULES FOR NONEMERGENCY TRANSPORTATION SERVICES. Subject to Sections 540A.0103 and 540A.0105, the executive commissioner shall adopt rules as necessary to ensure the safe and efficient provision of nonemergency transportation services by a Medicaid managed care organization under this subchapter. (Gov. Code, Sec. 533.002571(c).)

Sec. 540A.0103. MEDICAID MANAGED CARE ORGANIZATION: SUBCONTRACT WITH TRANSPORTATION NETWORK COMPANY. A Medicaid managed care organization may subcontract with a transportation network company to provide nonemergency transportation services under this subchapter. A rule or other requirement the executive commissioner adopts under Section 540A.0102 or Subchapter H, Chapter 526, does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. (Gov. Code, Sec. 533.002571(d) (part).)

Sec. 540A.0104. PERIODIC SCREENING OF TRANSPORTATION NETWORK COMPANY OR MOTOR VEHICLE OPERATOR AUTHORIZED. The commission or a Medicaid managed care organization that subcontracts with a transportation network company under Section 540A.0103 may require the transportation network company or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and entities the Office of Inspector General of the United States Department of Health and Human Services maintains. (Gov. Code, Sec. 533.002571(e).)

Sec. 540A.0105. ENROLLMENT AS MEDICAID PROVIDER BY CERTAIN MOTOR VEHICLE OPERATORS NOT REQUIRED. The commission or a Medicaid

managed care organization that subcontracts with a transportation network company under Section 540A.0103 may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this subchapter. (Gov. Code, Sec. 533.002571(d) (part).)

Sec. 540A.0106. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS. Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a Medicaid managed care organization under Section 540A.0103 and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this subchapter. The commission and the Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this subchapter. (Gov. Code, Sec. 533.002571(f).)

Sec. 540A.0107. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY. For purposes of this subchapter and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides a service under this subchapter may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting a passenger using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code. (Gov. Code, Sec. 533.002571(g).)

SUBCHAPTER D. NONMEDICAL TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION

Sec. 540A.0151. DELIVERY OF NONMEDICAL TRANSPORTATION SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATION. (a) The commission shall require each Medicaid managed care organization to arrange for the provision of nonmedical transportation services to a recipient enrolled in a Medicaid managed care plan offered by the organization.

(b) A Medicaid managed care organization may contract with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services. If a Medicaid managed care organization contracts with a third party that is not a transportation vendor to arrange for the provision of nonmedical transportation services, the third party shall contract with a transportation vendor to deliver the nonmedical transportation services.

(c) A Medicaid managed care organization that contracts with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services shall ensure the effective sharing and integration of service coordination, service authorization, and utilization management data between the managed care organization and the transportation vendor or third party.

(d) The commission may waive the applicability of Subsection (a) to a Medicaid managed care organization for not more than three months as necessary based on the results of a review conducted under Sections 540.0207 and 540.0209 and until enrollment of recipients in a Medicaid managed care plan offered by the

organization is permitted under that section. (Gov. Code, Secs. 533.002581(c), (d), (e), (h).)

Sec. 540A.0152. RULES FOR NONMEDICAL TRANSPORTATION SERVICES. (a) The executive commissioner shall adopt rules regarding the manner in which nonmedical transportation services may be arranged and provided.

(b) The rules must require a Medicaid managed care organization to create a process to:

(1) verify that a passenger is eligible to receive nonmedical transportation services;

(2) ensure that nonmedical transportation services are provided only to and from covered health care services in areas in which a transportation network company operates; and

(3) ensure the timely delivery of nonmedical transportation services to a recipient, including by setting reasonable service response goals.

(c) The rules must require a transportation vendor to, before permitting a motor vehicle operator to provide nonmedical transportation services:

(1) confirm that the operator:

(A) is at least 18 years of age;

(B) maintains a valid driver's license issued by this state, another state, or the District of Columbia; and

(C) possesses proof of registration and automobile financial responsibility for each motor vehicle to be used to provide nonmedical transportation services;

(2) conduct, or cause to be conducted, a local, state,

and national criminal background check for the operator that includes the use of:

(A) a commercial multistate and multijurisdiction criminal records locator or other similar commercial nationwide database; and

(B) the national sex offender public website the United States Department of Justice or a successor agency maintains;

(3) confirm that any vehicle to be used to provide nonmedical transportation services:

(A) meets the applicable requirements of Chapter 548, Transportation Code; and

(B) except as provided by Section 540A.0156, has at least four doors; and

(4) obtain and review the operator's driving record.

(d) The rules may not permit a motor vehicle operator to provide nonmedical transportation services if the operator:

(1) has been convicted in the three-year period preceding the issue date of the driving record obtained under Subsection (c)(4) of:

(A) more than three offenses the Department of Public Safety classifies as moving violations; or

(B) one or more of the following offenses:

(i) fleeing or attempting to elude a police officer under Section 545.421, Transportation Code;

(ii) reckless driving under Section 545.401, Transportation Code;

(iii) driving without a valid driver's license under Section 521.025, Transportation Code; or

(iv) driving with an invalid driver's license under Section 521.457, Transportation Code;

(2) has been convicted in the preceding seven-year period of any of the following:

(A) driving while intoxicated under Section 49.04 or 49.045, Penal Code;

(B) use of a motor vehicle to commit a felony;

(C) a felony crime involving property damage;

(D) fraud;

(E) theft;

(F) an act of violence; or

(G) an act of terrorism; or

(3) is found to be registered in the national sex offender public website the United States Department of Justice or a successor agency maintains. (Gov. Code, Secs. 533.00258(b), (c), (e), (f).)

Sec. 540A.0153. PERIODIC SCREENING OF TRANSPORTATION VENDOR OR MOTOR VEHICLE OPERATOR AUTHORIZED. The commission or a Medicaid managed care organization that contracts with a transportation vendor may require the transportation vendor or a motor vehicle operator who provides services under this subchapter to be periodically screened against the list of excluded individuals and entities the Office of Inspector General of the United States Department of Health and Human Services maintains. (Gov. Code, Sec. 533.00258(h).)

Sec. 540A.0154. ENROLLMENT AS MEDICAID PROVIDER BY, OR CREDENTIALING OF, MOTOR VEHICLE OPERATOR NOT REQUIRED. (a) The commission or a Medicaid managed care organization may not require a motor vehicle operator to enroll as a Medicaid provider to provide nonmedical transportation services.

(b) The commission may not require a Medicaid managed care organization to credential a motor vehicle operator to provide nonmedical transportation services, and the organization may not require the credentialing of a motor vehicle operator to provide those services. (Gov. Code, Secs. 533.00258(g), 533.002581(f).)

Sec. 540A.0155. DRIVER REQUIREMENTS FOR CERTAIN MOTOR VEHICLE OPERATORS. Notwithstanding any other law, a motor vehicle operator who is part of a transportation network company's network and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide nonmedical transportation services. The commission and a Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide nonmedical transportation services. (Gov. Code, Sec. 533.00258(i).)

Sec. 540A.0156. MOTOR VEHICLE OPERATOR: VEHICLE ACCESSIBILITY. For purposes of this subchapter and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides a service under this subchapter may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting a passenger using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the

requirements of Section 2402.111, Occupations Code. (Gov. Code, Secs. 533.00258(j), 533.002581(g).)

CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

SUBCHAPTER A. GENERAL PROVISIONS

SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM REDESIGN

SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING SERVICE DELIVERY MODELS

CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 542.0001. DEFINITIONS. In this chapter:

(1) "Advisory committee" means the intellectual and developmental disability system redesign advisory committee

established under Section 542.0052.

(2) "Basic attendant service" means a service provided to an individual to assist the individual with an activity of daily living, including an instrumental activity of daily living, because of a physical, cognitive, or behavioral limitation related to the individual's disability or chronic health condition.

(3) "Comprehensive long-term services and supports provider" means a provider of long-term services and supports under this chapter that ensures the coordinated, seamless delivery of the full range of services in a recipient's program plan. The term includes:

(A) an ICF-IID program provider; and

(B) a Medicaid waiver program provider.

(4) "Consumer direction model" has the meaning assigned by Section 546.0101.

(5) "Functional need" means the measurement of an individual's services and supports needs, including the individual's intellectual, psychiatric, medical, and physical support needs.

(6) "Habilitation service" includes a service provided to an individual to assist the individual with acquiring, retaining, or improving:

(A) a skill related to the activities of daily living; and

(B) the social and adaptive skills necessary for the individual to live and fully participate in the community.

(7) "ICF-IID" means the Medicaid program serving

individuals with an intellectual or developmental disability who receive care in intermediate care facilities other than a state supported living center.

(8) "ICF-IID program" means a Medicaid program serving individuals with an intellectual or developmental disability who reside in and receive care from:

(A) an intermediate care facility licensed under Chapter 252, Health and Safety Code; or

(B) a community-based intermediate care facility operated by a local intellectual and developmental disability authority.

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

(10) "Managed care organization" has the meaning assigned by Section 543A.0001.

(11) "Medicaid waiver program" means only the following programs that are authorized under Section 1915(c) of the Social Security Act (42 U.S.C. Section 1396n(c)) for the provision of services to individuals with an intellectual or developmental disability:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the home and community-based services (HCS) waiver program;

(C) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(12) "Potentially preventable event" has the meaning assigned by Section 543A.0001.

(13) "Residential service" means a service provided to an individual with an intellectual or developmental disability through a community-based ICF-IID, three- or four-person home or host home setting under the home and community-based services (HCS) waiver program, or a group home under the deaf-blind with multiple disabilities (DBMD) waiver program.

(14) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code. (Gov. Code, Sec. 534.001 (part).)

Sec. 542.0002. CONFLICT WITH OTHER LAW. To the extent of a conflict between a provision of this chapter and another state law, the provision of this chapter controls. (Gov. Code, Sec. 534.002.)

Sec. 542.0003. DELAYED IMPLEMENTATION AUTHORIZED. Notwithstanding any other law, the commission may delay implementing a provision of this chapter without additional investigation, adjustment, or legislative action if the commission determines implementing the provision would adversely affect the system of services and supports to persons and programs to which this chapter applies. (Gov. Code, Sec. 534.251.)

SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM REDESIGN

Sec. 542.0051. REDESIGN OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. The commission shall

design and implement an acute care services and long-term services and supports system for individuals with an intellectual or developmental disability that supports the following goals:

(1) provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to an individual's needs and preferences in the most integrated and least restrictive setting;

(2) improve access to services and supports by ensuring that an individual receives information about all available programs and services, including employment and least restrictive housing assistance, and the manner of applying for the programs and services;

(3) improve the assessment of an individual's needs and available supports, including the assessment of an individual's functional needs;

(4) promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;

(5) promote individualized budgeting based on an assessment of an individual's needs and person-centered planning;

(6) promote integrated service coordination of acute care services and long-term services and supports;

(7) improve acute care and long-term services and supports outcomes, including reducing unnecessary institutionalization and potentially preventable events;

(8) promote high-quality care;

(9) provide fair hearing and appeals processes in

accordance with federal law;

(10) ensure the availability of a local safety net provider and local safety net services;

(11) promote independent service coordination and independent ombudsmen services; and

(12) ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent the inappropriate institutionalization of an individual. (Gov. Code, Sec. 534.051.)

Sec. 542.0052. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The intellectual and developmental disability system redesign advisory committee shall advise the commission on implementing the acute care services and long-term services and supports system redesign under this chapter.

(b) The executive commissioner shall appoint stakeholders from the intellectual and developmental disabilities community to serve as advisory committee members, including:

(1) individuals with an intellectual or developmental disability who receive services under a Medicaid waiver program;

(2) individuals with an intellectual or developmental disability who receive services under an ICF-IID program;

(3) representatives who are advocates for individuals described by Subdivisions (1) and (2), including at least three representatives from intellectual and developmental disability advocacy organizations;

(4) representatives of Medicaid managed care and nonmanaged care health care providers, including:

(A) physicians who are primary care providers;

(B) physicians who are specialty care providers;

(C) nonphysician mental health professionals; and

(D) long-term services and supports providers, including direct service workers;

(5) representatives of entities with responsibilities for delivering Medicaid long-term services and supports or for other Medicaid service delivery, including:

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

(B) representatives of community mental health and intellectual disability centers;

(C) representatives of and service coordinators or case managers from private and public home and community-based services providers that serve individuals with an intellectual or developmental disability; and

(D) representatives of private and public ICF-IID providers; and

(6) representatives of managed care organizations that contract with this state to provide services to individuals with an intellectual or developmental disability.

(c) To the greatest extent possible, the executive commissioner shall appoint members to the advisory committee who reflect the geographic diversity of this state and include members

who represent rural Medicaid recipients.

(d) The executive commissioner shall appoint the presiding officer of the advisory committee.

(e) The advisory committee must meet at least quarterly or more frequently if the presiding officer determines that more frequent meetings are necessary to address planning and development needs related to implementation of the acute care services and long-term services and supports system. The advisory committee may establish work groups that meet at other times to study and make recommendations on issues the advisory committee considers appropriate.

(f) An advisory committee member serves without compensation. An advisory committee member who is a Medicaid recipient or the relative of a Medicaid recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

(g) Chapter 551 applies to the advisory committee.

(h) On the second anniversary of the date the commission completes implementation of the transition required under Section 542.0201:

(1) the advisory committee is abolished; and

(2) this section expires. (Gov. Code, Sec. 534.053.)

Sec. 542.0053. IMPLEMENTATION OF SYSTEM REDESIGN. The commission shall, in collaboration with the advisory committee, implement the acute care services and long-term services and supports system for individuals with an intellectual or developmental disability in the manner and in the stages described

by this chapter. (Gov. Code, Sec. 534.052.)

Sec. 542.0054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in collaboration with the advisory committee, shall prepare and submit to the legislature a report that includes:

(1) an assessment of the implementation of the system required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with an intellectual or developmental disability under Medicaid;

(2) recommendations regarding implementation of and improvements to the system redesign, including recommendations regarding appropriate statutory changes to facilitate the implementation; and

(3) an assessment of the effect of the system on:

(A) access to long-term services and supports;

(B) the quality of acute care services and long-term services and supports;

(C) meaningful outcomes for Medicaid recipients using person-centered planning, individualized budgeting, and self-determination, including an individual's inclusion in the community;

(D) the integration of service coordination of acute care services and long-term services and supports;

(E) the efficiency and use of funding;

(F) the placement of individuals in housing that is the least restrictive setting appropriate to an individual's

needs;

(G) employment assistance and customized, integrated, competitive employment options; and

(H) the number and types of fair hearing and appeals processes in accordance with federal law.

(b) This section expires on the second anniversary of the date the commission completes implementation of the transition required under Section 542.0201. (Gov. Code, Sec. 534.054.)

SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING SERVICE DELIVERY MODELS

Sec. 542.0101. DEFINITIONS. In this subchapter:

(1) "Capitation" means a method of compensating a provider on a monthly basis for providing or coordinating the provision of a defined set of services and supports that is based on a predetermined payment per services recipient.

(2) "Pilot program" means the pilot program established under this subchapter.

(3) "Pilot program participant" means an individual who is enrolled in and receives services through the pilot program.

(4) "Pilot program work group" means the pilot program work group established under Section 542.0104. (Gov. Code, Sec. 534.101; New.)

Sec. 542.0102. PILOT PROGRAM TO TEST PERSON-CENTERED MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall develop and implement a pilot program to test the delivery of long-term services and supports to

pilot program participants through the STAR+PLUS Medicaid managed care program.

(b) A managed care organization participating in the pilot program shall provide Medicaid long-term services and supports to individuals with an intellectual or developmental disability and individuals with similar functional needs to test the organization's managed care strategy based on capitation.

(c) The pilot program must be designed to:

(1) increase access to long-term services and supports;

(2) improve the quality of acute care services and long-term services and supports;

(3) promote:

(A) informed choice and meaningful outcomes by using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination; and

(B) community inclusion and engagement;

(4) promote integrated service coordination of acute care services and long-term services and supports;

(5) promote efficiency and best funding use based on a pilot program participant's needs and preferences;

(6) promote, through housing supports and navigation services, stability in housing that is the most integrated and least restrictive based on a pilot program participant's needs and preferences;

(7) promote employment assistance and customized, integrated, competitive employment;

(8) provide fair hearing and appeals processes in accordance with federal and state law;

(9) promote the use of innovative technologies and benefits, including telemedicine, telemonitoring, the testing of remote monitoring, transportation services, and other innovations that support community integration;

(10) ensure a provider network that is adequate and includes comprehensive long-term services and supports providers and ensure that pilot program participants have a choice among those providers;

(11) ensure the timely initiation and consistent provision of long-term services and supports in accordance with a pilot program participant's person-centered plan;

(12) ensure that pilot program participants with complex behavioral, medical, and physical needs are assessed and receive appropriate services in the most integrated and least restrictive setting based on the participants' needs and preferences;

(13) increase access to, expand flexibility of, and promote the use of the consumer direction model;

(14) promote independence, self-determination, the use of the consumer direction model, and decision making by pilot program participants by using alternatives to guardianship, including a supported decision-making agreement as defined by Section 1357.002, Estates Code; and

(15) promote sufficient flexibility to achieve, through the pilot program, the goals listed in:

(A) this subsection;

(B) Subsection (b); and

(C) Sections 542.0103, 542.0110(a), 542.0113, and 542.0116(c). (Gov. Code, Secs. 534.102, 534.104(a), (h).)

Sec. 542.0103. ALTERNATIVE PAYMENT RATE OR METHODOLOGY. (a) The pilot program must be designed to test the use of innovative payment rates and methodologies for the provision of long-term services and supports to achieve the goals of the pilot program. The payment methodologies must include:

(1) the payment of a bundled amount without downside risk to a comprehensive long-term services and supports provider for some or all services delivered as part of a comprehensive array of long-term services and supports;

(2) enhanced incentive payments to comprehensive long-term services and supports providers based on the completion of predetermined outcomes or quality metrics; and

(3) any other payment model the commission approves.

(b) An alternative payment rate or methodology may be used for a managed care organization and comprehensive long-term services and supports provider only if the organization and provider agree in advance and in writing to use the rate or methodology.

(c) In developing an alternative payment rate or methodology, the commission, managed care organizations, and comprehensive long-term services and supports providers shall consider:

(1) the historical costs of long-term services and

supports, including Medicaid fee-for-service rates;

(2) reasonable cost estimates for new services under the pilot program; and

(3) whether an alternative payment rate or methodology is sufficient to promote quality outcomes and ensure a provider's continued participation in the pilot program.

(d) An alternative payment rate or methodology may not reduce the minimum payment a provider receives for delivering long-term services and supports under the pilot program to an amount that is less than the fee-for-service reimbursement rate the provider received for delivering those services before participating in the pilot program. (Gov. Code, Secs. 534.104(c), (d), (e), (f).)

Sec. 542.0104. PILOT PROGRAM WORK GROUP. (a) The executive commissioner, in consultation with the advisory committee, shall establish a pilot program work group to assist in developing and provide advice on the operation of the pilot program.

(b) The pilot program work group is composed of:

(1) representatives of the advisory committee;

(2) stakeholders representing individuals with an intellectual or developmental disability;

(3) stakeholders representing individuals with similar functional needs as the individuals described by Subdivision (2); and

(4) representatives of managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program.

(c) Chapter 2110 applies to the pilot program work group. (Gov. Code, Sec. 534.1015.)

Sec. 542.0105. STAKEHOLDER INPUT. As part of developing and implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop a process to receive and evaluate:

(1) input from:

(A) statewide stakeholders; and

(B) stakeholders from a STAR+PLUS Medicaid managed care service area in which the pilot program will be implemented; and

(2) other evaluations and data. (Gov. Code, Sec. 534.103.)

Sec. 542.0106. MEASURABLE GOALS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall:

(1) identify, using national core indicators, the National Quality Forum long-term services and supports measures, and other appropriate Consumer Assessment of Healthcare Providers and Systems measures, measurable goals the pilot program is to achieve;

(2) develop specific strategies and performance measures for achieving the identified goals; and

(3) ensure that mechanisms to report, track, and assess specific strategies and performance measures for achieving the identified goals are established before implementing the pilot program.

(b) A strategy proposed under Subsection (a)(2) may be evidence-based if an evidence-based strategy is available for meeting the identified goals. (Gov. Code, Sec. 534.105.)

Sec. 542.0107. MANAGED CARE ORGANIZATION SELECTION. The commission shall:

(1) in collaboration with the advisory committee and pilot program work group, develop criteria regarding the selection of a managed care organization to participate in the pilot program; and

(2) select and contract with not more than two managed care organizations that contract with the commission to provide services under the STAR+PLUS Medicaid managed care program to participate in the pilot program. (Gov. Code, Sec. 534.1035.)

Sec. 542.0108. MANAGED CARE ORGANIZATION PARTICIPATION REQUIREMENTS. The commission shall require that a managed care organization participating in the pilot program:

(1) ensures that pilot program participants have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model;

(2) demonstrates to the commission's satisfaction that the organization's network of acute care, long-term services and supports, and comprehensive long-term services and supports providers have experience and expertise in providing services for individuals with an intellectual or developmental disability and individuals with similar functional needs;

(3) has a process for preventing the inappropriate

institutionalization of pilot program participants; and

(4) ensures the timely initiation and consistent provision of services in accordance with a pilot program participant's person-centered plan. (Gov. Code, Sec. 534.107(a).)

Sec. 542.0109. REQUIRED BENEFITS. (a) The commission shall ensure that a managed care organization participating in the pilot program provides:

(1) all Medicaid state plan acute care benefits available under the STAR+PLUS Medicaid managed care program;

(2) long-term services and supports under the Medicaid state plan, including:

(A) Community First Choice services;

(B) personal assistance services;

(C) day activity health services; and

(D) habilitation services;

(3) long-term services and supports under the STAR+PLUS home and community-based services (HCBS) waiver program, including:

(A) assisted living services;

(B) personal assistance services;

(C) employment assistance;

(D) supported employment;

(E) adult foster care;

(F) dental care;

(G) nursing care;

(H) respite care;

(I) home-delivered meals;

(J) cognitive rehabilitative therapy;

(K) physical therapy;

(L) occupational therapy;

(M) speech-language pathology;

(N) medical supplies;

(O) minor home modifications; and

(P) adaptive aids;

(4) the following long-term services and supports under a Medicaid waiver program:

(A) enhanced behavioral health services;

(B) behavioral supports;

(C) day habilitation; and

(D) community support transportation;

(5) the following additional long-term services and supports:

(A) housing supports;

(B) behavioral health crisis intervention services; and

(C) high medical needs services;

(6) other nonresidential long-term services and supports that the commission, in collaboration with the advisory committee and pilot program work group, determines are appropriate and consistent with requirements governing the Medicaid waiver programs, person-centered approaches, home and community-based setting requirements, and achievement of the most integrated and least restrictive setting based on an individual's needs and preferences; and

(7) dental services benefits in accordance with Subsection (b).

(b) In developing the pilot program, the commission shall:

(1) evaluate dental services benefits provided through Medicaid waiver programs and dental services benefits provided as a value-added service under the Medicaid managed care delivery model;

(2) determine which dental services benefits are the most cost-effective in reducing emergency room and inpatient hospital admissions resulting from poor oral health; and

(3) based on the determination made under Subdivision (2), provide the most cost-effective dental services benefits to pilot program participants.

(c) Before implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall:

(1) for pilot program purposes only, develop recommendations to modify adult foster care and supported employment and employment assistance benefits to increase access to and availability of those services; and

(2) as necessary, define services listed under Subsections (a)(4) and (5) and any other services the commission determines to be appropriate under Subsection (a)(6). (Gov. Code, Secs. 534.1045(a), (a-1), (f).)

Sec. 542.0110. PROVIDER PARTICIPATION. (a) The pilot program must allow a comprehensive long-term services and supports provider for individuals with an intellectual or developmental

disability or similar functional needs that contracts with the commission to provide Medicaid services before the date the pilot program is implemented to voluntarily participate in the pilot program. A provider's choice not to participate in the pilot program does not affect the provider's status as a significant traditional provider.

(b) For the duration of the pilot program, the commission shall ensure that comprehensive long-term services and supports providers are:

(1) considered significant traditional providers; and

(2) included in the provider network of a managed care organization participating in the pilot program.

(c) A comprehensive long-term services and supports provider may deliver services listed under the following provisions only if the provider also delivers the services under a Medicaid waiver program:

(1) Sections 542.0109(a)(2)(A) and (D);

(2) Sections 542.0109(a)(3)(B), (C), (D), (G), (H), (J), (K), (L), and (M); and

(3) Section 542.0109(a)(4).

(d) A comprehensive long-term services and supports provider may deliver services listed under Sections 542.0109(a)(5) and (6) only if the managed care organization in the network of which the provider participates agrees, in a contract with the provider, to the provision of those services.

(e) Day habilitation services listed under Section 542.0109(a)(4)(C) may be delivered by a provider who contracts or

subcontracts with the commission to provide day habilitation services under the home and community-based services (HCS) waiver program or the ICF-IID program. (Gov. Code, Secs. 534.104(g), 534.1045(b), (c), (d), 534.107(b).)

Sec. 542.0111. CARE COORDINATION. (a) A comprehensive long-term services and supports provider participating in the pilot program shall work in coordination with the care coordinators of a managed care organization participating in the pilot program to ensure the seamless daily delivery of acute care and long-term services and supports in accordance with a pilot program participant's plan of care.

(b) A managed care organization may reimburse a comprehensive long-term services and supports provider for coordinating with care coordinators under this section. (Gov. Code, Sec. 534.1045(e).)

Sec. 542.0112. PERSON-CENTERED PLANNING. The commission, in collaboration with the advisory committee and pilot program work group, shall ensure that each pilot program participant or the participant's legally authorized representative has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the participant and drives the development of the individualized budget. The consumer direction model must be an available option for a participant to achieve self-determination, choice, and control. (Gov. Code, Sec. 534.109.)

Sec. 542.0113. USE OF INNOVATIVE TECHNOLOGY. A pilot program participant is not required to use an innovative technology described by Section 542.0102(c)(9). If a participant chooses to

use an innovative technology described by that subdivision, the commission shall ensure that:

(1) services associated with the technology are delivered in a manner that:

(A) ensures the participant's privacy, health, and well-being;

(B) provides access to housing in the most integrated and least restrictive environment;

(C) assesses individual needs and preferences to promote autonomy, self-determination, the use of the consumer direction model, and privacy;

(D) increases personal independence;

(E) specifies the extent to which the innovative technology will be used, including:

(i) the times of day during which the technology will be used;

(ii) the place in which the technology is authorized to be used;

(iii) the types of telemonitoring or remote monitoring that will be used; and

(iv) the purposes for which the technology will be used; and

(F) is consistent with and agreed on during the person-centered planning process;

(2) staff overseeing the use of the innovative technology:

(A) review the person-centered and

implementation plans for each participant before overseeing the use of the innovative technology; and

(B) demonstrate competency regarding the support needs of each participant using the innovative technology;

(3) a participant using the innovative technology is able to request the removal of equipment associated with the technology and, on receipt of a request for the removal, the equipment is immediately removed; and

(4) a participant is not required to use telemedicine at any point during the pilot program and, if the participant refuses to use telemedicine, the managed care organization providing pilot program health care services to the participant arranges for services that do not include telemedicine. (Gov. Code, Sec. 534.104(b).)

Sec. 542.0114. INFORMATIONAL MATERIALS. (a) To ensure that prospective pilot program participants are able to make an informed decision on whether to participate in the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop and distribute informational materials that describe the pilot program's benefits and impact on current services and other related information.

(b) The commission shall establish a timeline and process for developing and distributing the informational materials and ensure that:

(1) the materials are developed and distributed to individuals eligible to participate in the pilot program with sufficient time to educate the individuals, their families, and

other persons actively involved in their lives regarding the pilot program;

(2) individuals eligible to participate in the pilot program, including individuals enrolled in the STAR+PLUS Medicaid managed care program, their families, and other persons actively involved in their lives receive the materials and oral information on the pilot program;

(3) the materials contain clear, simple language presented in a manner that is easy to understand; and

(4) at a minimum, the materials explain that:

(A) on the pilot program's conclusion, each pilot program participant will be asked to provide feedback on the participant's experience, including feedback on whether the pilot program was able to meet the participant's unique support needs;

(B) participation in the pilot program does not remove an individual from any Medicaid waiver program interest list;

(C) a pilot program participant who, during the pilot program's operation, is offered enrollment in a Medicaid waiver program may accept the enrollment, transition, or diversion offer; and

(D) a pilot program participant has a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model and comprehensive services model. (Gov. Code, Sec. 534.1065(b).)

Sec. 542.0115. IMPLEMENTATION, LOCATION, AND DURATION. The

commission shall:

(1) implement the pilot program on September 1, 2023;

(2) conduct the pilot program in a STAR+PLUS Medicaid managed care service area the commission selects; and

(3) operate the pilot program for at least 24 months. (Gov. Code, Sec. 534.106.)

Sec. 542.0116. RECIPIENT ENROLLMENT, PARTICIPATION, AND ELIGIBILITY. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall develop pilot program participant eligibility criteria. The criteria must ensure that pilot program participants:

(1) include individuals with an intellectual or developmental disability or a cognitive disability, including:

(A) individuals with autism;

(B) individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program;

(C) individuals enrolled in the STAR+PLUS Medicaid managed care program who:

(i) are on a Medicaid waiver program interest list;

(ii) meet the criteria for an intellectual or developmental disability; or

(iii) have a traumatic brain injury that occurred after the age of 21; and

(D) other individuals with disabilities who have

similar functional needs without regard to the age of onset or diagnosis; and

(2) do not include individuals who are receiving only acute care services under the STAR+PLUS Medicaid managed care program and are enrolled in the community-based ICF-IID program or another Medicaid waiver program.

(b) An individual who is eligible to participate in the pilot program will be enrolled automatically. The decision to opt out of participating may be made only by the individual or the individual's legally authorized representative.

(c) Before implementing the pilot program, the commission, in collaboration with the advisory committee and pilot program work group, shall develop and implement a process to ensure that pilot program participants remain eligible for Medicaid for 12 consecutive months during the pilot program. (Gov. Code, Secs. 534.104(k), 534.1065(a), (c).)

Sec. 542.0117. PILOT PROGRAM INFORMATION COLLECTION AND ANALYSIS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall determine the information to collect from a managed care organization participating in the pilot program for use in conducting the evaluation and preparing the report under Section 542.0119.

(b) For the duration of the pilot program, a managed care organization participating in the pilot program shall submit to the commission and the advisory committee quarterly reports on the services provided to each pilot program participant. The reports must include information on:

(1) the level of each requested service and the authorization and utilization rates for those services;

(2) timelines of:

(A) the authorization of each requested service;

(B) the initiation of each requested service;

(C) the delivery of each requested service; and

(D) each unplanned break in the delivery of requested services and the duration of the break;

(3) the number of pilot program participants using employment assistance and supported employment services;

(4) the number of service denials and fair hearings and the dispositions of the fair hearings;

(5) the number of complaints and inquiries the managed care organization received and the outcome of each complaint; and

(6) the number of pilot program participants who choose the consumer direction model and the reasons other participants did not choose the consumer direction model.

(c) The commission shall ensure that the mechanisms to report and track the information and data required by Subsections (a) and (b) are established before implementing the pilot program.

(d) For purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules, the commission, in collaboration with the advisory committee and pilot program work group, shall analyze:

(1) information provided by managed care organizations participating in the pilot program; and

(2) any information the commission collects during the

operation of the pilot program.

(e) The analysis under Subsection (d) must include an assessment of the effect of the managed care strategies implemented in the pilot program on the goals described by Sections 542.0102(b) and (c), 542.0103, 542.0110(a), 542.0113, and 542.0116(c). (Gov. Code, Secs. 534.104(i), (j), 534.108.)

Sec. 542.0118. PILOT PROGRAM CONCLUSION; PUBLICATION OF CONTINUATION. On September 1, 2025, the pilot program is concluded unless the commission continues the pilot program under Section 542.0120. If the commission continues the pilot program, the commission shall publish notice of that continuation in the Texas Register not later than September 1, 2025. (Gov. Code, Sec. 534.111.)

Sec. 542.0119. EVALUATIONS AND REPORTS. (a) The commission, in collaboration with the advisory committee and pilot program work group, shall review and evaluate the progress and outcomes of the pilot program and submit, as part of the annual report required under Section 542.0054, a report on the pilot program's status that includes recommendations for improving the pilot program.

(b) Not later than September 1, 2026, the commission, in collaboration with the advisory committee and pilot program work group, shall prepare and submit to the legislature a written report that evaluates the pilot program based on a comprehensive analysis. The analysis must:

(1) assess the effect of the pilot program on:

(A) access to and quality of long-term services

and supports;

(B) informed choice and meaningful outcomes using person-centered planning, flexible consumer-directed services, individualized budgeting, and self-determination, including a pilot program participant's inclusion in the community;

(C) the integration of service coordination of acute care services and long-term services and supports;

(D) employment assistance and customized, integrated, competitive employment options;

(E) the number, types, and dispositions of fair hearings and appeals in accordance with federal and state law;

(F) increasing the use and flexibility of the consumer direction model;

(G) increasing the use of alternatives to guardianship, including supported decision-making agreements as defined by Section 1357.002, Estates Code;

(H) achieving the best and most cost-effective funding use based on a pilot program participant's needs and preferences; and

(I) attendant recruitment and retention;

(2) analyze the experiences and outcomes of the following systems changes:

(A) the comprehensive assessment instrument described by Section 533A.0335, Health and Safety Code;

(B) the 21st Century Cures Act (Pub. L. No. 114-255);

(C) implementation of the federal rule adopted by

the Centers for Medicare and Medicaid Services and published at 79 Fed. Reg. 2948 (January 16, 2014) related to the provision of long-term services and supports through a home and community-based services (HCS) waiver program under Section 1915(c), 1915(i), or 1915(k) of the Social Security Act (42 U.S.C. Section 1396n(c), (i), or (k));

(D) the provision of basic attendant and habilitation services under Section 542.0152; and

(E) the benefits of providing STAR+PLUS Medicaid managed care services to individuals based on functional needs;

(3) include feedback on the pilot program based on the personal experiences of:

(A) individuals with an intellectual or developmental disability and individuals with similar functional needs who were pilot program participants;

(B) families of and other persons actively involved in the lives of individuals described by Paragraph (A); and

(C) comprehensive long-term services and supports providers who delivered services under the pilot program;

(4) be incorporated in the annual report required under Section 542.0054; and

(5) include recommendations on:

(A) a system of programs and services for the legislature's consideration;

(B) necessary statutory changes; and

(C) whether to implement the pilot program

statewide under the STAR+PLUS Medicaid managed care program for eligible individuals. (Gov. Code, Sec. 534.112.)

Sec. 542.0120. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF CARE. (a) During the evaluation of the pilot program required under Section 542.0119, the commission may continue the pilot program to ensure continuity of care for pilot program participants. If, following the evaluation, the commission does not continue the pilot program, the commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits for pilot program participants to the benefits provided before participation in the pilot program.

(b) A transition plan under Subsection (a) shall be developed in collaboration with the advisory committee and pilot program work group and with stakeholder input as described by Section 542.0105. (Gov. Code, Sec. 534.110.)

Sec. 542.0121. SERVICE TRANSITION REQUIREMENTS. (a) For purposes of implementing the pilot program and transitioning the provision of services provided to recipients under certain Medicaid waiver programs to a Medicaid managed care delivery model following completion of the pilot program, the commission shall:

(1) implement and maintain a certification process for and maintain regulatory oversight over providers under the Texas home living (TxHmL) and home and community-based services (HCS) waiver programs; and

(2) require managed care organizations to include in the organizations' provider networks providers who are certified in accordance with the certification process described by Subdivision

(1).

(b) For purposes of implementing the pilot program and transitioning the provision of services described by Section 542.0201 to the STAR+PLUS Medicaid managed care program, a comprehensive long-term services and supports provider:

(1) must report to the managed care organization in the network of which the provider participates each encounter of any directly contracted service;

(2) must provide to the managed care organization quarterly reports on:

(A) coordinated services and time frames for the delivery of those services; and

(B) the goals and objectives outlined in an individual's person-centered plan and progress made toward meeting those goals and objectives; and

(3) may not be held accountable for the provision of services specified in an individual's service plan that are not authorized or are subsequently denied by the managed care organization.

(c) On transitioning services under a Medicaid waiver program to a Medicaid managed care delivery model, the commission shall ensure that individuals do not lose benefits the individuals receive under the Medicaid waiver program. (Gov. Code, Sec. 534.252.)

SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND CERTAIN OTHER SERVICES

Sec. 542.0151. DELIVERY OF ACUTE CARE SERVICES TO

INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a) Subject to Sections 540.0701 and 540.0753, the commission shall:

(1) provide acute care Medicaid benefits to individuals with an intellectual or developmental disability through the STAR+PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model; and

(2) monitor the provision of those benefits.

(b) The commission, in collaboration with the advisory committee, shall analyze the outcomes of providing acute care Medicaid benefits to individuals with an intellectual or developmental disability under a model described by Subsection (a). The analysis must:

(1) include an assessment of the effects of the delivery model on:

(A) access to and quality of acute care services; and

(B) the number and types of fair hearing and appeals processes in accordance with federal law;

(2) be incorporated into the annual report to the legislature required under Section 542.0054; and

(3) include recommendations for delivery model improvements and implementation for the legislature's consideration, including recommendations for needed statutory changes. (Gov. Code, Sec. 534.151.)

Sec. 542.0152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR+PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM

PROVIDERS. (a) The commission shall:

(1) implement the option for the delivery of basic attendant and habilitation services to individuals with an intellectual or developmental disability under the STAR+PLUS Medicaid managed care program that:

(A) is the most cost-effective; and

(B) maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR+PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss a personal attendant providing basic attendant and habilitation services under the program.

(b) The commission shall require each managed care organization that contracts with the commission to provide basic attendant and habilitation services under the STAR+PLUS Medicaid managed care program in accordance with this section to:

(1) include in the organization's provider network for the provision of those services:

(A) home and community support services agencies licensed under Chapter 142, Health and Safety Code, with which the commission has a contract to provide services under the community living assistance and support services (CLASS) waiver program; and

(B) persons exempted from licensing under Section 142.003(a)(19), Health and Safety Code, with which the commission has a contract to provide services under:

(i) the home and community-based services

(HCS) waiver program; or

(ii) the Texas home living (TxHmL) waiver program;

(2) review and consider any assessment conducted by a local intellectual and developmental disability authority providing intellectual and developmental disability service coordination under Subsection (c); and

(3) enter into a written agreement with each local intellectual and developmental disability authority in the service area regarding the processes the organization and the authority will use to coordinate the services provided to individuals with an intellectual or developmental disability.

(c) The commission shall contract with and make contract payments to local intellectual and developmental disability authorities to:

(1) provide intellectual and developmental disability service coordination to individuals with an intellectual or developmental disability under the STAR+PLUS Medicaid managed care program by assisting individuals who are eligible to receive services in a community-based setting, including individuals transitioning to a community-based setting;

(2) provide to the appropriate managed care organization, based on the functional need, risk factors, and desired outcomes of an individual with an intellectual or developmental disability, an assessment of whether the individual needs attendant or habilitation services;

(3) assist individuals with an intellectual or

developmental disability with developing the individuals' plans of care under the STAR+PLUS Medicaid managed care program, including with making any changes resulting from periodic reassessments of the plans;

(4) provide to the appropriate managed care organization and the commission information regarding the recommended plans of care with which the authorities provide assistance as provided by Subdivision (3), including documentation necessary to demonstrate the need for care described by a plan; and

(5) annually provide to the appropriate managed care organization and the commission a description of outcomes based on an individual's plan of care.

(d) Local intellectual and developmental disability authorities providing service coordination under this section may not also provide attendant and habilitation services under this section.

(e) A local intellectual and developmental disability authority with which the commission contracts under Subsection (c) may subcontract with an eligible person, including a nonprofit entity, to coordinate the delivery of services to individuals with an intellectual or developmental disability under this section. The executive commissioner by rule shall establish minimum qualifications a person must meet to be considered an eligible person under this subsection.

(f) The commission may contract with providers participating in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, the

community living assistance and support services (CLASS) waiver program, or the deaf-blind with multiple disabilities (DBMD) waiver program for the delivery of basic attendant and habilitation services to individuals as described by Subsection (a). The commission has regulatory and oversight authority over the providers with which the commission contracts for the delivery of those services. (Gov. Code, Secs. 534.152(a), (b), (c), (d), (f), (g).)

SUBCHAPTER E. STAGE TWO: TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM

Sec. 542.0201. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) This section applies to individuals with an intellectual or developmental disability who are receiving long-term services and supports under:

(1) a Medicaid waiver program; or

(2) an ICF-IID program.

(b) After implementing the pilot program under Subchapter C and completing the evaluations required by Section 542.0119, the commission, in collaboration with the advisory committee, shall develop a plan for transitioning all or a portion of the services provided through a Medicaid waiver program or an ICF-IID program to a Medicaid managed care model. The plan must include:

(1) a process for transitioning the services in the following phases:

(A) beginning September 1, 2027, the Texas home

living (TxHmL) waiver program services;

(B) beginning September 1, 2029, the community living assistance and support services (CLASS) waiver program services;

(C) beginning September 1, 2031, nonresidential services provided under the home and community-based services (HCS) waiver program and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) subject to Subdivision (2), the residential services provided under an ICF-IID program, the home and community-based services (HCS) waiver program, and the deaf-blind with multiple disabilities (DBMD) waiver program; and

(2) a process for evaluating and determining the feasibility and cost efficiency of transitioning residential services described by Subdivision (1)(D) to a Medicaid managed care model based on an evaluation of a separate pilot program the commission, in collaboration with the advisory committee, conducts that operates after the transition process described by Subdivision (1).

(c) Before implementing the transition plan, the commission shall determine whether to:

(1) continue operating the Medicaid waiver programs or ICF-IID program only for purposes of providing, if applicable:

(A) supplemental long-term services and supports not available under the managed care program delivery model the commission selects; or

(B) long-term services and supports to Medicaid

waiver program recipients who choose to continue receiving benefits under the waiver programs as provided by Section 542.0202(a); or

(2) provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs or ICF-IID program through the managed care program delivery model the commission selects.

(d) In implementing the transition plan, the commission shall develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input the advisory committee provides.

(e) The commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits under this section that protects the continuity of care provided to individuals to whom this section applies and ensures that individuals have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model.

(f) Before transitioning the provision of Medicaid benefits for children under this section, a managed care organization providing services under the managed care program delivery model the commission selects must demonstrate to the commission's satisfaction that the providers in the organization's provider network have experience and expertise in providing services to children with an intellectual or developmental disability.

(g) Before transitioning the provision of Medicaid benefits for adults under this section, a managed care organization providing services under the managed care program delivery model

the commission selects must demonstrate to the commission's satisfaction that the providers in the organization's provider network have experience and expertise in providing services to adults with an intellectual or developmental disability. (Gov. Code, Secs. 534.202(a), (b), (c), (d), (e), (f).)

Sec. 542.0202. RECIPIENT CHOICE OF DELIVERY MODEL. (a) If the commission determines under Section 542.0201(c)(2) that all or a portion of the long-term services and supports previously available under Medicaid waiver programs should be provided through a managed care program delivery model, the commission shall, at the time of the transition, allow each recipient receiving long-term services and supports under a Medicaid waiver program the option of:

(1) continuing to receive the services and supports under the Medicaid waiver program; or

(2) receiving the services and supports through the managed care program delivery model the commission selects.

(b) A recipient who chooses under Subsection (a) to receive long-term services and supports through a managed care program delivery model may not subsequently choose to receive the services and supports under a Medicaid waiver program. (Gov. Code, Secs. 534.202(g), (h).)

Sec. 542.0203. REQUIRED CONTRACT PROVISIONS. In addition to the requirements of Subchapter F, Chapter 540, a contract between a managed care organization and the commission for the organization to provide Medicaid benefits under Section 542.0201 must contain a requirement that the organization implement a

process for individuals with an intellectual or developmental disability that:

(1) ensures that the individuals have a choice among acute care and comprehensive long-term services and supports providers and service delivery options, including the consumer direction model;

(2) to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including through the use of single-case agreements with out-of-network providers; and

(3) provides access to a member services telephone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary and specialty services and other long-term services and supports. (Gov. Code, Sec. 534.202(i).)

Sec. 542.0204. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure, on making a determination to transition services under Section 542.0201:

(1) that the commission is responsible for setting the minimum reimbursement rate paid to an ICF-IID services or group home provider under the integrated managed care system, including the staff rate enhancement paid to an ICF-IID services or group home provider;

(2) that an ICF-IID services or group home provider is paid not later than the 10th day after the date the provider submits

a clean claim in accordance with the criteria the commission uses to reimburse an ICF-IID services or group home provider, as applicable;

(3) the establishment of an electronic portal through which an ICF-IID services or group home provider participating in the STAR+PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as appropriate, may submit long-term services and supports claims to any participating managed care organization; and

(4) that the consumer direction model is an available option for each individual with an intellectual or developmental disability who receives Medicaid benefits in accordance with this subchapter to achieve self-determination, choice, and control and that the individual or the individual's legally authorized representative has access to a comprehensive, facilitated, person-centered plan that identifies outcomes for the individual. (Gov. Code, Sec. 534.203.)

CHAPTER 543. CLINICAL INITIATIVES TO IMPROVE MEDICAID QUALITY OF CARE AND COST-EFFECTIVENESS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 543.0001. EFFECT OF CHAPTER ON COMMISSION'S AUTHORITY

Sec. 543.0002. RULES

Sec. 543.0003. INTERNET WEBSITE

SUBCHAPTER B. ASSESSMENT OF CLINICAL INITIATIVES

Sec. 543.0051. MEDICAID QUALITY IMPROVEMENT PROCESS

CHAPTER 543. CLINICAL INITIATIVES TO IMPROVE MEDICAID QUALITY OF CARE AND COST-EFFECTIVENESS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 543.0001. EFFECT OF CHAPTER ON COMMISSION'S AUTHORITY. This chapter does not affect the commission's authority, or give the commission additional authority, to:

(1) affect any individual health care treatment decision for a Medicaid recipient;

(2) replace or affect:

(A) the process of determining Medicaid benefits, including the approval process for receiving benefits for durable medical equipment; or

(B) any applicable approval process required for reimbursement for services or other equipment under Medicaid;

(3) implement a clinical initiative or associated rule or program policy that is otherwise prohibited under state or federal law; or

(4) implement any initiative that would expand eligibility for Medicaid benefits. (Gov. Code, Sec. 538.002.)

Sec. 543.0002. RULES. The executive commissioner shall

adopt rules necessary to implement this chapter. (Gov. Code, Sec. 538.003.)

Sec. 543.0003. INTERNET WEBSITE. The commission shall maintain an Internet website related to the quality improvement process required under this chapter. The website must include:

(1) an explanation of the process for submission, preliminary review, analysis, and approval of a clinical initiative under this chapter;

(2) an explanation of how members of the public may submit comments or research related to an initiative;

(3) a copy of each initiative selected for analysis under Section 543.0054;

(4) the status of each initiative in the approval process; and

(5) a copy of each final report prepared under this chapter. (Gov. Code, Sec. 538.056.)

SUBCHAPTER B. ASSESSMENT OF CLINICAL INITIATIVES

Sec. 543.0051. MEDICAID QUALITY IMPROVEMENT PROCESS. The commission shall, in accordance with this chapter, develop and implement a quality improvement process by which the commission:

(1) receives suggestions for clinical initiatives designed to improve:

(A) the quality of care provided under Medicaid; and

(B) the cost-effectiveness of Medicaid;

(2) conducts a preliminary review under Section 543.0053(2) of each suggestion received under Section 543.0052 to

determine whether the suggestion warrants further consideration and analysis; and

(3) conducts an analysis under Section 543.0054 of each suggestion that is selected for analysis in accordance with Subdivision (2). (Gov. Code, Sec. 538.051.)

Sec. 543.0052. SOLICITATION OF SUGGESTIONS FOR CLINICAL INITIATIVES. (a) Subject to Subsection (b), the commission shall solicit and accept written or electronic suggestions for clinical initiatives from:

(1) a member of the legislature;

(2) the executive commissioner;

(3) the commissioner of state health services;

(4) the commissioner of the Department of Family and Protective Services; and

(5) the medical care advisory committee appointed under Section 32.022, Human Resources Code.

(b) The commission may not accept a suggestion for a clinical initiative that:

(1) is undergoing clinical trials; or

(2) expands a health care provider's scope of practice beyond the law governing the provider's practice. (Gov. Code, Sec. 538.052.)

Sec. 543.0053. CLINICAL INITIATIVE EVALUATION PROCESS. The commission shall establish and implement an evaluation process for the submission, preliminary review, analysis, and approval of a clinical initiative. The process must:

(1) require that a suggestion for a clinical

initiative be submitted to the state Medicaid director;

(2) allow the commission to conduct, with the assistance of an appropriate advisory committee or similar group as determined by the commission, a preliminary review of each suggested clinical initiative to determine whether the initiative warrants further consideration and analysis under Section 543.0054;

(3) require the commission to publish on the Internet website maintained in accordance with Section 543.0003 the criteria the commission uses in the preliminary review under Subdivision (2) to determine whether an initiative warrants analysis under Section 543.0054;

(4) limit the number of suggestions analyzed under Section 543.0054;

(5) require that a suggestion for a clinical initiative selected for analysis under Section 543.0054 be published on the Internet website maintained in accordance with Section 543.0003 not later than the 30th day after the date the state Medicaid director receives the suggestion;

(6) provide for a formal public comment period that lasts at least 30 days during which the public may submit comments and research relating to a suggested clinical initiative;

(7) require commission employees to analyze, in accordance with Section 543.0054, each suggested clinical initiative selected for analysis; and

(8) require the development and publication of a final report in accordance with Section 543.0055 on each clinical

initiative selected for analysis under Section 543.0054 not later than the 180th day after the date the state Medicaid director receives the suggestion. (Gov. Code, Sec. 538.053.)

Sec. 543.0054. ANALYSIS OF CLINICAL INITIATIVES. After conducting a preliminary review of a clinical initiative under Section 543.0053(2), the commission shall analyze the clinical initiative if the commission selects the initiative for analysis. The analysis must include a review of:

(1) any public comments and submitted research relating to the initiative;

(2) the available clinical research and historical utilization information relating to the initiative;

(3) published medical literature relating to the initiative;

(4) any adoption of the initiative by a medical society or other clinical group;

(5) whether the initiative has been implemented under:

(A) the Medicare program;

(B) another state medical assistance program; or

(C) a state-operated health care program, including the child health plan program;

(6) the results of reports, research, pilot programs, or clinical studies relating to the initiative conducted by:

(A) institutions of higher education, including related medical schools;

(B) governmental entities and agencies; and

(C) private and nonprofit think tanks and

research groups;

(7) the impact the initiative would have on Medicaid if the initiative were implemented in this state, including:

(A) an estimate of the number of Medicaid recipients that would be impacted by implementing the initiative; and

(B) a description of any potential cost savings to the state that would result from implementing the initiative; and

(8) any statutory barriers to implementing the initiative. (Gov. Code, Sec. 538.054.)

Sec. 543.0055. FINAL REPORT ON CLINICAL INITIATIVE. The commission shall prepare a final report based on the analysis of a clinical initiative conducted under Section 543.0054. The final report must include:

(1) a final determination of:

(A) the feasibility of implementing the initiative;

(B) the likely impact implementing the initiative would have on the quality of care provided under Medicaid; and

(C) the anticipated cost savings to the state that would result from implementing the initiative;

(2) a summary of the public comments, including a description of any opposition to the initiative;

(3) an identification of any statutory barriers to implementing the initiative; and

(4) if the initiative is not implemented, an explanation of that decision. (Gov. Code, Sec. 538.055.)

Sec. 543.0056. COMMISSION ACTION ON CLINICAL INITIATIVE. After the commission analyzes a clinical initiative under Section 543.0054:

(1) if the commission determined that the initiative is cost-effective and will improve the quality of care under Medicaid, the commission may:

(A) implement the initiative if implementing the initiative is not otherwise prohibited by law; or

(B) if implementation requires a change in law, submit a copy of the final report together with recommendations relating to the initiative's implementation to the standing committees of the senate and house of representatives with jurisdiction over Medicaid; and

(2) if the commission determined that the initiative is not cost-effective or will not improve quality of care under Medicaid, the commission may not implement the initiative. (Gov. Code, Sec. 538.057.)

CHAPTER 543A. QUALITY-BASED OUTCOMES AND PAYMENTS UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 543A.0001. DEFINITIONS

Sec. 543A.0002. DEVELOPMENT OF OUTCOME AND PROCESS MEASURES; CORRELATION WITH INCREASED REIMBURSEMENT RATES

CHAPTER 543A. QUALITY-BASED OUTCOMES AND PAYMENTS UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 543A.0001. DEFINITIONS. In this chapter:

(1) "Alternative payment system" includes:

(A) a global payment system;

(B) an episode-based bundled payment system; and

(C) a blended payment system.

(2) "Blended payment system" means a system for compensating a physician or other health care provider that:

(A) includes at least one feature of a global payment system and an episode-based bundled payment system; and

(B) may include a system under which a portion of the compensation paid to a physician or other health care provider is based on a fee-for-service payment arrangement.

(3) "Enrollee" means an individual enrolled in the child health plan program.

(4) "Episode-based bundled payment system" means a system for compensating a physician or other health care provider for providing or arranging for health care services to an enrollee or recipient that is based on a flat payment for all services provided in connection with a single episode of medical care.

(5) "Exclusive provider benefit plan" means a managed care plan subject to 28 T.A.C. Part 1, Chapter 3, Subchapter KK.

(6) "Freestanding emergency medical care facility" means a facility licensed under Chapter 254, Health and Safety Code.

(7) "Global payment system" means a system for compensating a physician or other health care provider for providing or arranging for a defined set of covered health care services to an enrollee or recipient for a specified period that is based on a predetermined payment per enrollee or recipient for the specified period, without regard to the quantity of services actually provided.

(8) "Health care provider" means a person, facility, or institution licensed, certified, registered, or chartered by this state to provide health care. The term includes an employee, independent contractor, or agent of a health care provider acting in the course and scope of the employment or contractual relationship.

(9) "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

(10) "Hospital" means an institution licensed under Chapter 241 or 577, Health and Safety Code, including a general or special hospital as defined by Section 241.003 of that code.

(11) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan. The term includes a health maintenance organization and an exclusive provider organization.

(12) "Managed care plan" means a plan, including an exclusive provider benefit plan, under which a person undertakes to provide, arrange or pay for, or reimburse any part of the cost of health care services. The plan must include arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(13) "Physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(14) "Potentially preventable admission" means an individual's admission to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

(15) "Potentially preventable ancillary service" means a health care service that:

(A) a physician or other health care provider provides or orders to supplement or support evaluating or treating

a patient, including a diagnostic test, laboratory test, therapy service, or radiology service; and

(B) might not be reasonably necessary to provide quality health care or treatment.

(16) "Potentially preventable complication" means a harmful event or negative outcome with respect to an individual, including an infection or surgical complication, that:

(A) occurs after the individual's admission to a hospital or long-term care facility; and

(B) may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

(17) "Potentially preventable emergency room visit" means an individual's treatment in a hospital emergency room or freestanding emergency medical care facility for a condition that might not require emergency medical attention because the condition could be treated, or could have been prevented, by a physician or other health care provider in a nonemergency setting.

(18) "Potentially preventable event" means a:

(A) potentially preventable admission;

(B) potentially preventable ancillary service;

(C) potentially preventable complication;

(D) potentially preventable emergency room visit;

(E) potentially preventable readmission; or

(F) combination of those events.

(19) "Potentially preventable readmission" means an individual's return hospitalization within a period the commission specifies that may have resulted from deficiencies in the individual's care or treatment provided during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the individual's discharge. The term includes an individual's readmission to a hospital for:

(A) the same condition or procedure for which the individual was previously admitted;

(B) an infection or other complication resulting from care previously provided;

(C) a condition or procedure indicating that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or

(D) another condition or procedure of a similar nature that the executive commissioner determines.

(20) "Quality-based payment system" means a system, including an alternative payment system, for compensating a physician or other health care provider that:

(A) provides incentives to the physician or other health care provider to provide high-quality, cost-effective care; and

(B) bases some portion of the payment made to the physician or other health care provider on quality-of-care outcomes, which may include the extent to which the physician or other health care provider reduces potentially preventable events.

(21) "Recipient" means a Medicaid recipient. (Gov. Code, Secs. 536.001, 536.003(h); New.)

Sec. 543A.0002. DEVELOPMENT OF OUTCOME AND PROCESS MEASURES; CORRELATION WITH INCREASED REIMBURSEMENT RATES. (a) The commission shall develop quality-based outcome and process measures that:

(1) promote the provision of efficient, quality health care; and

(2) can be used in the child health plan program and Medicaid to implement quality-based payments for acute care services and long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems.

(b) The commission, in coordination with the Department of State Health Services, shall develop and implement a quality-based outcome measure for the child health plan program and Medicaid to annually measure the percentage of enrollees or recipients with HIV infection, regardless of age, whose most recent viral load test indicates a viral load of less than 200 copies per milliliter of blood.

(c) To the extent feasible, the commission shall develop outcome and process measures:

(1) consistently across all child health plan program and Medicaid delivery models and payment systems;

(2) in a manner that takes into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness;

(3) that will have the greatest effect on improving quality of care and the efficient use of services, including acute care services and long-term services and supports;

(4) that are similar to outcome and process measures used in the private sector, as appropriate;

(5) that reflect effective coordination of acute care services and long-term services and supports;

(6) that can be tied to expenditures; and

(7) that reduce preventable health care utilization and costs.

(d) In developing the outcome and process measures, the commission must include measures that are based on potentially preventable events and advance quality improvement and innovation. The outcome measures based on potentially preventable events must:

(1) allow for a rate-based determination of health care provider performance compared to statewide norms; and

(2) be risk-adjusted to account for the severity of the illnesses of patients a provider serves.

(e) The commission may modify the outcome and process measures to:

(1) promote continuous system reform, improved quality, and reduced costs; and

(2) account for managed care organizations added to a service area.

(f) To the extent feasible, the commission shall align the outcome and process measures with measures required or recommended under reporting guidelines established by:

(1) the Centers for Medicare and Medicaid Services;

(2) the Agency for Healthcare Research and Quality; or

(3) another federal agency.

(g) The executive commissioner by rule may require physicians, other health care providers, and managed care organizations participating in the child health plan program and Medicaid to report information necessary to develop the outcome and process measures to the commission in a format the executive commissioner specifies.

(h) If the commission increases physician and other health care provider reimbursement rates under the child health plan program or Medicaid as a result of an increase in the amounts appropriated for those programs for a state fiscal biennium as compared to the preceding state fiscal biennium, the commission shall, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, correlate the increased reimbursement rates with the quality-based outcome and process measures. (Gov. Code, Secs. 536.003(a), (a-1), (b), (c), (d), (e), (f).)

Sec. 543A.0003. USE OF QUALITY-BASED OUTCOME MEASURE FOR ENROLLEES OR RECIPIENTS WITH HIV INFECTION. (a) The commission shall include aggregate, nonidentifying data collected using the quality-based outcome measure described by Section 543A.0002(b) in the annual report required by Section 543A.0008. The commission may include the data in any other report required by this chapter.

(b) The commission shall determine the appropriateness of including the quality-based outcome measure described by Section

543A.0002(b) in the quality-based payments and payment systems developed under Sections 543A.0004 and 543A.0051. (Gov. Code, Sec. 536.003(g).)

Sec. 543A.0004. DEVELOPMENT OF QUALITY-BASED PAYMENT SYSTEMS. (a) Using the quality-based outcome and process measures developed under Section 543A.0002 and after consulting with appropriate stakeholders with an interest in the provision of acute care and long-term services and supports under the child health plan program and Medicaid, the commission shall develop and require managed care organizations to develop quality-based payment systems for compensating a physician or other health care provider participating in the child health plan program or Medicaid that:

(1) align payment incentives with high-quality, cost-effective health care;

(2) reward the use of evidence-based best practices;

(3) promote health care coordination;

(4) encourage appropriate physician and other health care provider collaboration;

(5) promote effective health care delivery models; and

(6) take into account the specific needs of the enrollee and recipient populations.

(b) The commission shall develop the quality-based payment systems in the manner specified by this chapter. To the extent necessary to maximize the receipt of federal funds or reduce administrative burdens, the commission shall coordinate the timeline for developing and implementing a payment system with the implementation of other initiatives such as:

(1) the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations;

(2) the ICD-10 code sets initiative; or

(3) the ongoing Enterprise Data Warehouse (EDW) planning process.

(c) In developing the quality-based payment systems, the commission shall examine and consider implementing:

(1) an alternative payment system;

(2) an existing performance-based payment system used under the Medicare program that meets the requirements of this chapter, modified as necessary to account for programmatic differences, if implementing the system would:

(A) reduce unnecessary administrative burdens; and

(B) align quality-based payment incentives for physicians and other health care providers with the Medicare program; and

(3) alternative payment methodologies within a system that are used in the Medicare program, modified as necessary to account for programmatic differences, and that will achieve cost savings and improve quality of care in the child health plan program and Medicaid.

(d) In developing the quality-based payment systems, the commission shall ensure that a system will not reward a physician, other health care provider, or managed care organization for withholding or delaying medically necessary care.

(e) The commission may modify a quality-based payment

system to account for:

(1) programmatic differences between the child health plan program and Medicaid; and

(2) delivery systems under those programs. (Gov. Code, Sec. 536.004.)

Sec. 543A.0005. PAYMENT METHODOLOGY CONVERSION. (a) To the extent possible, the commission shall convert hospital reimbursement systems under the child health plan program and Medicaid to a diagnosis-related groups (DRG) methodology that will allow the commission to more accurately classify specific patient populations and account for the severity of patient illness and mortality risk.

(b) Subsection (a) does not authorize the commission to direct a managed care organization to compensate a physician or other health care provider providing services under the organization's managed care plan based on a diagnosis-related groups (DRG) methodology.

(c) Notwithstanding Subsection (a) and to the extent possible, the commission shall convert outpatient hospital reimbursement systems under the child health plan program and Medicaid to an appropriate prospective payment system that will allow the commission to:

(1) more accurately classify the full range of outpatient service episodes;

(2) more accurately account for the intensity of services provided; and

(3) motivate outpatient service providers to increase

efficiency and effectiveness. (Gov. Code, Sec. 536.005.)

Sec. 543A.0006. TRANSPARENCY; CONSIDERATIONS. (a) The commission shall:

(1) ensure transparency in developing and establishing:

(A) quality-based payment and reimbursement systems under Section 543A.0004 and Subchapters B, C, and D, including in developing outcome and process measures under Section 543A.0002; and

(B) quality-based payment initiatives under Subchapter E, including developing quality-of-care and cost-efficiency benchmarks under Section 543A.0203(a) and approving efficiency performance standards under Section 543A.0203(b); and

(2) for developing and establishing the quality-based payment and reimbursement systems and initiatives described by Subdivision (1), develop guidelines that establish procedures to provide notice and information to and receive input from managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate.

(b) In developing and establishing the quality-based payment and reimbursement systems and initiatives described by Subsection (a)(1), the commission shall consider that there will be a diminishing rate of improved performance over time as the performance of a physician, other health care provider, or managed care organization improves with respect to an outcome or process

measure, quality-of-care and cost-efficiency benchmark, or efficiency performance standard, as applicable.

(c) The commission shall develop web-based capability that:

(1) provides health care providers and managed care organizations with data on their clinical and utilization performance, including comparisons to peer organizations and providers located in this state and in the provider's respective region; and

(2) supports the requirements of the electronic health information exchange system under Sections 525.0206, 525.0207, and 525.0208. (Gov. Code, Sec. 536.006.)

Sec. 543A.0007. PERIODIC EVALUATION. At least once each two-year period, the commission shall evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under this chapter. (Gov. Code, Sec. 536.007.)

Sec. 543A.0008. ANNUAL REPORT. (a) The commission shall submit to the legislature and make available to the public an annual report on:

(1) the quality-based outcome and process measures developed under Section 543A.0002, including measures based on each potentially preventable event; and

(2) the progress of implementing quality-based payment systems and other payment initiatives under this chapter.

(b) The commission shall, as appropriate, report outcome and process measures under Subsection (a)(1) by:

(1) geographic location, which may require reporting

by county, health care service region, or another appropriately defined geographic area;

(2) enrollee or recipient population or eligibility group served;

(3) type of health care provider, such as acute care or long-term care provider;

(4) number of enrollees and recipients who relocated to a community-based setting from a less integrated setting;

(5) quality-based payment system; and

(6) service delivery model.

(c) The report may not identify a specific health care provider. (Gov. Code, Sec. 536.008.)

SUBCHAPTER B. QUALITY-BASED PAYMENTS RELATING TO MANAGED CARE ORGANIZATIONS

Sec. 543A.0051. QUALITY-BASED PREMIUM PAYMENTS; PERFORMANCE REPORTING. (a) Subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other federal law, the commission shall base a percentage of the premiums paid to a managed care organization participating in the child health plan program or Medicaid on the organization's performance with respect to outcome and process measures developed under Section 543A.0002 that address potentially preventable events. The percentage may increase each year.

(b) The commission shall make available information relating to a managed care organization's performance with respect to outcome and process measures under this subchapter to an enrollee or recipient before the enrollee or recipient chooses a

managed care plan. (Gov. Code, Sec. 536.051.)

Sec. 543A.0052. FINANCIAL INCENTIVES AND CONTRACT AWARD PREFERENCES. (a) The commission may allow a managed care organization participating in the child health plan program or Medicaid increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, to:

(1) achieve high-quality, cost-effective health care;

(2) increase the use of high-quality, cost-effective delivery models;

(3) reduce the incidence of unnecessary institutionalization and potentially preventable events; and

(4) in collaboration with physicians and other health care providers, increase the use of alternative payment systems, including shared savings models.

(b) The commission shall develop quality-of-care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to:

(1) reducing potentially preventable events; and

(2) containing the growth rate of health care costs.

(c) The commission may include in a contract between a managed care organization and the commission financial incentives that are based on the organization's successful implementation of quality initiatives under Subsection (a) or success in achieving quality-of-care and cost-efficiency benchmarks under Subsection (b). The commission may implement the financial incentives only if implementing the incentives would be cost-effective.

(d) In awarding contracts to managed care organizations under the child health plan program and Medicaid, the commission shall, in addition to considerations under Section 540.0204 of this code and Section 62.155, Health and Safety Code, give preference to an organization that offers a managed care plan that:

(1) successfully implements quality initiatives under Subsection (a) as the commission determines based on data or other evidence the organization provides; or

(2) meets quality-of-care and cost-efficiency benchmarks under Subsection (b). (Gov. Code, Sec. 536.052.)

SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

Sec. 543A.0101. DEFINITION. In this subchapter, "health home" means a primary care provider practice or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under the child health plan program and Medicaid. (Gov. Code, Sec. 536.101(1).)

Sec. 543A.0102. QUALITY-BASED HEALTH HOME PAYMENTS. (a) The commission may develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. A quality-based payment system must:

(1) base payments made to an enrollee's or recipient's health home on quality and efficiency measures that may include measurable wellness and prevention criteria and the use of

evidence-based best practices, sharing a portion of any realized cost savings the health home achieves, and ensuring quality of care outcomes, including a reduction in potentially preventable events; and

(2) allow for the examination of measurable wellness and prevention criteria, use of evidence-based best practices, and quality-of-care outcomes based on the type of primary or specialty care provider practice.

(b) The commission may develop a quality-based payment system for health homes only if implementing the system would be feasible and cost-effective. (Gov. Code, Sec. 536.102.)

Sec. 543A.0103. HEALTH HOME ELIGIBILITY. To be eligible to receive reimbursement under a quality-based payment system under this subchapter, a health home must:

(1) directly or indirectly provide enrollees or recipients who have a health home with access to health care services outside of regular business hours;

(2) educate those enrollees and recipients about the availability of health care services outside of regular business hours; and

(3) provide evidence satisfactory to the commission that the health home meets the requirement of Subdivision (1). (Gov. Code, Sec. 536.103.)

SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

Sec. 543A.0151. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN HOSPITALS. (a) The executive commissioner shall adopt rules for identifying:

(1) potentially preventable admissions and readmissions of enrollees and recipients, including preventable admissions to long-term care facilities;

(2) potentially preventable ancillary services provided to or ordered for enrollees and recipients;

(3) potentially preventable emergency room visits by enrollees and recipients; and

(4) potentially preventable complications experienced by enrollees and recipients.

(b) The commission shall collect data from hospitals on present-on-admission indicators for purposes of this section.

(c) The commission shall establish a program to provide to each hospital in this state that participates in the child health plan program or Medicaid a report regarding the hospital's performance with respect to each potentially preventable event described by Subsection (a). To the extent possible, the report should include all potentially preventable events across all child health plan program and Medicaid payment systems. A hospital shall distribute the information in the report to physicians and other health care providers providing services at the hospital.

(d) Except as provided by Subsection (e), a report provided to a hospital under Subsection (c) is confidential and not subject to Chapter 552.

(e) The commission may release information in a report described by Subsection (c):

(1) not earlier than one year after the date the report is provided to the hospital; and

(2) only after deleting any data that relates to a hospital's performance with respect to a particular diagnosis-related group or an individual patient. (Gov. Code, Sec. 536.151.)

Sec. 543A.0152. REIMBURSEMENT ADJUSTMENTS. (a) The commission shall use the data collected under Section 543A.0151 and the diagnosis-related groups (DRG) methodology implemented under Section 543A.0005, if applicable, to adjust, to the extent feasible, child health plan program and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs. The commission shall base an adjustment for a hospital on the hospital's performance with respect to exceeding or failing to achieve outcome and process measures developed under Section 543A.0002 that address the rates of potentially preventable readmissions and potentially preventable complications.

(b) The commission must provide the report required by Section 543A.0151(c) to a hospital at least one year before adjusting child health plan program and Medicaid reimbursements to the hospital under this section. (Gov. Code, Sec. 536.152.)

SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

Sec. 543A.0201. PAYMENT INITIATIVES; DETERMINATION OF BENEFIT TO STATE. (a) The commission shall establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care providers to develop health

care interventions for enrollees or recipients that will:

(1) improve the quality of health care provided to the enrollees or recipients;

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

(4) increase the use of evidence-based best practices;

(5) increase appropriate physician and other health care provider collaboration;

(6) contain costs; and

(7) improve integration of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports.

(b) The commission shall:

(1) establish a process through which a physician, other health care provider, or managed care organization may submit a proposal for a payment initiative; and

(2) determine whether implementing one or more proposed payment initiatives is feasible and cost-effective.

(c) If the commission determines that implementing one or more payment initiatives is feasible and cost-effective for this state, the commission shall establish one or more payment initiatives as provided by this subchapter. (Gov. Code, Secs. 536.202, 536.203(a).)

Sec. 543A.0202. PAYMENT INITIATIVE ADMINISTRATION. (a) The commission shall administer any payment initiative the commission establishes under this subchapter. The executive

commissioner may adopt rules, plans, and procedures and enter into contracts and other agreements as the executive commissioner considers appropriate and necessary to administer this subchapter.

(b) The commission may limit a payment initiative to:

(1) one or more regions in this state;

(2) one or more organized networks of physicians and other health care providers; or

(3) specified types of services provided under the child health plan program or Medicaid, or specified types of enrollees or recipients.

(c) An implemented payment initiative must be operated for at least one calendar year. (Gov. Code, Secs. 536.203(b), (c), (d).)

Sec. 543A.0203. QUALITY-OF-CARE AND COST-EFFICIENCY BENCHMARKS AND GOALS; EFFICIENCY PERFORMANCE STANDARDS. (a) The executive commissioner shall develop quality-of-care and cost-efficiency benchmarks and measurable goals that a payment initiative must meet to ensure high-quality and cost-effective health care services and healthy outcomes.

(b) In addition to the benchmarks and goals described by Subsection (a), the executive commissioner may approve efficiency performance standards that may include the sharing of realized cost savings with physicians and other health care providers who provide health care services that exceed the standards. The standards may not create a financial incentive for or involve making a payment to a physician or other health care provider that directly or indirectly induces limiting medically necessary services. (Gov.

Code, Sec. 536.204.)

Sec. 543A.0204. PAYMENT RATES UNDER PAYMENT INITIATIVES. The executive commissioner may contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for an implemented payment initiative. (Gov. Code, Sec. 536.205.)

SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENT SYSTEMS

Sec. 543A.0251. QUALITY-BASED PAYMENT SYSTEMS FOR LONG-TERM SERVICES AND SUPPORTS. (a) The commission, after consulting with appropriate stakeholders representing nursing facility providers with an interest in providing long-term services and supports, may develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. A quality-based payment system must base payments made to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and the use of evidence-based best practices, sharing a portion of any realized cost savings the provider achieves, and ensuring quality of care outcomes, including a reduction in potentially preventable events.

(b) The commission may develop a quality-based payment system for Medicaid long-term services and supports providers only if implementing the system would be feasible and cost-effective. (Gov. Code, Sec. 536.251.)

Sec. 543A.0252. DATA SET EVALUATION. To ensure that the commission is using the best data to inform developing and

implementing quality-based payment systems under Section 543A.0251, the commission shall evaluate the reliability, validity, and functionality of post-acute and long-term services and supports data sets. The commission's evaluation should assess:

(1) to what degree data sets on which the commission relies meet a standard:

(A) for integrating care;

(B) for developing coordinated care plans; and

(C) that would allow for the meaningful development of risk adjustment techniques;

(2) whether the data sets will provide value for outcome or performance measures and cost containment; and

(3) how classification systems and data sets used for Medicaid long-term services and supports providers can be standardized and, where possible, simplified. (Gov. Code, Sec. 536.252.)

Sec. 543A.0253. COLLECTING CERTAIN INFORMATION; REPORTS TO CERTAIN PROVIDERS. (a) The executive commissioner shall adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term services and supports recipients.

(b) The commission shall establish a program to provide to each Medicaid long-term services and supports provider in this state a report regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits.

To the extent possible, the report should include applicable potentially preventable events information across all Medicaid payment systems.

(c) Except as provided by Subsection (d), a report provided to a provider under Subsection (b) is confidential and not subject to Chapter 552.

(d) The commission may release information in a report described by Subsection (b):

(1) not earlier than one year after the date the report is provided to the provider; and

(2) only after deleting any data that relates to a provider's performance with respect to a particular resource utilization group or an individual recipient. (Gov. Code, Sec. 536.253.)

CHAPTER 544. FRAUD, WASTE, ABUSE, AND OVERCHARGES RELATING TO HEALTH AND HUMAN SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 544.0001. DEFINITIONS

Sec. 544.0002. REFERENCE TO OFFICE OF INVESTIGATIONS AND ENFORCEMENT

Sec. 544.0003. AUTHORITY OF STATE AGENCY OR GOVERNMENTAL ENTITY NOT LIMITED

SUBCHAPTER B. HEALTH AND HUMAN SERVICES COMMISSION: ADMINISTRATIVE PROVISIONS

Sec. 544.0051. COORDINATION WITH OFFICE OF ATTORNEY GENERAL; ANNUAL REPORT

CHAPTER 544. FRAUD, WASTE, ABUSE, AND OVERCHARGES RELATING TO HEALTH AND HUMAN SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 544.0001. DEFINITIONS. In this chapter:

(1) "Abuse" means:

(A) a practice a provider engages in that is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) an unnecessary cost to Medicaid; or

(ii) reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; or

(B) a practice a recipient engages in that results in an unnecessary cost to Medicaid.

(2) "Allegation of fraud" means an allegation of Medicaid fraud the commission receives from any source that has not been verified by this state, including an allegation based on:

(A) a fraud hotline complaint;

(B) claims data mining;

(C) data analysis processes; or

(D) a pattern identified through provider audits, civil false claims cases, or law enforcement

investigations.

(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by this state. An allegation is considered credible when the commission has:

(A) verified that the allegation has indicia of reliability; and

(B) carefully reviewed all allegations, facts, and evidence and acts judiciously on a case-by-case basis.

(4) "Fraud" means an intentional deception or misrepresentation a person makes with the knowledge that the deception or misrepresentation could result in an unauthorized benefit to that person or another person. The term does not include unintentional technical, clerical, or administrative errors.

(5) "Furnished" refers to the provision of items or services directly by or under the direct supervision of, or the ordering of items or services by:

(A) a practitioner or other individual acting as an employee or in the individual's own capacity;

(B) a provider; or

(C) another supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

(6) "Inspector general" means the inspector general the governor appoints under Section 544.0101.

(7) "Office of inspector general" means the commission's office of inspector general.

(8) "Payment hold" means the temporary denial of

Medicaid reimbursement for items or services a specified provider furnished.

(9) "Physician" includes:

(A) an individual licensed to practice medicine in this state;

(B) a professional association composed solely of physicians;

(C) a partnership composed solely of physicians;

(D) a single legal entity authorized to practice medicine that is owned by two or more physicians; and

(E) a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code.

(10) "Practitioner" means a physician or other individual licensed under state law to practice the individual's profession.

(11) "Program exclusion" means the suspension of a provider's authorization under Medicaid to request reimbursement for items or services the provider furnished.

(12) "Provider" means, except as otherwise provided by this chapter, a person that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission. (Gov. Code, Sec. 531.1011; New.)

Sec. 544.0002. REFERENCE TO OFFICE OF INVESTIGATIONS AND ENFORCEMENT. Notwithstanding any other law, a reference in law or

rule to the commission's office of investigations and enforcement means the office of inspector general. (Gov. Code, Sec. 531.102(i).)

Sec. 544.0003. AUTHORITY OF STATE AGENCY OR GOVERNMENTAL ENTITY NOT LIMITED. Nothing in the following provisions limits the authority of any other state agency or governmental entity:

(1) Section 544.0052;

(2) Section 544.0101;

(3) Section 544.0102;

(4) Section 544.0103;

(5) Section 544.0104;

(6) Section 544.0105;

(7) Section 544.0106;

(8) Section 544.0108;

(9) Sections 544.0109(b) and (d);

(10) Section 544.0110;

(11) Section 544.0113;

(12) Section 544.0114;

(13) Section 544.0251;

(14) Section 544.0252(b);

(15) Section 544.0254;

(16) Section 544.0255;

(17) Section 544.0257;

(18) Section 544.0301;

(19) Section 544.0302;

(20) Section 544.0303; and

(21) Section 544.0304. (Gov. Code, Sec. 531.102(o).)

SUBCHAPTER B. HEALTH AND HUMAN SERVICES COMMISSION: ADMINISTRATIVE PROVISIONS

Sec. 544.0051. COORDINATION WITH OFFICE OF ATTORNEY GENERAL; ANNUAL REPORT. (a) The commission, acting through the office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing:

(1) cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law; or

(2) other violations of state or federal law under Medicaid or another program the commission or a health and human services agency administers, including:

(A) the financial assistance program under Chapter 31, Human Resources Code;

(B) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; and

(C) the child health plan program.

(b) The memorandum of understanding must:

(1) require the office of inspector general and the office of the attorney general to:

(A) set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to:

(i) enhance deterrence of fraud, waste, abuse, or other violations of state or federal law under the programs described by Subsection (a)(2), including a violation of Chapter 102, Occupations Code; and

(ii) maximize the imposition of penalties, the recovery of money, and the successful prosecution of cases; and

(B) submit information the comptroller requests about each resolved case for the comptroller's use in improving fraud detection;

(2) require the office of inspector general to:

(A) refer each case of suspected provider fraud, waste, or abuse to the office of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(B) keep detailed records for cases the office of inspector general or the office of the attorney general processes, including information on the total number of cases processed and, for each case:

(i) the agency and division to which the case is referred for investigation;

(ii) the date the case is referred; and

(iii) the nature of the suspected fraud, waste, or abuse; and

(C) notify each appropriate division of the office of the attorney general of each case the office of inspector general refers;

(3) require the office of the attorney general to:

(A) take appropriate action in response to each case referred to the attorney general, which may include:

(i) directly initiating prosecution, with

the appropriate local district or county attorney's consent;

(ii) directly initiating civil litigation;

(iii) referring the case to an appropriate United States attorney, a district attorney, or a county attorney; or

(iv) referring the case to a collections agency for initiation of civil litigation or other appropriate action;

(B) ensure that information relating to each case the office of the attorney general investigates is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse; and

(C) notify the office of inspector general of each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(4) require representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case;

(5) ensure that barriers to direct fraud referrals to the office of the attorney general's Medicaid fraud control unit or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are not imposed; and

(6) include procedures to facilitate the referral of cases directly to the office of the attorney general.

(c) An exchange of information under this section between the office of the attorney general and the commission, the office of

inspector general, or a health and human services agency does not affect whether the information is subject to disclosure under Chapter 552.

(d) The commission and the office of the attorney general may not assess or collect investigation and attorney's fees on any state agency's behalf unless the office of the attorney general or another state agency collects a penalty, restitution, or other reimbursement payment to this state.

(e) A district attorney, county attorney, city attorney, or private collection agency may collect and retain:

(1) costs associated with a case referred to the attorney or agency in accordance with procedures adopted under this section; and

(2) 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

(f) The commission and the office of the attorney general shall jointly prepare and submit to the governor, lieutenant governor, and speaker of the house of representatives an annual report concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under Medicaid or another program the commission or a health and human services agency administers. The commission and the office of the attorney general may consolidate the report with any other report relating to the same subject matter the commission or the office of the attorney general is required to submit under other law. (Gov. Code, Sec. 531.103.)

Sec. 544.0052. RULES REGARDING ENFORCEMENT AND PUNITIVE

ACTIONS. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules establishing criteria for determining enforcement and punitive actions regarding a provider who violated state law, program rules, or the provider's Medicaid provider agreement.

(b) The rules must include:

(1) direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration:

(A) the seriousness of the violation;

(B) the prevalence of errors by the provider;

(C) the financial or other harm to this state or recipients resulting or potentially resulting from those errors; and

(D) mitigating factors the office of inspector general determines appropriate; and

(2) a specific list of potential penalties, including the amount of the penalties, for fraud and other Medicaid violations. (Gov. Code, Sec. 531.102(x).)

Sec. 544.0053. PROVISION OF INFORMATION TO PHARMACY SUBJECT TO AUDIT; INFORMAL HEARING ON AUDIT FINDINGS. (a) To increase transparency, the office of inspector general shall, if the office has access to the information, provide to pharmacies that are subject to audit by the office or by an entity that contracts with the federal government to audit Medicaid providers information relating to the extrapolation methodology used as part of the audit and the methods used to determine whether the pharmacy has been

overpaid under Medicaid in sufficient detail so that the audit results may be demonstrated to be statistically valid and are fully reproducible.

(b) A pharmacy has a right to request an informal hearing before the commission's appeals division to contest the findings of an audit that the office of inspector general or an entity that contracts with the federal government to audit Medicaid providers conducted if the audit findings do not include findings that the pharmacy engaged in Medicaid fraud.

(c) In an informal hearing held under this section, the commission's appeals division staff, assisted by staff responsible for the commission's vendor drug program with expertise in the law governing pharmacies' participation in Medicaid, make the final decision on whether the audit findings are accurate. Office of inspector general staff may not serve on the panel that makes the decision on the accuracy of an audit. (Gov. Code, Sec. 531.1203.)

Sec. 544.0054. RECORDS OF ALLEGATIONS OF FRAUD OR ABUSE. The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 544.0259(e) and is subject to Section 544.0259(f). (Gov. Code, Sec. 531.118(a).)

Sec. 544.0055. RECORD AND CONFIDENTIALITY OF INFORMAL RESOLUTION MEETINGS. (a) On the written request of a provider who requests an informal resolution meeting held under Section 544.0304 or 544.0506(b), the commission shall, at no expense to the

provider, provide for the meeting to be recorded and for the recording to be made available to the provider. The commission may not record an informal resolution meeting unless the commission receives a written request from a provider.

(b) Notwithstanding Section 544.0259(e) and except as provided by this section:

(1) an informal resolution meeting held under Section 544.0304 or 544.0506(b) is confidential; and

(2) any information or materials the office of inspector general, including the office's employees or agents, obtains during or in connection with an informal resolution meeting, including a recording made under Subsection (a), are privileged, confidential, and not subject to disclosure under Chapter 552 or any other means of legal compulsion for release, including disclosure, discovery, or subpoena. (Gov. Code, Sec. 531.1202.)

Sec. 544.0056. EXPUNCTION OF CHILD'S CHEMICAL DEPENDENCY DIAGNOSIS IN CERTAIN RECORDS. (a) In this section:

(1) "Chemical dependency" has the meaning assigned by Section 461A.002, Health and Safety Code.

(2) "Child" means an individual who is 13 years of age or younger.

(b) After a chemical dependency treatment provider is finally convicted of an offense in which an element of the offense involves submitting a fraudulent claim for reimbursement for services under Medicaid, the commission or other health and human services agency that operates a portion of Medicaid shall expunge

or provide for the expunction of a child's diagnosis of chemical dependency that the provider made and that has been entered in any:

(1) appropriate official record of the commission or agency;

(2) applicable medical record that is in the commission's or agency's custody; and

(3) applicable record of a company with which the commission contracts for processing and paying Medicaid claims. (Gov. Code, Sec. 531.112.)

SUBCHAPTER C. OFFICE OF INSPECTOR GENERAL: GENERAL PROVISIONS

Sec. 544.0101. APPOINTMENT OF INSPECTOR GENERAL; TERM. (a) The governor shall appoint an inspector general to serve as director of the office of inspector general.

(b) The inspector general serves a one-year term that expires February 1. (Gov. Code, Sec. 531.102(a-1).)

Sec. 544.0102. COMMISSION POWERS AND DUTIES RELATED TO OFFICE OF INSPECTOR GENERAL. (a) The executive commissioner shall work in consultation with the office of inspector general when the executive commissioner is required by law to adopt a rule or policy necessary to implement a power or duty of the office of inspector general, including a rule necessary to carry out a responsibility of the office of inspector general under Section 544.0103(a).

(b) The executive commissioner is responsible for performing all administrative support services functions necessary to operate the office of inspector general in the same manner that the executive commissioner is responsible for providing administrative support services functions for the health and human

services system, including office functions related to:

(1) procurement processes;

(2) contracting policies;

(3) information technology services;

(4) legal services, but only those related to:

(A) open records;

(B) procurement;

(C) contracting;

(D) human resources;

(E) privacy;

(F) litigation support by the attorney general;

(G) bankruptcy; and

(H) other legal services as detailed in the memorandum of understanding or other written agreement required under Subchapter E, Chapter 524;

(5) budgeting; and

(6) personnel and employment policies.

(c) The commission's internal audit division shall:

(1) regularly audit the office of inspector general as part of the commission's internal audit program; and

(2) include the office of inspector general in the commission's risk assessments.

(d) The commission's chief counsel is the final authority for all legal interpretations related to statutes, rules, and commission policies on programs the commission administers.

(e) The commission shall:

(1) in consultation with the inspector general, set

clear objectives, priorities, and performance standards for the office of inspector general that emphasize:

(A) coordinating investigative efforts to aggressively recover money;

(B) allocating resources to cases that have the strongest supportive evidence and greatest potential to recover money; and

(C) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 544.0051; and

(2) train office of inspector general staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.

(f) The commission may require employees of health and human services agencies to provide assistance to the office of inspector general in connection with its duties relating to the investigation of fraud and abuse in the provision of health and human services. The office of inspector general is entitled to access to any information a health and human services agency maintains that is relevant to the office of inspector general's functions, including internal records.

(g) To the extent permitted by federal law, the executive commissioner, on the office of inspector general's behalf, shall adopt rules establishing:

(1) criteria for:

(A) initiating a full-scale fraud or abuse investigation;

(B) conducting the investigation;

(C) collecting evidence; and

(D) accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee; and

(2) minimum training requirements for Medicaid provider fraud or abuse investigators.

(h) The executive commissioner, in consultation with the office of inspector general, shall adopt rules establishing criteria:

(1) for opening a case;

(2) for prioritizing cases for the efficient management of the office of inspector general's workload, including rules that direct the office to prioritize:

(A) provider cases according to the highest potential for recovery or risk to this state as indicated through:

(i) the provider's volume of billings;

(ii) the provider's history of noncompliance with the law; and

(iii) identified fraud trends;

(B) recipient cases according to the highest potential for recovery and federal timeliness requirements; and

(C) internal affairs investigations according to the seriousness of the threat to recipient safety and the risk to program integrity in terms of the amount or scope of fraud, waste, and abuse the allegation that is the subject of the investigation poses; and

(3) to guide field investigators in closing a case that is not worth pursuing through a full investigation. (Gov. Code, Secs. 531.102(a-2), (a-3), (a-4), (a-7), (a-8), (b), (c), (d), (n), (p).)

Sec. 544.0103. OFFICE OF INSPECTOR GENERAL: GENERAL POWERS AND DUTIES. (a) The office of inspector general is responsible for:

(1) preventing, detecting, auditing, inspecting, reviewing, and investigating fraud, waste, and abuse in the provision and delivery of all health and human services in this state, including services provided:

(A) through any state-administered health or human services program that is wholly or partly federally funded; or

(B) by the Department of Family and Protective Services; and

(2) enforcing state law relating to providing those services.

(b) The commission may obtain any information or technology necessary for the office of inspector general to meet its responsibilities under this chapter or other law.

(c) The office of inspector general shall closely coordinate with the executive commissioner and relevant staff of health and human services system programs the office of inspector general oversees in performing functions relating to preventing fraud, waste, and abuse in the delivery of health and human services and enforcing state law relating to the provision of those

services, including audits, utilization reviews, provider education, and data analysis.

(d) The office of inspector general shall conduct audits, inspections, and investigations independent of the executive commissioner and the commission but shall rely on the coordination required by Subsection (c) to ensure that the office of inspector general has a thorough understanding of the health and human services system to knowledgeably and effectively perform its duties.

(e) The office of inspector general may:

(1) assess administrative penalties otherwise authorized by law on behalf of the commission or a health and human services agency;

(2) request that the attorney general obtain an injunction to prevent a person from disposing of an asset the office of inspector general identifies as potentially subject to recovery by the office of inspector general due to the person's fraud or abuse;

(3) provide for coordination between the office of inspector general and special investigative units formed by managed care organizations under Subchapter H or entities with which managed care organizations contract under that subchapter;

(4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from a health and human services agency;

(5) conduct investigations relating to the funds

described by Subdivision (4); and

(6) recommend policies to:

(A) promote the economical and efficient administration of the funds described by Subdivision (4); and

(B) prevent and detect fraud and abuse in the administration of those funds. (Gov. Code, Secs. 531.102(a), (a-5), (a-6), (h).)

Sec. 544.0104. EMPLOYMENT OF MEDICAL DIRECTOR. (a) The office of inspector general shall employ a medical director who:

(1) is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules the Texas Medical Board adopts under that subtitle; and

(2) preferably has significant knowledge of Medicaid.

(b) The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office of inspector general imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties. (Gov. Code, Sec. 531.102(l).)

Sec. 544.0105. EMPLOYMENT OF DENTAL DIRECTOR. (a) The office of inspector general shall employ a dental director who:

(1) is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules the State Board of Dental Examiners adopts under that subtitle; and

(2) preferably has significant knowledge of Medicaid.

(b) The dental director shall ensure that any investigative findings based on the necessity of dental services or the quality of

dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office of inspector general imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties. (Gov. Code, Sec. 531.102(m).)

Sec. 544.0106. CONTRACT FOR REVIEW OF INVESTIGATIVE FINDINGS BY QUALIFIED EXPERT. (a) If the commission does not receive any responsive bids under Chapter 2155 on a competitive solicitation for the services of a qualified expert to review investigative findings under Section 544.0104 or 544.0105 and the number of contracts to be awarded under this subsection is not otherwise limited, the commission may negotiate with and award a contract for the services to a qualified expert on the basis of:

(1) the contractor's agreement to a set fee, either as a range or lump-sum amount; and

(2) the contractor's affirmation and the office of inspector general's verification that the contractor possesses the necessary occupational licenses and experience.

(b) Notwithstanding Sections 2155.083 and 2261.051, a contract awarded under Subsection (a) is not subject to competitive advertising and proposal evaluation requirements. (Gov. Code, Secs. 531.102(m-1), (m-2).)

Sec. 544.0107. EMPLOYMENT OF PEACE OFFICERS. (a) The office of inspector general shall employ and commission not more than five peace officers at any given time to assist the office in carrying out the office's duties relating to the investigation of Medicaid fraud, waste, and abuse.

(b) A peace officer the office of inspector general employs

and commissions is administratively attached to the Department of Public Safety. The commission shall provide administrative support to the department as necessary to support the assignment of the peace officers.

(c) A peace officer the office of inspector general employs and commissions:

(1) is a peace officer for purposes of Article 2.12, Code of Criminal Procedure; and

(2) shall obtain the office of the attorney general's prior approval before carrying out any duties requiring peace officer status. (Gov. Code, Sec. 531.1022.)

Sec. 544.0108. INVESTIGATIVE PROCESS REVIEW. (a) Office of inspector general staff who are not directly involved in investigations the office conducts shall review the office's investigative process, including the office's use of sampling and extrapolation to audit provider records.

(b) The office of inspector general shall arrange for the Association of Inspectors General or a similar third party to conduct a peer review of the office's sampling and extrapolation techniques. Based on the review and generally accepted practices among other offices of inspectors general, the executive commissioner, in consultation with the office, shall by rule adopt sampling and extrapolation standards for the office's use in conducting audits. (Gov. Code, Secs. 531.102(r), (s).)

Sec. 544.0109. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Notwithstanding any other law, the office of inspector general may conduct a performance audit of any program or

project administered or agreement entered into by the commission or a health and human services agency, including an audit related to:

(1) the commission's or a health and human services agency's contracting procedures; or

(2) the commission's or a health and human services agency's performance.

(b) The office of inspector general shall coordinate all audit and oversight activities, including those relating to providers and including developing audit plans, risk assessments, and findings, with the commission to minimize duplicative activities. In coordinating the activities, the office shall:

(1) to determine whether to audit a Medicaid managed care organization, annually seek the commission's input and consider previous audits and on-site visits the commission made to determine whether to audit a Medicaid managed care organization; and

(2) request the results of an informal audit or on-site visit the commission performed that could inform the office's risk assessment when determining whether to conduct or the scope of an audit of a Medicaid managed care organization.

(c) In addition to the coordination required by Subsection (b), the office of inspector general shall coordinate the office's other audit activities with those of the commission, including developing audit plans, performing risk assessments, and reporting findings, to minimize duplicative audit activities. In coordinating audit activities with the commission under this subsection, the office shall:

(1) to determine whether to conduct a performance audit, seek the commission's input and consider previous audits the commission conducted; and

(2) request the results of an audit the commission conducted if those results could inform the office's risk assessment when determining whether to conduct or the scope of a performance audit.

(d) In accordance with Section 540.0057(b), the office of inspector general shall consult with the executive commissioner regarding the adoption of rules defining the office's role in and jurisdiction over, and the frequency of, audits of Medicaid managed care organizations that the office and commission conduct. (Gov. Code, Secs. 531.102(q), (v), (w), 531.1025.)

Sec. 544.0110. REPORTS ON AUDITS, INSPECTIONS, AND INVESTIGATIONS. (a) The office of inspector general shall prepare a final report on each audit, inspection, or investigation conducted under Section 544.0102, 544.0103, 544.0252(b), 544.0254, or 544.0257. The final report must include:

(1) a summary of the activities the office performed in conducting the audit, inspection, or investigation;

(2) a statement on whether the audit, inspection, or investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(b) A final report on an audit, inspection, or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit, inspection, or investigation remain confidential and not subject to required

disclosure in accordance with Section 544.0259(e).

(c) A confidential draft report on an audit, inspection, or investigation that concerns the death of a child may be shared with the Department of Family and Protective Services. A draft report that is shared with the Department of Family and Protective Services remains confidential and is not subject to disclosure under Chapter 552. (Gov. Code, Secs. 531.102(j), (k).)

Sec. 544.0111. COMPLIANCE WITH FEDERAL CODING GUIDELINES. (a) In this section, "federal coding guidelines" means the code sets and guidelines the United States Department of Health and Human Services adopts in accordance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

(b) The office of inspector general, including office staff and any third party with which the office contracts to perform coding services, and the commission's medical and utilization review appeals unit shall comply with federal coding guidelines, including guidelines for diagnosis-related group (DRG) validation and related audits. (Gov. Code, Sec. 531.1023.)

Sec. 544.0112. HOSPITAL UTILIZATION REVIEWS AND AUDITS: PROVIDER EDUCATION PROCESS. The executive commissioner, in consultation with the office of inspector general, shall develop by rule a process for the office, including office staff and any third party with which the office contracts to perform coding services, to communicate with and educate providers about the diagnosis-related group (DRG) validation criteria that the office uses in conducting hospital utilization reviews and audits. (Gov.

Code, Sec. 531.1024.)

Sec. 544.0113. PROGRAM EXCLUSIONS. The office of inspector general, in consultation with this state's Medicaid fraud control unit, shall establish guidelines under which program exclusions:

(1) may permissively be imposed on a provider; or

(2) shall automatically be imposed on a provider. (Gov. Code, Sec. 531.102(g)(7).)

Sec. 544.0114. REPORT. (a) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the commission's operation, the inspector general shall submit to the executive commissioner, the governor, and the legislature a report on:

(1) the office of inspector general's activities;

(2) the office's performance with respect to performance measures the executive commissioner establishes for the office;

(3) fraud trends the office has identified;

(4) any recommendations for policy changes to prevent or address fraud, waste, and abuse in the delivery of health and human services in this state; and

(5) the amount of money recovered during the preceding quarter as a result of investigations involving peace officers employed and commissioned by the office for each program for which the office has investigative authority.

(b) The office of inspector general shall publish each report required under this section on the office's Internet website. (Gov. Code, Secs. 531.102(t), (u).)

SUBCHAPTER D. MEDICAID PROVIDER CRIMINAL HISTORY RECORD INFORMATION AND ELIGIBILITY

Sec. 544.0151. DEFINITIONS. In this subchapter:

(1) "Health care professional" means an individual issued a license to engage in a health care profession.

(2) "License" means a license, certificate, registration, permit, or other authorization that:

(A) a licensing authority issues; and

(B) must be obtained before a person may practice or engage in a particular business, occupation, or profession.

(3) "Licensing authority" means a department, commission, board, office, or other state agency that issues a license.

(4) "Participating agency" means:

(A) the Medicaid fraud enforcement divisions of the office of the attorney general;

(B) each licensing authority with authority to issue a license to a health care professional or managed care organization that may participate in Medicaid; and

(C) the office of inspector general.

(5) "Provider" means a person that was or is approved by the commission to provide Medicaid services under a contract or provider agreement with the commission. (Gov. Code, Secs. 531.1011(10) (part), 531.1031(a)(1), (1-a), (1-b), (2), (3).)

Sec. 544.0152. EXCHANGE OF CRIMINAL HISTORY RECORD INFORMATION BETWEEN PARTICIPATING AGENCIES. (a) This section applies only to:

(1) criminal history record information a participating agency holds that relates to a health care professional; and

(2) information a participating agency holds that relates to a health care professional or managed care organization that is the subject of an investigation by a participating agency for alleged Medicaid fraud or abuse.

(b) A participating agency may submit to another participating agency a written request for information to which this section applies. The participating agency that receives the request shall provide the requesting agency with the requested information unless releasing the information:

(1) would jeopardize an ongoing investigation or prosecution by the participating agency that possesses the information; or

(2) is prohibited by other law.

(c) Notwithstanding any other law, a participating agency may enter into a memorandum of understanding or agreement with another participating agency for exchanging criminal history record information relating to a health care professional that both participating agencies are authorized access to under Chapter 411. Confidential criminal history record information in a participating agency's possession that is provided to another participating agency remains confidential while in the possession of the participating agency that receives the information.

(d) A participating agency that discovers information that may indicate fraud or abuse by a health care professional or managed

care organization may provide the information to any other participating agency unless the release of the information is prohibited by other law.

(e) If after receiving a request for information under Subsection (b) a participating agency determines that the agency is prohibited from releasing the information, the agency shall, not later than the 30th day after the date the agency received the request, inform the requesting agency of that determination in writing.

(f) Confidential information shared under this section is subject to the same confidentiality requirements and legal restrictions on access to the information that are imposed by law on the participating agency that originally obtained or collected the information. Sharing information under this section does not affect whether the information is subject to disclosure under Chapter 552.

(g) A participating agency that receives information from another participating agency under this section must obtain written permission from the agency that shared the information before using the information in a licensure or enforcement action.

(h) This section does not affect a participating agency's authority to exchange information under other law. (Gov. Code, Secs. 531.1031(b), (c), (c-1), (d), (e), (f), (g), (h).)

Sec. 544.0153. PROVIDER ELIGIBILITY FOR MEDICAID PARTICIPATION: CRIMINAL HISTORY RECORD INFORMATION. (a) The office of inspector general and each licensing authority that requires the submission of fingerprints to conduct a criminal

history record information check of a health care professional shall enter into a memorandum of understanding to ensure that only individuals who are licensed and in good standing as health care professionals participate as Medicaid providers. The memorandum under this section may be combined with a memorandum authorized under Section 544.0152(c) and must include a process by which:

(1) to determine a health care professional's eligibility to participate in Medicaid, the office may confirm with a licensing authority that the professional is licensed and in good standing; and

(2) the licensing authority immediately notifies the office if:

(A) a provider's license has been revoked or suspended; or

(B) the licensing authority has taken disciplinary action against a provider.

(b) To determine a health care professional's eligibility to participate as a Medicaid provider, the office of inspector general may not conduct a criminal history record information check of a health care professional who the office has confirmed under Subsection (a) is licensed and in good standing. This subsection does not prohibit the office from conducting a criminal history record information check of a provider that is required or appropriate for other reasons, including for conducting an investigation of fraud, waste, or abuse.

(c) To determine a provider's eligibility to participate in Medicaid and subject to Subsection (d), the office of inspector

general, after seeking public input, shall establish and the executive commissioner by rule shall adopt guidelines for evaluating criminal history record information of providers and potential providers. The guidelines must outline conduct, by provider type, that may be contained in criminal history record information that will result in excluding a person as a Medicaid provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided through Medicaid;

(2) the degree to which the person would interact with Medicaid recipients as a provider; and

(3) any previous evidence that the person engaged in Medicaid fraud, waste, or abuse.

(d) The guidelines adopted under Subsection (c) may not impose stricter standards for an individual's eligibility to participate in Medicaid than a licensing authority described by Subsection (a) requires for the individual to engage in a health care profession without restriction in this state.

(e) The office of inspector general and the commission shall use the guidelines the executive commissioner adopts under Subsection (c) to determine whether a Medicaid provider continues to be eligible to participate as a Medicaid provider.

(f) The provider enrollment contractor, if applicable, and a Medicaid managed care organization shall defer to the office of inspector general on whether an individual's criminal history record information precludes the individual from participating as a Medicaid provider. (Gov. Code, Secs. 531.1032(a), (b), (c), as

added Acts 84th Leg., R.S., Ch. 945, (d), (e), (f).)

Sec. 544.0154. MONITORING OF CERTAIN FEDERAL DATABASES. The office of inspector general shall routinely check appropriate federal databases, including databases referenced in 42 C.F.R. Section 455.436, to ensure that a person excluded by the federal government from participating in Medicaid or Medicare is not participating as a Medicaid provider. (Gov. Code, Sec. 531.1033.)

Sec. 544.0155. PERIOD FOR DETERMINING PROVIDER ELIGIBILITY FOR MEDICAID. (a) Not later than the 10th day after the date the office of inspector general receives a health care professional's complete application seeking to participate in Medicaid, the office shall inform the commission or the health care professional, as appropriate, of the office's determination of whether the health care professional should be denied participation in Medicaid based on:

(1) information concerning the health care professional's licensing status obtained as described by Section 544.0153(a);

(2) information contained in the criminal history record information check that is evaluated in accordance with guidelines the executive commissioner adopts under Section 544.0153(c);

(3) a review of federal databases under Section 544.0154;

(4) the pendency of an open investigation by the office; or

(5) any other reason the office determines

appropriate.

(b) Completion of an on-site visit of a health care professional during the period prescribed by Subsection (a) is not required.

(c) The office of inspector general shall develop performance metrics to measure the length of time for conducting a determination described by Subsection (a) with respect to:

(1) applications that are complete when submitted; and

(2) all other applications. (Gov. Code, Sec. 531.1034.)

SUBCHAPTER E. PREVENTION AND DETECTION OF FRAUD, WASTE, AND ABUSE

Sec. 544.0201. SELECTION AND REVIEW OF MEDICAID CLAIMS TO DETERMINE RESOURCE ALLOCATION. (a) The commission shall annually select and review a random, statistically valid sample of all claims for Medicaid reimbursement, including under the vendor drug program, for potential cases of fraud, waste, or abuse.

(b) In conducting the annual review of claims, the commission may directly contact a recipient by telephone, in person, or both to verify that the services for which a provider submitted a reimbursement claim were actually provided to the recipient.

(c) Based on the results of the annual review of claims, the commission shall determine the types of claims toward which commission resources for fraud and abuse detection should be primarily directed.

(d) Absent an allegation of fraud, waste, or abuse, the commission may conduct an annual review of claims only after the

commission completes the prior year's annual review of claims. (Gov. Code, Sec. 531.109.)

Sec. 544.0202. DUTIES RELATED TO FRAUD PREVENTION. (a) The office of inspector general shall compile and disseminate accurate information and statistics relating to:

(1) fraud prevention; and

(2) post-fraud referrals received and accepted or rejected from the commission's or a health and human services agency's case management system.

(b) The commission shall:

(1) aggressively publicize successful fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases; and

(2) ensure that the commission or a health and human services agency maintains and promotes a toll-free telephone hotline for reporting suspected fraud in programs the commission or a health and human services agency administers.

(c) The commission shall develop a cost-effective method to identify applicants for public assistance in counties bordering other states and in metropolitan areas the commission selects who are already receiving benefits in other states. If economically feasible, the commission may develop a computerized matching system.

(d) The commission shall:

(1) verify automobile information that is used as eligibility criteria; and

(2) establish with the Texas Department of Criminal

Justice a computerized matching system to prevent an incarcerated individual from illegally receiving public assistance benefits the commission administers.

(e) Not later than October 1 of each year, the commission shall submit to the governor and Legislative Budget Board a report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas Department of Criminal Justice. The commission may consolidate the report with any other report relating to the same subject matter the commission is required to submit under other law.

(f) The commission and each health and human services agency that administers part of Medicaid shall maintain statistics on the number, type, and disposition of fraudulent benefits claims submitted under the part of the program the agency administers. (Gov. Code, Secs. 531.0215, 531.108.)

Sec. 544.0203. FRAUD, WASTE, AND ABUSE DETECTION TRAINING. (a) The commission shall develop and implement a program to provide annual training on identifying potential cases of Medicaid fraud, waste, or abuse to:

(1) contractors who process Medicaid claims; and

(2) appropriate health and human services agency staff.

(b) The training must include clear criteria that specify:

(1) the circumstances under which a person should refer a potential case to the commission; and

(2) the time by which a referral should be made. (Gov.

Code, Sec. 531.105(a).)

Sec. 544.0204. HEALTH AND HUMAN SERVICES AGENCY MEDICAID FRAUD, WASTE, AND ABUSE DETECTION GOAL. (a) The health and human services agencies, in cooperation with the commission, shall periodically set a goal for the number of potential cases of Medicaid fraud, waste, or abuse that each agency will attempt to identify and refer to the commission.

(b) The commission shall include in the report required by Section 544.0051(f) information on the health and human services agencies' goals and the success of each agency in meeting the agency's goal. (Gov. Code, Sec. 531.105(b).)

Sec. 544.0205. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may grant an award to an individual who reports activity that constitutes fraud or abuse of Medicaid funds or who reports Medicaid overcharges if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity the individual reported.

(b) The commission shall determine the amount of an award. The award may not exceed five percent of the amount of the administrative penalty imposed under Section 32.039, Human Resources Code, that resulted from the individual's disclosure. In determining the award amount, the commission:

(1) shall consider how important the disclosure is in

ensuring the fiscal integrity of Medicaid; and

(2) may consider whether the individual participated in the fraud, abuse, or overcharge.

(c) A person who brings an action under Subchapter C, Chapter 36, Human Resources Code, is not eligible for an award under this section. (Gov. Code, Sec. 531.101.)

SUBCHAPTER F. INVESTIGATION OF FRAUD, WASTE, ABUSE, AND OVERCHARGES

Sec. 544.0251. CLAIMS CRITERIA REQUIRING COMMENCEMENT OF INVESTIGATION. The executive commissioner, in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office of inspector general to begin an investigation. (Gov. Code, Sec. 531.102(e).)

Sec. 544.0252. CIRCUMSTANCES REQUIRING COMMENCEMENT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE. (a) The office of inspector general shall conduct a preliminary investigation of an allegation of fraud or abuse against a provider that the commission receives from any source to determine whether there is a sufficient basis to warrant a full investigation. The office must begin a preliminary investigation not later than the 30th day and complete the preliminary investigation not later than the 45th day after the date the commission receives or identifies an allegation of fraud or abuse.

(b) The office of inspector general shall conduct a preliminary investigation as provided by Section 544.0253 of a complaint or allegation of Medicaid fraud or abuse that the commission receives from any source to determine whether there is a

sufficient basis to warrant a full investigation. The office must begin a preliminary investigation not later than the 30th day and complete the preliminary investigation not later than the 45th day after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. (Gov. Code, Secs. 531.102(f)(1), 531.118(b).)

Sec. 544.0253. CONDUCT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE. In conducting a preliminary investigation of an allegation of fraud or abuse and before the allegation may proceed to a full investigation, the office of inspector general must:

(1) review the allegation and all facts and evidence relating to the allegation; and

(2) prepare a preliminary investigation report that documents:

(A) the allegation;

(B) the evidence the office reviewed, if available;

(C) the procedures the office used to conduct the preliminary investigation;

(D) the preliminary investigation findings; and

(E) the office's determination of whether a full investigation is warranted. (Gov. Code, Sec. 531.118(c).)

Sec. 544.0254. FINDING OF CERTAIN MEDICAID FRAUD OR ABUSE FOLLOWING PRELIMINARY INVESTIGATION: CRIMINAL REFERRAL OR FULL INVESTIGATION. If the findings of a preliminary investigation give the office of inspector general reason to believe that an incident

of Medicaid fraud or abuse involving possible criminal conduct has occurred, not later than the 30th day after completing the preliminary investigation, the office, as appropriate:

(1) must refer the case to this state's Medicaid fraud control unit if a provider is suspected of fraud or abuse involving criminal conduct, provided that the criminal referral does not preclude the office from continuing the office's investigation of the provider that may lead to the imposition of appropriate administrative or civil sanctions; or

(2) may conduct a full investigation, subject to Section 544.0253, if there is reason to believe that a recipient has defrauded Medicaid. (Gov. Code, Sec. 531.102(f)(2).)

Sec. 544.0255. IMMEDIATE CRIMINAL REFERRAL UNDER CERTAIN CIRCUMSTANCES. If the office of inspector general learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to this state's Medicaid fraud control unit. The criminal referral does not preclude the office from continuing the office's investigation of the provider that may lead to the imposition of appropriate administrative or civil sanctions. (Gov. Code, Sec. 531.102(g)(1).)

Sec. 544.0256. CONTINUATION OF PAYMENT HOLD FOLLOWING REFERRAL TO LAW ENFORCEMENT AGENCY. (a) If this state's Medicaid fraud control unit or another law enforcement agency accepts a fraud referral from the office of inspector general for investigation, a payment hold based on a credible allegation of fraud may be continued until:

(1) the investigation and any associated enforcement proceedings are complete; or

(2) the Medicaid fraud control unit, another law enforcement agency, or another prosecuting authority determines that there is insufficient evidence of fraud by the provider that is the subject of the investigation.

(b) If this state's Medicaid fraud control unit or another law enforcement agency declines to accept a fraud referral from the office of inspector general for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless:

(1) the commission has alternative federal or state authority under which the commission may impose a payment hold; or

(2) the office makes a fraud referral to another law enforcement agency.

(c) On a quarterly basis, the office of inspector general shall request a certification from this state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter the unit or agency accepted on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of a payment hold is warranted. (Gov. Code, Secs. 531.118(d), (e), (f).)

Sec. 544.0257. COMPLETION OF FULL INVESTIGATION OF ALLEGED MEDICAID FRAUD OR ABUSE. (a) The office of inspector general shall complete a full investigation of a complaint or allegation of Medicaid fraud or abuse against a provider not later than the 180th day after the date the full investigation begins unless the office determines that more time is needed to complete the investigation.

(b) Except as otherwise provided by this subsection, if the office of inspector general determines that more time is needed to complete a full investigation, the office shall provide notice to the provider who is the subject of the investigation stating that the length of the investigation will exceed 180 days and specifying the reasons why the office was unable to complete the investigation within the 180-day period. The office is not required to provide notice to the provider under this subsection if the office determines that providing notice would jeopardize the investigation. (Gov. Code, Sec. 531.102(f-1).)

Sec. 544.0258. MEMORANDUM OF UNDERSTANDING FOR ASSISTING ATTORNEY GENERAL INVESTIGATIONS RELATED TO MEDICAID. (a) The commission and the attorney general shall enter into a memorandum of understanding under which the commission shall:

(1) provide investigative support to the attorney general as required in connection with cases under Subchapter B, Chapter 36, Human Resources Code; and

(2) assist in performing preliminary investigations and ongoing investigations for actions the attorney general prosecutes under Subchapter C, Chapter 36, Human Resources Code.

(b) The memorandum of understanding must specify the type, scope, and format of the investigative support the commission provides to the attorney general.

(c) The memorandum of understanding must ensure that barriers to direct fraud referrals to this state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the Medicaid

fraud control unit are not imposed. (Gov. Code, Sec. 531.104.)

Sec. 544.0259. SUBPOENAS. (a) The office of inspector general may issue a subpoena in connection with an investigation the office conducts. The subpoena may be:

(1) issued to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence in this state; and

(2) served personally or by certified mail.

(b) The office of inspector general, acting through the attorney general, may file suit in a district court in this state to enforce a subpoena with which a person fails to comply. On finding that good cause exists for issuing the subpoena, the court shall order the person to comply with the subpoena. The court may punish a person who fails to obey the court order.

(c) Reimbursement of the expenses of a witness whose attendance is compelled under this section is governed by Section 2001.103.

(d) The office of inspector general shall pay a reasonable fee for subpoenaed photocopies. The fee may not exceed the amount the office of inspector general may charge for copies of its records.

(e) Except for the disclosure of information to the state auditor's office, law enforcement agencies, and other entities as permitted by other law, all information and materials subpoenaed or compiled by the office of inspector general in connection with an audit, inspection, or investigation or by the office of the attorney general in connection with a Medicaid fraud investigation

are:

(1) confidential and not subject to disclosure under Chapter 552; and

(2) not subject to disclosure, discovery, subpoena, or other means of legal compulsion for release to anyone other than the office of inspector general, the attorney general, or the office's or attorney general's employees or agents involved in the audit, inspection, or investigation.

(f) A person who receives information under Subsection (e) may disclose the information only in accordance with Subsection (e) and in a manner that is consistent with the authorized purpose for which the person first received the information. (Gov. Code, Sec. 531.1021.)

SUBCHAPTER G. PAYMENT HOLDS

Sec. 544.0301. IMPOSITION OF PAYMENT HOLD. (a) As authorized by state and federal law and except as provided by Subsections (d) and (e), the office of inspector general shall impose, as a serious enforcement tool to mitigate ongoing financial risk to this state, a payment hold on claims for reimbursement submitted by a provider only:

(1) to compel production of records;

(2) when requested by this state's Medicaid fraud control unit; or

(3) on the determination that a credible allegation of fraud exists, subject to Sections 544.0104(b) and 544.0105(b), as applicable.

(b) The office of inspector general shall impose a payment

hold under this section without prior notice, and the payment hold takes effect immediately.

(c) The office of inspector general shall, in consultation with this state's Medicaid fraud control unit, establish guidelines regarding the imposition of payment holds authorized under this section.

(d) On the determination that a credible allegation of fraud exists and in accordance with 42 C.F.R. Sections 455.23(e) and (f), the office of inspector general may find that good cause exists to not impose a payment hold, to not continue a payment hold, to impose a payment hold only in part, or to convert a payment hold imposed in whole to one imposed only in part if:

(1) law enforcement officials specifically requested that a payment hold not be imposed because a payment hold would compromise or jeopardize an investigation;

(2) available remedies implemented by this state other than a payment hold would more effectively or quickly protect Medicaid funds;

(3) the office of inspector general determines, based on the submission of written evidence by the provider who is the subject of the payment hold, that the payment hold should be removed;

(4) Medicaid recipients' access to items or services would be jeopardized by a full or partial payment hold because the provider who is the subject of the payment hold:

(A) is the sole community physician or the sole source of essential specialized services in a community; or

(B) serves a large number of Medicaid recipients within a designated medically underserved area;

(5) the attorney general declines to certify that a matter continues to be under investigation; or

(6) the office of inspector general determines that a full or partial payment hold is not in the best interests of Medicaid.

(e) Unless the office of inspector general has evidence that a provider materially misrepresented documentation relating to medically necessary services, the office of inspector general may not impose a payment hold on claims for reimbursement the provider submits for those services if the provider obtained prior authorization from the commission or a commission contractor. (Gov. Code, Secs. 531.102(g)(2) (part), (7-a), (8), (9).)

Sec. 544.0302. NOTICE. (a) The office of inspector general shall notify a provider of a payment hold imposed under Section 544.0301(a) in accordance with 42 C.F.R. Section 455.23(b) and, except as provided by that regulation, not later than the fifth day after the date the office imposes the payment hold.

(b) In addition to the requirements of 42 C.F.R. Section 455.23(b), the payment hold notice must also include:

(1) the specific basis for the hold, including:

(A) the claims supporting the allegation at that point in the investigation;

(B) a representative sample of any documents that form the basis for the hold; and

(C) a detailed summary of the office of inspector

general's evidence relating to the allegation;

(2) a description of administrative and judicial due process rights and remedies, including:

(A) the provider's option to seek informal resolution;

(B) the provider's right to seek a formal administrative appeal hearing; or

(C) the provider's ability to seek both an informal resolution and a formal administrative appeal hearing; and

(3) a detailed timeline for the provider to pursue the rights and remedies described in Subdivision (2). (Gov. Code, Sec. 531.102(g)(2) (part).)

Sec. 544.0303. EXPEDITED ADMINISTRATIVE HEARING. (a) A provider subject to a payment hold imposed under Section 544.0301(a), other than a hold this state's Medicaid fraud control unit requested, must request an expedited administrative hearing not later than the 10th day after the date the provider receives notice of the hold from the office of inspector general under Section 544.0302.

(b) On a provider's timely written request, the office of inspector general shall, not later than the third day after the date the office of inspector general receives the request, file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the payment hold for which the provider submitted the request.

(c) Not later than the 45th day after the date the State Office of Administrative Hearings receives a request from the

office of inspector general for an expedited administrative hearing, the State Office of Administrative Hearings shall hold the hearing.

(d) In an expedited administrative hearing held under this section:

(1) the provider and the office of inspector general are each limited to four hours of testimony, excluding time for responding to questions from the administrative law judge;

(2) the provider and the office of inspector general are each entitled to two continuances under reasonable circumstances; and

(3) the office of inspector general is required to show probable cause that:

(A) the credible allegation of fraud that is the basis of the imposed payment hold has an indicia of reliability; and

(B) continuing to pay the provider presents an ongoing significant financial risk to this state and a threat to the integrity of Medicaid.

(e) The office of inspector general is responsible for the costs of the expedited administrative hearing, but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(f) In the expedited administrative hearing, the administrative law judge shall decide whether the payment hold should continue but may not adjust the amount or percent of the payment hold.

(g) Notwithstanding any other law, including Section

2001.058(e), the administrative law judge's decision in the expedited administrative hearing is final and may not be appealed. (Gov. Code, Secs. 531.102(g)(3), (4), (5).)

Sec. 544.0304. INFORMAL RESOLUTION. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules that allow a provider subject to a payment hold imposed under Section 544.0301(a), other than a hold this state's Medicaid fraud control unit requested, to seek an informal resolution of the issues the office identifies in the notice provided under Section 544.0302.

(b) A provider must request an initial informal resolution meeting under this section not later than the deadline prescribed by Section 544.0303(a) for requesting an expedited administrative hearing.

(c) On receipt of a timely request, the office of inspector general shall:

(1) decide whether to grant the provider's request for an initial informal resolution meeting; and

(2) if the office decides to grant the request, schedule the initial informal resolution meeting and give notice to the provider of the time and place of the meeting.

(d) A provider may request a second informal resolution meeting after the date of an initial informal resolution meeting. On receipt of a timely request, the office of inspector general shall:

(1) decide whether to grant the provider's request for a second informal resolution meeting; and

(2) if the office decides to grant the request, schedule the second informal resolution meeting and give notice to the provider of the time and place of the second meeting.

(e) Before a second informal resolution meeting is held, a provider must have an opportunity to provide additional information for the office of inspector general to consider.

(f) A provider's decision to seek an informal resolution under this section does not extend the time by which the provider must request an expedited administrative hearing under Section 544.0303(a). The informal resolution process shall run concurrently with the administrative hearing process, and the informal resolution process shall be discontinued when the State Office of Administrative Hearings issues a final determination on the payment hold. (Gov. Code, Sec. 531.102(g)(6).)

Sec. 544.0305. WEBSITE POSTING. The office of inspector general shall post on the office's publicly available Internet website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider under this subchapter. (Gov. Code, Sec. 531.119.)

SUBCHAPTER H. MANAGED CARE ORGANIZATION PREVENTION AND INVESTIGATION OF FRAUD AND ABUSE

Sec. 544.0351. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program, including Medicaid and the child health plan program. (Gov. Code, Sec. 531.113(a)

(part).)

Sec. 544.0352. SPECIAL INVESTIGATIVE UNIT OR CONTRACTED ENTITY TO INVESTIGATE FRAUD AND ABUSE. (a) A managed care organization to which this subchapter applies shall:

(1) establish and maintain a special investigative unit within the organization to investigate fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers; or

(2) contract with another entity to investigate fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers.

(b) A managed care organization that contracts for the investigation of fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers under Subsection (a)(2) shall file with the office of inspector general:

(1) a copy of the written contract;

(2) the names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the organization contracts; and

(3) a description of the qualifications of the principals of the entity with which the organization contracts. (Gov. Code, Secs. 531.113(a) (part), (c).)

Sec. 544.0353. FRAUD AND ABUSE PREVENTION PLAN. (a) A managed care organization to which this subchapter applies shall:

(1) adopt a plan to prevent and reduce fraud and abuse; and

(2) annually file the plan with the office of inspector general for approval.

(b) The plan must include:

(1) a description of the organization's procedures for:

(A) detecting and investigating possible acts of fraud or abuse;

(B) mandatory reporting of possible acts of fraud or abuse to the office of inspector general; and

(C) educating and training personnel to prevent fraud and abuse;

(2) the name, address, telephone number, and fax number of the individual responsible for carrying out the plan;

(3) a description or chart outlining the organizational arrangement of the organization's personnel responsible for investigating and reporting possible acts of fraud or abuse;

(4) a detailed description of the results of fraud and abuse investigations the organization's special investigative unit or the entity with which the organization contracts under Section 544.0352(a)(2) conducts; and

(5) provisions for maintaining the confidentiality of any patient information relevant to a fraud or abuse investigation. (Gov. Code, Sec. 531.113(b).)

Sec. 544.0354. ASSISTANCE AND OVERSIGHT BY OFFICE OF INSPECTOR GENERAL. (a) The office of inspector general may review the records of a managed care organization to which this subchapter

applies to determine compliance with this subchapter.

(b) The office of inspector general, in consultation with the commission, shall:

(1) investigate, including by means of regular audits, possible fraud, waste, and abuse by managed care organizations to which this subchapter applies;

(2) establish requirements for providing training to and regular oversight of special investigative units established by managed care organizations under Section 544.0352(a)(1) and entities with which managed care organizations contract under Section 544.0352(a)(2);

(3) establish requirements for approving plans to prevent and reduce fraud and abuse that managed care organizations adopt under Section 544.0353;

(4) evaluate statewide Medicaid fraud, waste, and abuse trends and communicate those trends to special investigative units and contracted entities to determine the prevalence of those trends;

(5) as needed, assist managed care organizations in discovering or investigating fraud, waste, and abuse; and

(6) provide ongoing, regular training to appropriate commission and office staff concerning fraud, waste, and abuse in a managed care setting, including training relating to fraud, waste, and abuse by service providers, recipients, and enrollees. (Gov. Code, Secs. 531.113(d), (d-1).)

Sec. 544.0355. RULES. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt

rules as necessary to accomplish the purposes of this subchapter, including rules defining the investigative role of the office with respect to the investigative role of special investigative units established by managed care organizations under Section 544.0352(a)(1) and entities with which managed care organizations contract under Section 544.0352(a)(2).

(b) The rules must specify the office of inspector general's role in:

(1) reviewing the findings of special investigative units and contracted entities;

(2) investigating cases in which the overpayment amount sought to be recovered exceeds $100,000; and

(3) investigating providers who are enrolled in more than one managed care organization. (Gov. Code, Sec. 531.113(e).)

SUBCHAPTER I. FINANCIAL ASSISTANCE FRAUD

Sec. 544.0401. DEFINITION. In this subchapter, "financial assistance" means assistance provided under the financial assistance program under Chapter 31, Human Resources Code. (Gov. Code, Sec. 531.114(a) (part).)

Sec. 544.0402. FALSE OR MISLEADING INFORMATION RELATED TO FINANCIAL ASSISTANCE ELIGIBILITY. To establish or maintain the eligibility of an individual and the individual's family for financial assistance or to increase or prevent a reduction in the amount of that assistance, an individual may not intentionally:

(1) make a statement that the individual knows is false or misleading;

(2) misrepresent, conceal, or withhold a fact; or

(3) knowingly misrepresent a statement as being true. (Gov. Code, Sec. 531.114(a) (part).)

Sec. 544.0403. COMMISSION ACTION FOLLOWING DETERMINATION OF VIOLATION. If after an investigation the commission determines that an individual violated Section 544.0402, the commission shall:

(1) notify the individual of the alleged violation not later than the 30th day after the date the commission completes the investigation and provide the individual with an opportunity for a hearing on the matter; or

(2) refer the matter to the appropriate prosecuting attorney for prosecution. (Gov. Code, Sec. 531.114(b).)

Sec. 544.0404. INELIGIBILITY FOR FINANCIAL ASSISTANCE FOLLOWING VIOLATION; RIGHT TO APPEAL. (a) An individual is not eligible to receive financial assistance as provided by Subsection (b) if the individual waives the right to a hearing or a hearing officer at an administrative hearing held under this subchapter determines that the individual violated Section 544.0402. An individual who a hearing officer determines violated Section 544.0402 may appeal that determination by filing a petition in the district court in the county in which the violation occurred not later than the 30th day after the date the hearing officer makes the determination.

(b) An individual determined under Subsection (a) to have violated Section 544.0402 is not eligible for financial assistance:

(1) before the first anniversary of the date of that determination if the individual has no previous violations; and

(2) permanently if the individual was previously

determined to have committed a violation.

(c) An individual who is convicted of a state or federal offense for conduct described by Section 544.0402 or who is granted deferred adjudication or placed on community supervision for that conduct is permanently disqualified from receiving financial assistance. (Gov. Code, Secs. 531.114(c), (d), (e).)

Sec. 544.0405. HOUSEHOLD ELIGIBILITY FOR FINANCIAL ASSISTANCE NOT AFFECTED. This subchapter does not affect the eligibility for financial assistance of any other member of the household of an individual who is ineligible as a result of Section 544.0404(b) or (c). (Gov. Code, Sec. 531.114(f).)

Sec. 544.0406. RULES. The executive commissioner shall adopt rules as necessary to implement this subchapter. (Gov. Code, Sec. 531.114(g).)

SUBCHAPTER J. USE OF TECHNOLOGY TO DETECT, INVESTIGATE, AND PREVENT FRAUD, ABUSE, AND OVERCHARGES

Sec. 544.0451. LEARNING, NEURAL NETWORK, OR OTHER TECHNOLOGY RELATING TO MEDICAID. (a) The commission shall:

(1) use learning, neural network, or other technology to identify and deter Medicaid fraud throughout this state; and

(2) require each health and human services agency that performs any part of Medicaid to participate in implementing and using the technology.

(b) The commission shall contract with a private or public entity to develop and implement the technology. The commission may require the contracted entity to install and operate the technology at locations the commission specifies, including commission

offices.

(c) The commission shall maintain all information necessary to apply the technology to claims data covering a period of at least two years. The data used for data processing shall be maintained as an independent subset for security purposes.

(d) The commission shall refer cases the technology identifies to the office of inspector general or the office of the attorney general, as appropriate.

(e) Each month, the technology must match vital statistics unit death records with Medicaid claims filed by a provider. If the commission determines that a provider filed a claim for services provided to an individual after the individual's date of death, as determined by the vital statistics unit death records, the commission shall refer the case to the office of inspector general for investigation. (Gov. Code, Sec. 531.106.)

Sec. 544.0452. MEDICAID FRAUD INVESTIGATION TRACKING SYSTEM. (a) The commission shall use an automated fraud investigation tracking system through the office of inspector general to monitor the progress of an investigation of suspected fraud, abuse, or insufficient quality of care in Medicaid.

(b) For each case of suspected fraud, abuse, or insufficient quality of care the technology required under Section 544.0451 identifies, the automated fraud investigation tracking system must:

(1) receive from the technology electronically transferred records relating to the case;

(2) record the details and monitor the status of an

investigation of the case, including maintaining a record of the beginning and completion dates for each phase of the case investigation;

(3) generate documents and reports related to the status of the case investigation; and

(4) generate standard letters to a provider regarding the status or outcome of an investigation.

(c) The commission shall require each health and human services agency that performs any part of Medicaid to participate in implementing and using the automated fraud investigation tracking system. (Gov. Code, Sec. 531.1061.)

Sec. 544.0453. MEDICAID FRAUD DETECTION TECHNOLOGY. The commission may contract with a contractor who specializes in developing technology capable of identifying fraud patterns exhibited by Medicaid recipients to:

(1) develop and implement the fraud detection technology; and

(2) determine whether a fraud pattern by Medicaid recipients is present in the recipients' eligibility files the commission maintains. (Gov. Code, Sec. 531.111.)

Sec. 544.0454. DATA MATCHING AGAINST FEDERAL FELON LIST. The commission shall develop and implement a system to cross-reference the list of fugitive felons the federal government maintains with data collected for the following programs:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) nutritional assistance programs under Chapter 33, Human Resources Code;

(5) long-term care services, as defined by Section 22.0011, Human Resources Code;

(6) community-based support services identified or provided in accordance with Subchapter D, Chapter 546; and

(7) other health and human services programs, as appropriate. (Gov. Code, Sec. 531.115.)

Sec. 544.0455. ELECTRONIC DATA MATCHING. (a) In this section, "public assistance program" includes:

(1) Medicaid;

(2) the financial assistance program under Chapter 31, Human Resources Code; and

(3) a nutritional assistance program under Chapter 33, Human Resources Code, including the supplemental nutrition assistance program under that chapter.

(b) At least quarterly, the commission shall conduct electronic data matches for a recipient of public assistance program benefits to verify the identity, income, employment status, and other factors that affect the recipient's eligibility. To verify a recipient's eligibility, the electronic data matching must match information the recipient provided with information contained in databases appropriate federal and state agencies maintain.

(c) Health and human services agencies shall cooperate with the commission by providing data or any other assistance necessary

to conduct the electronic data matches required by this section.

(d) The commission shall enter into a memorandum of understanding with each state agency from which data is required to conduct electronic data matches under this section and Section 544.0456.

(e) The commission may contract with a public or private entity to conduct the electronic data matches required by this section.

(f) The executive commissioner shall establish procedures by which the commission or a health and human services agency the commission designates verifies the electronic data matches the commission conducts under this section. Not later than the 20th day after the date an electronic data match is verified, the commission shall remove from eligibility a recipient who is determined to be ineligible for a public assistance program. (Gov. Code, Sec. 531.110.)

Sec. 544.0456. METHODS TO REDUCE FRAUD, WASTE, AND ABUSE IN CERTAIN PUBLIC ASSISTANCE PROGRAMS. (a) In this section:

(1) "Financial assistance benefits" means monetary payments under:

(A) the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code; or

(B) this state's temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Supplemental nutrition assistance benefits"

means monetary payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code.

(b) To the extent not otherwise provided by this subtitle or Title 2, Human Resources Code, and in accordance with this section, the commission shall develop and implement methods for reducing fraud, waste, and abuse in public assistance programs.

(c) On a monthly basis, the commission shall:

(1) conduct electronic data matches with the Texas Lottery Commission to determine whether a recipient of supplemental nutrition assistance benefits or a recipient's household member received reportable lottery winnings;

(2) use the database system developed under Section 532.0201 to:

(A) match vital statistics unit death records with a list of individuals eligible for financial assistance or supplemental nutrition assistance benefits; and

(B) ensure that any individual receiving assistance under either program who is discovered to be deceased has the individual's eligibility for assistance promptly terminated; and

(3) review the out-of-state electronic benefit transfer card transactions a recipient of supplemental nutrition assistance benefits made to determine whether those transactions indicate a possible change in the recipient's residence.

(d) The commission shall immediately review a recipient's eligibility for public assistance benefits if the commission discovers information under this section that affects the

recipient's eligibility.

(e) A recipient presumptively commits a program violation if the recipient fails to disclose lottery winnings that are required to be reported to the commission under a public assistance program.

(f) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 531.1081.)

SUBCHAPTER K. RECOVERY AND RECOUPMENT IN CASES OF FRAUD, ABUSE, AND OVERCHARGES

Sec. 544.0501. RECOVERY MONITORING SYSTEM. (a) The commission shall use an automated recovery monitoring system to monitor the collections process for a settled case of fraud, abuse, or insufficient quality of care in Medicaid.

(b) The recovery monitoring system must:

(1) monitor the collection of funds resulting from settled cases, including by recording:

(A) monetary payments received from a provider who agreed to a monetary payment plan; and

(B) deductions taken through the recoupment program from subsequent Medicaid claims the provider filed; and

(2) provide immediate notice of a provider who:

(A) agreed to a monetary payment plan or to deductions through the recoupment program from subsequent Medicaid claims; and

(B) fails to comply with the settlement agreement, including by providing notice of a provider who:

(i) does not make a scheduled payment; or

(ii) pays less than a scheduled amount. (Gov. Code, Sec. 531.1062.)

Sec. 544.0502. PAYMENT RECOVERY EFFORTS BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) In this section, "contracted entity" means an entity with which a managed care organization contracts under Section 544.0352(a)(2).

(b) A managed care organization or the organization's contracted entity that discovers Medicaid or child health plan program fraud or abuse shall:

(1) immediately submit written notice to the office of inspector general and the office of the attorney general that:

(A) is in the form and manner the office of inspector general prescribes; and

(B) contains a detailed description of:

(i) the fraud or abuse; and

(ii) each payment made to a provider as a result of the fraud or abuse;

(2) subject to Subsection (c), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with rules the executive commissioner adopts.

(c) A managed care organization or the organization's contracted entity may not engage in payment recovery efforts if:

(1) the amount sought to be recovered under Subsection (b)(2) exceeds $100,000; and

(2) not later than the 10th business day after the date

the organization or entity notifies the office of inspector general and the office of the attorney general under Subsection (b)(1), the organization or entity receives a notice from either office indicating that the organization or entity is not authorized to proceed with recovery efforts.

(d) A managed care organization may retain one-half of any money the organization or the organization's contracted entity recovers under Subsection (b)(2). The organization shall remit the remaining amount of recovered money to the office of inspector general for deposit to the credit of the general revenue fund.

(e) If the office of inspector general notifies a managed care organization in accordance with Subsection (c), proceeds with recovery efforts, and recovers all or part of the payments the organization identified as required by Subsection (b)(1), the organization is entitled to one-half of the amount recovered for each payment the organization identified after any applicable federal share is deducted. The organization may not receive more than one-half of the total amount recovered after any applicable federal share is deducted.

(f) Notwithstanding this section, if the office of inspector general discovers Medicaid or child health plan program fraud, waste, or abuse in performing the office's duties, the office of inspector general may recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this chapter. All payments the office of inspector general recovers under this subsection shall be deposited to the credit of the general revenue fund.

(g) The office of inspector general shall coordinate with appropriate managed care organizations to ensure that the office of inspector general and an organization or an organization's contracted entity do not both begin payment recovery efforts under this section for the same case of fraud, waste, or abuse.

(h) A managed care organization shall submit a quarterly report to the office of inspector general detailing the amount of money the organization recovered under Subsection (b)(2).

(i) The executive commissioner shall adopt rules necessary to implement this section, including rules establishing due process procedures that a managed care organization must follow when engaging in payment recovery efforts as provided by this section. In adopting the rules establishing due process procedures, the executive commissioner shall require that a managed care organization or an organization's contracted entity that engages in payment recovery efforts as provided by this section and Section 544.0503 provide to a provider required to use electronic visit verification:

(1) written notice of the organization's intent to recoup overpayments in accordance with Section 544.0503; and

(2) at least 60 days to cure any defect in a claim before the organization may begin efforts to collect overpayments. (Gov. Code, Sec. 531.1131.)

Sec. 544.0503. PROCESS FOR MANAGED CARE ORGANIZATIONS TO RECOUP OVERPAYMENTS RELATED TO ELECTRONIC VISIT VERIFICATION TRANSACTIONS. (a) The executive commissioner shall adopt rules that standardize the process by which a managed care organization

collects alleged overpayments that are made to a health care provider and discovered through an audit or investigation the organization conducts secondary to missing electronic visit verification information. The rules must require that the organization:

(1) provide written notice to a provider:

(A) of the organization's intent to recoup overpayments not later than the 30th day after the date an audit is complete;

(B) of the specific claims and electronic visit verification transactions that are the basis of the overpayment;

(C) of the process the provider should use to communicate with the organization to provide information about the electronic visit verification transactions;

(D) of the provider's option to seek an informal resolution of the alleged overpayment;

(E) of the process to appeal the determination that an overpayment was made; and

(F) if the provider intends to respond to the notice, that the provider must respond not later than the 30th day after the date the provider receives the notice; and

(2) limit the duration of audits to 24 months.

(b) Notwithstanding any other law, a managed care organization may not attempt to recover an overpayment described by Subsection (a) until the provider exhausts all rights to an appeal. (Gov. Code, Sec. 531.1135.)

Sec. 544.0504. RECOVERY AUDIT CONTRACTORS. To the extent

required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), the commission shall establish a program under which the commission contracts with one or more recovery audit contractors to identify Medicaid underpayments and overpayments and recover the overpayments. (Gov. Code, Sec. 531.117.)

Sec. 544.0505. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Not later than December 1 of each year, the commission shall prepare and submit to the legislature a report on the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Subchapter H and Section 544.0502 by special investigative units or entities with which a managed care organization contracts under Section 544.0352(a)(2). The report must specify the amount of money each managed care organization retained under Section 544.0502(d). (Gov. Code, Sec. 531.1132.)

Sec. 544.0506. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the office of inspector general shall provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation. The notice must include:

(1) the specific basis for the overpayment or debt;

(2) a description of facts and supporting evidence;

(3) a representative sample of any documents that form the basis for the overpayment or debt;

(4) the extrapolation methodology;

(5) information relating to the extrapolation methodology used as part of the investigation and the methods used to determine the overpayment or debt in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and are fully reproducible;

(6) the calculation of the overpayment or debt amount;

(7) the amount of damages and penalties, if applicable; and

(8) a description of administrative and judicial due process remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both.

(b) A provider may request an informal resolution meeting. On receipt of the request, the office of inspector general shall schedule the meeting and give notice to the provider of the time and place of the meeting. The informal resolution process shall run concurrently with the administrative hearing process, and the administrative hearing process may not be delayed on account of the informal resolution process.

(c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid. (Gov. Code, Sec. 531.120.)

Sec. 544.0507. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) A provider must request an appeal under this section not later than the 30th day after the date the provider

is notified that the commission or the office of inspector general will seek to recover an overpayment or debt from the provider.

(b) On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the commission's appeals division, as the provider requests, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office of inspector general shall file the docketing request not later than the 60th day after the date of the provider's request or not later than the 60th day after completing the informal resolution process, if applicable.

(c) The office of inspector general is responsible for the costs of an administrative hearing, but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(d) A provider who is the subject of a recoupment of overpayment or debt arising out of a fraud or abuse investigation may appeal a final administrative order issued after an administrative hearing by filing a petition for judicial review in a district court in Travis County. (Gov. Code, Sec. 531.1201.)

CHAPTER 545. CERTAIN PUBLIC ASSISTANCE BENEFITS

SUBCHAPTER A. PUBLIC ASSISTANCE BENEFITS PROGRAM ELIGIBILITY DETERMINATION AND SERVICE DELIVERY INTEGRATION

Sec. 545.0001. DEFINITIONS

CHAPTER 545. CERTAIN PUBLIC ASSISTANCE BENEFITS

SUBCHAPTER A. PUBLIC ASSISTANCE BENEFITS PROGRAM ELIGIBILITY DETERMINATION AND SERVICE DELIVERY INTEGRATION

Sec. 545.0001. DEFINITIONS. In this subchapter:

(1) "Integrated system" means the integrated eligibility determination and service delivery system that is

implemented under the integration plan.

(2) "Integration plan" means the plan to integrate services and functions relating to eligibility determination and service delivery required by Section 545.0002. (New.)

Sec. 545.0002. DEVELOPMENT AND IMPLEMENTATION OF INTEGRATION PLAN. (a) The commission, subject to the approval of the governor and the Legislative Budget Board, shall develop and implement a plan to integrate services and functions relating to eligibility determination and service delivery by health and human services agencies, the Texas Workforce Commission, and other agencies. The integration plan must include:

(1) a reengineering of eligibility determination business processes;

(2) streamlined service delivery;

(3) a unified and integrated process for the transition from welfare to work; and

(4) improved access to benefits and services for clients.

(b) In developing and implementing the integration plan, the commission:

(1) shall give priority to the design and development of computer hardware and software for and provide technical support relating to the integrated eligibility determination system;

(2) shall consult with agencies whose programs are included in the plan, including the Department of State Health Services and the Texas Workforce Commission; and

(3) may contract for appropriate professional and

technical assistance.

(c) The commission shall develop and implement the integrated system to achieve:

(1) increased quality of and client access to services; and

(2) savings in the cost of providing administrative and other services and staff as a result of streamlining and eliminating duplication of services. (Gov. Code, Secs. 531.191(a) (part), (b) (part).)

Sec. 545.0003. METHODS TO ADDRESS FRAUD AND ELIGIBILITY ERROR RATE. The commission shall examine cost-effective methods to address:

(1) fraud in assistance programs; and

(2) the error rate in eligibility determination. (Gov. Code, Sec. 531.191(c).)

Sec. 545.0004. CONTRACT FOR INTEGRATION PLAN IMPLEMENTATION. (a) On receipt by this state of any necessary federal approval and subject to the approval of the governor and the Legislative Budget Board, the commission may contract to implement all or part of the integration plan if the commission determines that contracting:

(1) may advance the objectives of Sections 545.0002 and 545.0006(b); and

(2) meets the criteria set out in the cost-benefit analysis described by this section.

(b) Before awarding a contract, the commission shall provide to the governor and the Legislative Budget Board a detailed

cost-benefit analysis that demonstrates:

(1) the integration plan's cost-effectiveness;

(2) mechanisms for monitoring performance under the plan; and

(3) specific improvements the plan makes to the service delivery system and client access.

(c) The commission shall make the cost-benefit analysis described by Subsection (b) available to the public.

(d) On or before the 10th day after releasing a request for bids, proposals, offers, or other applicable expressions of interest relating to developing or implementing the integration plan, the commission shall hold a public hearing and receive public comment on the request. (Gov. Code, Sec. 531.191(d).)

Sec. 545.0005. USE OF OTHER AGENCIES' STAFF AND RESOURCES. (a) The commission, in developing and implementing the integration plan, may use the staff and resources of agencies whose programs are included in the plan.

(b) The agencies whose programs are included in the integration plan shall cooperate with a commission request to provide available staff and resources that will be subject to the commission's direction. (Gov. Code, Secs. 531.191(a) (part), (e).)

Sec. 545.0006. FUNDING. (a) The design, development, and operation of an automated data processing system to support the integration plan may be financed through the issuance of bonds or other obligations under Chapter 1232.

(b) The commission, subject to any spending limitation prescribed in the General Appropriations Act, may use savings

described by Section 545.0002(c)(2) to further develop the integrated system and provide other health and human services. (Gov. Code, Secs. 531.191(b) (part), (f).)

SUBCHAPTER B. ADMINISTRATION OF CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAMS

Sec. 545.0051. CONSOLIDATED RECIPIENT IDENTIFICATION AND BENEFITS ISSUANCE METHOD. (a) If the commission determines that the implementation would be feasible and cost-effective, the commission may develop and implement a method to consolidate, to the extent possible, recipient identification and benefits issuance for the commission and health and human services agencies.

(b) The method may:

(1) provide for the use of a single integrated benefits issuance card or multiple cards capable of integrating benefits issuance or other program functions;

(2) incorporate a fingerprint image identifier to enable personal identity verification at a point of service and reduce fraud;

(3) enable immediate electronic verification of recipient eligibility; and

(4) replace multiple forms, cards, or other methods used for fraud reduction or provision of health and human services benefits, including:

(A) electronic benefits transfer cards; and

(B) smart cards used in Medicaid.

(c) In developing and implementing the method, the commission shall:

(1) to the extent possible, use industry-standard communication, messaging, and electronic benefits transfer protocols;

(2) ensure that all identifying and descriptive information of recipients of each health and human services program included in the method can be accessed only by a provider or other entity participating in the particular program;

(3) ensure that a provider or other entity participating in a health and human services program included in the method cannot identify whether a program recipient is receiving benefits under another program included in the method; and

(4) ensure that the storage and communication of all identifying and descriptive information included in the method comply with existing federal and state privacy laws governing individually identifiable information for recipients of public benefits programs. (Gov. Code, Sec. 531.091.)

Sec. 545.0052. EXPANSION OF BILLING COORDINATION AND INFORMATION COLLECTION ACTIVITIES. (a) If cost-effective, the commission may:

(1) contract to expand all or part of the billing coordination system established under Section 532.0058 to process claims for services provided through other benefits programs the commission or a health and human services agency administers;

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

services agency administers; and

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

(b) Notwithstanding any other state law, each health and human services agency shall provide the commission with information necessary to allow the commission or the commission's designee to perform the billing coordination and information collection activities authorized by this section. (Gov. Code, Sec. 531.024131.)

Sec. 545.0053. SERVICE DELIVERY AREA ALIGNMENT. Notwithstanding Section 540.0701(d) or any other law and to the extent possible, the commission shall align Medicaid and the child health plan program service delivery areas. (Gov. Code, Sec. 531.024115.)

Sec. 545.0054. PROGRAM TO IMPROVE AND MONITOR CERTAIN OUTCOMES OF MEDICAID RECIPIENTS AND CHILD HEALTH PLAN PROGRAM ENROLLEES. The commission may design and implement a program to improve and monitor clinical and functional outcomes of a Medicaid recipient or child health plan program enrollee. The program may use financial, clinical, and other criteria based on pharmacy, medical services, and other claims data related to Medicaid or the child health plan program. (Gov. Code, Sec. 531.067.)

Sec. 545.0055. MINIMUM COLLECTION GOAL FOR RECOVERY OF CERTAIN BENEFITS. (a) Not later than August 30 of each year, the

executive commissioner by rule shall set a minimum goal for the commission specifying the percentage of the amount of benefits the commission granted in error under the supplemental nutrition assistance program under Chapter 33, Human Resources Code, or the financial assistance program under Chapter 31, Human Resources Code, that the commission should recover. The executive commissioner shall set the percentage based on:

(1) comparable recovery rates other states reported; or

(2) other appropriate factors the executive commissioner identifies.

(b) If the commission fails to meet the goal set under Subsection (a) for the fiscal year, the executive commissioner shall notify the comptroller, and the comptroller shall reduce the commission's general revenue appropriation by an amount equal to the difference between the amount of state funds the commission would have collected had the commission met the goal and the amount of state funds the commission actually collected.

(c) The executive commissioner, the governor, and the Legislative Budget Board shall monitor the commission's performance in meeting the goal set under Subsection (a). The commission shall cooperate by providing to the governor and the Legislative Budget Board, on request, information concerning the commission's collection efforts. (Gov. Code, Sec. 531.050.)

Sec. 545.0056. DISTRIBUTION OF EARNED INCOME TAX CREDIT INFORMATION. (a) The commission shall ensure that educational materials relating to the federal earned income tax credit are

provided in accordance with this section to each individual receiving assistance or benefits under:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; or

(5) another appropriate health and human services program.

(b) In accordance with Section 526.0002, the commission shall, by mail or through the Internet, provide an individual described by Subsection (a) with access to:

(1) Internal Revenue Service publications relating to the federal earned income tax credit or information the comptroller prepares under Section 403.025 relating to that credit;

(2) federal income tax forms necessary to claim the federal earned income tax credit; and

(3) where feasible, the location of at least one program that:

(A) is in close geographic proximity to the individual; and

(B) provides free federal income tax preparation services to low-income and other eligible persons.

(c) In January of each year, the commission or a commission representative shall mail to each individual described by Subsection (a) information about the federal earned income tax

credit that provides the individual with referrals to the resources described by Subsection (b). (Gov. Code, Sec. 531.087.)

Sec. 545.0057. APPLICATION ASSISTANCE FOR FINANCIAL ASSISTANCE RECIPIENTS ELIGIBLE FOR FEDERAL PROGRAMS. The commission shall assist recipients of financial assistance under Chapter 31, Human Resources Code, who are eligible for assistance under federal programs to apply for benefits under those federal programs. The commission may delegate this responsibility to a health and human services agency, contract with a unit of local government, or use any other cost-effective method to assist financial assistance recipients who are eligible for federal programs. (Gov. Code, Sec. 531.044.)

SUBCHAPTER C. CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAM ELIGIBILITY

Sec. 545.0101. MEMORANDUM OF UNDERSTANDING REGARDING MEDICAID AND CHILD HEALTH PLAN PROGRAM ELIGIBILITY DETERMINATIONS FOR CERTAIN CHILDREN. (a) The commission shall enter into a memorandum of understanding with the Texas Juvenile Justice Department to ensure that the commission assesses each individual who is committed, placed, or detained under Title 3, Family Code, for Medicaid and child health plan program eligibility before that individual's release from commitment, placement, or detention. A local juvenile probation department is subject to the requirements of the memorandum.

(b) The memorandum of understanding must specify:

(1) the information that must be provided to the commission;

(2) the process by which and time frame within which the information must be provided; and

(3) the roles and responsibilities of all parties to the memorandum, including a requirement that the commission pursue the actions necessary to complete eligibility applications.

(c) The memorandum of understanding must be tailored to:

(1) achieve the goal of ensuring that an individual described by Subsection (a) who the commission determines is eligible for Medicaid or the child health plan program:

(A) is enrolled in the program for which the individual is eligible; and

(B) may begin receiving services through the program as soon as possible after the eligibility determination is made; and

(2) if possible, achieve the goal of ensuring that the individual may begin receiving services through the program on the date of the individual's release from commitment, placement, or detention.

(d) The executive commissioner may adopt rules as necessary to implement this section. (Gov. Code, Sec. 531.02418.)

Sec. 545.0102. VERIFICATION OF IMMIGRATION STATUS OF CERTAIN APPLICANTS FOR PUBLIC ASSISTANCE BENEFITS. (a) This section applies only with respect to the following benefits programs:

(1) the child health plan program under Chapter 62, Health and Safety Code;

(2) the financial assistance program under Chapter 31,

Human Resources Code;

(3) Medicaid; and

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.

(b) If an individual states at the time of application for benefits under a program to which this section applies that the individual is a qualified alien, as that term is defined by 8 U.S.C. Section 1641(b), the commission shall, to the extent allowed by federal law, verify information regarding the individual's immigration status using an automated system where available.

(c) The executive commissioner shall adopt rules necessary to implement this section.

(d) Nothing in this section adds to or changes the eligibility requirements for a benefits program to which this section applies. (Gov. Code, Sec. 531.024181.)

Sec. 545.0103. VERIFICATION OF SPONSORSHIP INFORMATION FOR CERTAIN BENEFITS RECIPIENTS OR ENROLLEES; REIMBURSEMENT. (a) In this section, "sponsored alien" means an individual who:

(1) has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.); and

(2) as a condition of that admission, was sponsored by another individual who executed an affidavit of support on the lawfully admitted individual's behalf.

(b) This section applies only with respect to the following benefits programs:

(1) the child health plan program under Chapter 62,

Health and Safety Code;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid; and

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.

(c) If an individual states at the time of application for benefits under a program to which this section applies that the individual is a sponsored alien, the commission:

(1) shall make a reasonable effort to notify the individual that the commission may seek reimbursement from the individual's sponsor for any program benefits the individual receives; and

(2) may, to the extent allowed by federal law and using an automated system where available, verify information relating to the sponsorship after the individual is determined eligible for and begins receiving program benefits.

(d) If the commission verifies that an individual who receives benefits under a program to which this section applies is a sponsored alien and determines that seeking reimbursement is cost-effective, the commission may seek reimbursement from the individual's sponsor for the program benefits provided to the individual to the extent allowed by federal law.

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules that specify the most cost-effective procedures by which the commission may seek reimbursement under Subsection (d).

(f) Nothing in this section adds to or changes the eligibility requirements for a benefits program to which this section applies. (Gov. Code, Sec. 531.024182.)

Sec. 545.0104. CALL CENTERS. (a) If cost-effective, the executive commissioner by rule shall establish at least one but not more than four call centers to determine and certify or recertify an individual's eligibility and need for services related to the following programs:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) nutritional assistance programs under Chapter 33, Human Resources Code;

(5) long-term care services, as defined by Section 22.0011, Human Resources Code;

(6) community-based support services identified or provided in accordance with Subchapter D, Chapter 546; and

(7) other health and human services programs, as appropriate.

(b) The commission shall contract with at least one but not more than four private entities to operate the call centers unless the commission determines that contracting would not be cost-effective.

(c) Each call center:

(1) must be located in this state, except that this subdivision does not prohibit a call center located in this state

from processing overflow calls through a center located in another state; and

(2) shall provide translation services as required by federal law for consumers who are unable to speak, hear, or comprehend the English language.

(d) The commission shall develop consumer service and performance standards for the operation of each call center and make those standards available to the public. The standards must address a call center's:

(1) ability to serve consumers in a timely manner, including consideration of:

(A) consumers' ability to access the call center;

(B) whether the call center has toll-free telephone access;

(C) the average amount of time a consumer spends on hold;

(D) the frequency of call transfers;

(E) whether a consumer is able to communicate with a live individual at the call center; and

(F) whether the call center makes mail correspondence available;

(2) staff, including employee courtesy, friendliness, training, and knowledge about the programs listed under Subsection (a); and

(3) complaint handling procedures, including:

(A) the level of difficulty involved in filing a complaint; and

(B) whether the call center's complaint responses are timely.

(e) The commission shall develop:

(1) mechanisms for measuring consumer service satisfaction; and

(2) performance measures to evaluate whether each call center meets the standards the commission develops under Subsection (d).

(f) The commission may inspect a call center and analyze the call center's consumer service performance through a consumer service evaluator posing as a consumer.

(g) Notwithstanding Subsection (a), the executive commissioner shall develop and implement policies that provide an applicant for services related to a program listed under Subsection (a) with an opportunity to appear in person to establish initial eligibility or comply with periodic eligibility recertification requirements if the applicant requests a personal interview. In implementing the policies, the commission shall maintain offices to serve applicants who request a personal interview. This subsection does not affect a law or rule that requires an applicant to appear in person to establish initial eligibility or comply with periodic eligibility recertification requirements. (Gov. Code, Sec. 531.063.)

SUBCHAPTER D. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN PUBLIC ASSISTANCE BENEFITS DECISIONS

Sec. 545.0151. DEFINITION. In this subchapter, "public assistance benefits" means benefits provided under a public

assistance program under Chapter 31, 32, or 33, Human Resources Code. (Gov. Code, Sec. 531.019(a).)

Sec. 545.0152. ELECTRONIC RECORDING OF HEARING. A hearing conducted by the commission, or by a health and human services agency to which the commission delegates a function related to public assistance benefits, that relates to a decision regarding public assistance benefits that is contested by an applicant for or recipient of the benefits must be recorded electronically. (Gov. Code, Sec. 531.019(b) (part).)

Sec. 545.0153. ADMINISTRATIVE REVIEW. (a) Before an applicant for or recipient of public assistance benefits may appeal a decision of a hearing officer for the commission or a health and human services agency related to those benefits and in accordance with rules of the executive commissioner, the applicant or recipient must request an administrative review by an appropriate attorney of the commission or a health and human services agency, as applicable.

(b) Not later than the 15th business day after the date the appropriate attorney described by Subsection (a) receives the request for administrative review, the attorney shall:

(1) complete an administrative review of the decision; and

(2) notify the applicant or recipient in writing of the results of that review. (Gov. Code, Sec. 531.019(c).)

Sec. 545.0154. JUDICIAL REVIEW. (a) An appeal of a decision made by a hearing officer for the commission or a health and human services agency related to public assistance benefits

brought by an applicant for or recipient of the benefits:

(1) is governed by Subchapters G and H, Chapter 2001, except as provided by this subchapter; and

(2) takes precedence over all civil cases except workers' compensation and unemployment compensation cases.

(b) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits has exhausted all available administrative remedies and a decision, including a decision under Section 31.034 or 32.035, Human Resources Code, is final and appealable on the date that, after a hearing:

(1) the hearing officer for the commission or a health and human services agency reaches a final decision related to the benefits; and

(2) the appropriate attorney completes an administrative review of the decision and notifies the applicant or recipient in writing of the results of that review.

(c) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits is not required to file a motion for rehearing with the commission or a health and human services agency, as applicable.

(d) Notwithstanding Section 2001.177, the cost of preparing the record and transcript of a hearing described by Section 545.0152 that is required to be sent to a reviewing court may not be charged to the applicant for or recipient of the public assistance benefits.

(e) Judicial review of a decision described by Subsection (a) is:

(1) instituted by filing a petition with a district court in Travis County, as provided by Subchapter G, Chapter 2001; and

(2) under the substantial evidence rule.

(f) The appellee is the commission. (Gov. Code, Secs. 531.019(b) (part), (d), (e), (f), (g), (h), (i).)

SUBCHAPTER E. CERTAIN PUBLIC ASSISTANCE BENEFITS PROGRAM PROVIDERS

Sec. 545.0201. COMPLIANCE WITH SOLICITATION PROHIBITIONS. (a) In this section, "furnish" and "provider" have the meanings assigned by Section 544.0001.

(b) A provider who furnishes Medicaid or child health plan program services is subject to Chapter 102, Occupations Code. The provider's compliance with that chapter is a condition of the provider's eligibility to participate as a provider under those programs. (Gov. Code, Sec. 531.116; New.)

Sec. 545.0202. MARKETING ACTIVITIES BY MEDICAID OR CHILD HEALTH PLAN PROGRAM PROVIDERS. (a) A Medicaid or child health plan program provider, including a provider participating in the network of a managed care organization that contracts with the commission to provide services under Medicaid or the child health plan program, may not engage in any marketing activity, including engaging in the dissemination of material or another attempt to communicate, that:

(1) involves unsolicited personal contact with a Medicaid recipient or a parent whose child is a Medicaid recipient or child health plan program enrollee, including by:

(A) door-to-door solicitation;

(B) solicitation at a child-care facility or other type of facility;

(C) direct mail; or

(D) telephone;

(2) is directed at an individual solely because the individual is a Medicaid recipient or is a parent of a child who is a Medicaid recipient or child health plan program enrollee; and

(3) is intended to influence the Medicaid recipient's or parent's choice of provider.

(b) A provider participating in the network of a managed care organization that contracts with the commission to provide services under Medicaid or the child health plan program must comply with the marketing guidelines the commission establishes under Section 540.0055.

(c) Nothing in this section prohibits:

(1) a Medicaid or child health plan program provider from:

(A) engaging in a marketing activity, including engaging in the dissemination of material or another attempt to communicate, that is intended to influence the choice of provider by a Medicaid recipient or a parent whose child is a Medicaid recipient or child health plan program enrollee, if the marketing activity:

(i) is conducted at a community-sponsored educational event, health fair, outreach activity, or other similar community or nonprofit event in which the provider participates and does not involve unsolicited personal contact or promotion of the

provider's practice; or

(ii) involves only the general dissemination of information, including by television, radio, newspaper, or billboard advertisement, and does not involve unsolicited personal contact;

(B) as permitted under the provider's contract, engaging in the dissemination of material or another attempt to communicate with a Medicaid recipient or a parent whose child is a Medicaid recipient or child health plan program enrollee, including communication in person or by direct mail or telephone, to:

(i) provide an appointment reminder;

(ii) distribute promotional health materials;

(iii) provide information about the types of services the provider offers; or

(iv) coordinate patient care; or

(C) engaging in a marketing activity that the provider has submitted for review and for which the provider has received a notice of prior authorization under Subsection (d); or

(2) a STAR+PLUS Medicaid managed care program provider from, as permitted under the provider's contract, engaging in a marketing activity, including engaging in the dissemination of material or another attempt to communicate, that is intended to educate a Medicaid recipient about available long-term services and supports.

(d) The commission shall establish a process by which a provider may submit a proposed marketing activity for review and

prior authorization to ensure that the provider is in compliance with the requirements of this section and, if applicable, Section 540.0055, or to determine whether the provider is exempt from a requirement of this section and, if applicable, Section 540.0055. The commission may grant or deny a provider's request for authorization to engage in a proposed marketing activity.

(e) The executive commissioner shall adopt rules as necessary to implement this section, including rules relating to provider marketing activities that are exempt from the requirements of this section and, if applicable, Section 540.0055. (Gov. Code, Sec. 531.02115.)

Sec. 545.0203. REIMBURSEMENT CLAIMS FOR CERTAIN MEDICAID OR CHILD HEALTH PLAN SERVICES INVOLVING SUPERVISED PROVIDERS. (a) In this section, "national provider identifier" means the national provider identifier required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) If a Medicaid or child health plan program provider, including a nurse practitioner or physician assistant, provides a referral or orders health care services for a Medicaid recipient or child health plan program enrollee at the direction or under the supervision of another provider and the referral or order is based on the supervised provider's evaluation of the recipient or enrollee, the names and associated national provider identifier numbers of the supervised provider and the supervising provider must be included on any claim for reimbursement a provider submits based on the referral or order.

(c) The executive commissioner shall adopt rules necessary

to implement this section. (Gov. Code, Sec. 531.024161.)

Sec. 545.0204. PARTICIPATION OF DIAGNOSTIC LABORATORY SERVICE PROVIDERS IN CERTAIN PROGRAMS. Notwithstanding any other law, a diagnostic laboratory may participate as an in-state provider under any program a health and human services agency or the commission administers that involves diagnostic laboratory services, regardless of the location where any specific service is performed or where the laboratory's facilities are located, if:

(1) the laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains diagnostic laboratory operations in this state;

(2) the laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory collectively employ at least 1,000 individuals at places of employment located in this state;

(3) the laboratory is otherwise qualified to provide the services under the program; and

(4) the laboratory is not prohibited from participating as a provider under any benefits program a health and human services agency or the commission administers based on conduct that constitutes fraud, waste, or abuse. (Gov. Code, Sec. 531.066.)

CHAPTER 546. LONG-TERM CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES AND ELDERLY INDIVIDUALS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 546.0001. DEFINITIONS

CHAPTER 546. LONG-TERM CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES AND ELDERLY INDIVIDUALS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 546.0001. DEFINITIONS. In this chapter:

(1) "ICF-IID" and "local intellectual and developmental disability authority" have the meanings assigned by Section 531.002, Health and Safety Code.

(2) "Recipient" means a Medicaid recipient. (New.)

Sec. 546.0002. LONG-TERM CARE PLAN; COORDINATION OF SERVICES. (a) In this section, "long-term care" means the provision of health care, personal care, and assistance related to health and social services over a sustained period to individuals of all ages and their families, regardless of the setting in which

the care is provided.

(b) In conjunction with appropriate state agencies, the executive commissioner shall develop a plan for access to individualized long-term care services for individuals with functional limitations or medical needs and their families that assists those individuals in achieving and maintaining the greatest possible independence, autonomy, and quality of life.

(c) The guiding principles and goals of the plan that focus on the individual and the individual's family must:

(1) recognize that it is the policy of this state that:

(A) children should grow up in families; and

(B) individuals with disabilities and elderly individuals should reside in the setting of their choice; and

(2) ensure that an individual needing assistance and the individual's family will have:

(A) the maximum possible control over their services;

(B) a choice of a broad, comprehensive array of services designed to meet individual needs; and

(C) the easiest possible access to appropriate care and support, regardless of the area of this state in which they reside.

(d) The guiding principles and goals of the plan that focus on services and delivery of those services by the state must:

(1) emphasize the development of home-based and community-based services and housing alternatives to complement the long-term care services already in existence;

(2) ensure that the services will be of the highest possible quality, with a minimum amount of regulation, structure, and complexity at the service level;

(3) recognize that maximum independence and autonomy represent major goals, and with those comes a certain degree of risk;

(4) maximize resources to the greatest extent possible, with the consumer receiving only the services that the consumer prefers and that are indicated by a functional needs assessment; and

(5) structure the service delivery system to support these goals, ensuring that any necessary system complexity is at the administrative level rather than at the client level.

(e) The commission shall coordinate state services to ensure that:

(1) the roles and responsibilities of agencies providing long-term care are clarified; and

(2) duplication of services and resources is minimized. (Gov. Code, Sec. 531.043.)

Sec. 546.0003. EMPLOYMENT-FIRST POLICY. (a) It is the policy of this state that earning a living wage through competitive employment in the general workforce is the priority and preferred outcome for working-age individuals with disabilities who receive public benefits.

(b) The commission, the Texas Education Agency, and the Texas Workforce Commission shall jointly adopt and implement an employment-first policy in accordance with the state's policy under

Subsection (a). The policy must:

(1) affirm that an individual with a disability is able to meet the same employment standards as an individual who does not have a disability;

(2) ensure that all working-age individuals with disabilities, including young adults, are offered factual information regarding employment as an individual with a disability, including the relationship between an individual's earned income and the individual's public benefits;

(3) ensure that individuals with disabilities are given the opportunity to understand and explore options for education or training, including postsecondary, graduate, and postgraduate education, vocational or technical training, or other training, as pathways to employment;

(4) promote the availability and accessibility of individualized training designed to prepare an individual with a disability for the individual's preferred employment;

(5) promote partnerships with employers to overcome barriers in meeting workforce needs with the creative use of technology and innovation;

(6) ensure that staff of public schools, vocational service programs, and community providers are supported and trained to assist in achieving the goal of competitive employment for all individuals with disabilities; and

(7) ensure that competitive employment, while being the priority and preferred outcome, is not required of an individual with a disability to secure or maintain public benefits

for which the individual is otherwise eligible. (Gov. Code, Sec. 531.02447.)

Sec. 546.0004. LONG-TERM CARE INSURANCE AWARENESS AND EDUCATION CAMPAIGN. (a) The commission, in consultation with the Texas Department of Insurance, shall develop and implement a public awareness and education campaign designed to:

(1) educate the public on:

(A) the cost of long-term care, including the limits of Medicaid eligibility and the limits of Medicare benefits; and

(B) the value and availability of long-term care insurance; and

(2) encourage individuals to obtain long-term care insurance.

(b) The Texas Department of Insurance shall cooperate with and assist the commission in implementing the campaign.

(c) The commission may coordinate the implementation of the campaign with any other state outreach campaign or activity relating to long-term care issues. (Gov. Code, Sec. 531.0841.)

SUBCHAPTER B. CARE SETTINGS AND SERVICE AND SUPPORT OPTIONS

Sec. 546.0051. DEFINITIONS. In this subchapter:

(1) "General residential operation" has the meaning assigned by Section 42.002, Human Resources Code.

(2) "Legally authorized representative" has the meaning assigned by Section 241.151, Health and Safety Code. (New.)

Sec. 546.0052. COMPREHENSIVE PLAN FOR ENSURING APPROPRIATE CARE SETTING FOR INDIVIDUALS WITH DISABILITIES; BIENNIAL REPORT.

(a) The commission and appropriate health and human services agencies shall implement a comprehensive, effectively working plan that provides a system of services and support to foster independence and productivity and provide meaningful opportunities for an individual with a disability to reside in the most appropriate care setting, considering:

(1) the individual's physical, medical, and behavioral needs;

(2) the least restrictive care setting in which the individual can reside;

(3) the individual's choice of care settings in which to reside;

(4) the availability of state resources; and

(5) the availability of state programs for which the individual qualifies that can assist the individual.

(b) The plan must require appropriate health and human services agencies to:

(1) provide to an individual with a disability residing in an institution or another individual as required by Sections 546.0053 and 546.0054 information regarding care and support options available to the individual with a disability, including community-based services appropriate to that individual's needs;

(2) recognize that certain individuals with disabilities are represented by a legally authorized representative, whom the agencies must include in any decision-making facilitated by the plan's implementation;

(3) facilitate a timely and appropriate transfer of an individual with a disability from an institution to an appropriate community setting if:

(A) the individual chooses to reside in the community;

(B) the individual's treating professionals determine the transfer is appropriate; and

(C) the transfer can be reasonably accommodated, considering this state's available resources and the needs of other individuals with disabilities; and

(4) develop strategies to prevent the unnecessary placement in an institution of an individual with a disability who is:

(A) residing in the community; and

(B) in imminent risk of requiring placement in an institution because of a lack of community services.

(c) In implementing the plan, a health and human services agency may not deny an eligible individual with a disability access to an institution or remove an eligible individual with a disability from an institution if the individual prefers the type and degree of care provided in the institution and that care is appropriate for the individual. A health and human services agency may deny the individual with a disability access to an institution or remove the individual from an institution to protect the individual's health or safety.

(d) Subject to the availability of funds, each appropriate health and human services agency shall implement the strategies and

recommendations under the plan.

(e) To determine the appropriateness of transfers under Subsection (b)(3) and develop the strategies described by Subsection (b)(4), a health and human services agency shall presume that a child residing in a general residential operation is eligible for transfer to an appropriate community-based setting.

(f) To develop the strategies described by Subsection (b)(4), an individual with a mental illness who is admitted to a commission facility for inpatient mental health services three or more times during a 180-day period is presumed to be in imminent risk of requiring placement in an institution. The strategies must be developed in a manner that presumes the individual's eligibility for and the appropriateness of intensive community-based services and support.

(g) Not later than December 1 of each even-numbered year, the executive commissioner shall submit to the governor and the legislature a report on the status of the implementation of the plan. The report must include recommendations on any statutory or other action necessary to implement the plan.

(h) This section does not create a cause of action. (Gov. Code, Sec. 531.0244.)

Sec. 546.0053. INFORMATION AND ASSISTANCE REGARDING CARE AND SUPPORT OPTIONS FOR INDIVIDUALS WITH DISABILITIES. (a) The executive commissioner by rule shall require each health and human services agency to provide to each patient or client of the agency and to at least one family member of the patient or client, if possible, information regarding all care and support options

available to the patient or client, including community-based services appropriate to the patient's or client's needs, before the agency allows the patient or client to be placed in a care setting, including a nursing facility, an intermediate care facility for individuals with an intellectual disability, or a general residential operation for children with an intellectual disability that is licensed by the commission, to receive care or services provided by the agency or by a person under an agreement with the agency.

(b) The rules must require each health and human services agency to provide information about all long-term care and long-term support options available to the patient or client, including community-based options and options available through another agency or a private provider. The information must be provided in a manner designed to maximize the patient's or client's understanding of all available options. If the patient or client has a legally authorized representative, the information must also be provided to that representative. If the patient or client is in the conservatorship of a health and human services agency or the Department of Family and Protective Services, the information must be provided to the patient's or client's agency caseworker and foster parents, if applicable.

(c) A health and human services agency that provides a patient, client, or other individual with information regarding care and support options available to the patient or client shall assist the patient, client, or other individual in taking advantage of an option selected by the patient, client, or other individual,

subject to the availability of funds. If the selected option is not immediately available for any reason, the agency shall provide assistance in placing the patient or client on a waiting list for that option. (Gov. Code, Sec. 531.042.)

Sec. 546.0054. COMMUNITY LIVING OPTIONS INFORMATION PROCESS FOR CERTAIN INDIVIDUALS WITH INTELLECTUAL DISABILITY. (a) In this section, "institution" means:

(1) a residential care facility the commission operates or maintains to provide 24-hour services, including residential services, to individuals with an intellectual disability; or

(2) an ICF-IID.

(b) In addition to providing information regarding care and support options as required by Section 546.0053, the commission shall implement a community living options information process in each institution to inform individuals with an intellectual disability who reside in the institution and the individuals' legally authorized representatives of alternative community living options.

(c) The commission shall:

(1) at least annually provide the information required by Subsection (b) through the community living options information process; and

(2) provide the information at any other time on request by an individual with an intellectual disability who resides in an institution or the individual's legally authorized representative.

(d) If an individual with an intellectual disability residing in an institution or the individual's legally authorized representative indicates a desire to pursue an alternative community living option after receiving the information provided under this section, the commission shall refer the individual or the individual's legally authorized representative to the local intellectual and developmental disability authority. The local authority shall place the individual:

(1) in an alternative community living option, subject to the availability of funds; or

(2) on a waiting list for those options if for any reason the options are not available to the individual on or before the 30th day after the date the individual or the individual's legally authorized representative is referred to the local authority.

(e) The commission shall document in the records of each individual with an intellectual disability who resides in an institution:

(1) the information provided to the individual or the individual's legally authorized representative through the community living options information process; and

(2) the results of that process. (Gov. Code, Secs. 531.02442(a)(1-a), (b), (c), (d), (e).)

Sec. 546.0055. IMPLEMENTATION OF COMMUNITY LIVING OPTIONS INFORMATION PROCESS AT STATE INSTITUTIONS FOR CERTAIN ADULT RESIDENTS. (a) In this section:

(1) "Adult resident" means an individual with an

intellectual disability who:

(A) is at least 22 years of age; and

(B) resides in a state supported living center.

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

(b) This section applies only to the community living options information process for an adult resident.

(c) The commission shall contract with local intellectual and developmental disability authorities to implement the community living options information process required by Section 546.0054 for an adult resident.

(d) The commission's contract with a local intellectual and developmental disability authority must:

(1) delegate to the local authority the commission's duties under Section 546.0054 with regard to implementing the community living options information process at a state supported living center;

(2) include performance measures designed to assist the commission in evaluating the effectiveness of the local authority in implementing the community living options information process; and

(3) ensure that the local authority provides service coordination and relocation services to an adult resident who chooses, is eligible for, and is recommended by the interdisciplinary team for a community living option to facilitate a timely, appropriate, and successful transition from the state supported living center to the community living option.

(e) The commission, with the advice and assistance of representatives of family members or legally authorized representatives of adult residents, individuals with an intellectual disability, state supported living centers, and local intellectual and developmental disability authorities, shall:

(1) develop an effective community living options information process;

(2) create uniform procedures for implementing the community living options information process; and

(3) minimize any potential conflict of interest regarding the community living options information process between a state supported living center and an adult resident, an adult resident's legally authorized representative, or a local intellectual and developmental disability authority.

(f) A state supported living center shall:

(1) allow a local intellectual and developmental disability authority to participate in the interdisciplinary planning process involving the consideration of community living options for an adult resident;

(2) to the extent not otherwise prohibited by state or federal confidentiality laws, provide a local intellectual and developmental disability authority with access to an adult resident and an adult resident's records to assist the authority in implementing the community living options information process; and

(3) provide an adult resident or the adult resident's legally authorized representative with accurate information regarding the risks of moving the adult resident to a community

living option. (Gov. Code, Secs. 531.02443(a)(1), (5), (b), (c), (d), (e), (f).)

Sec. 546.0056. VOUCHER PROGRAM FOR TRANSITIONAL LIVING ASSISTANCE FOR INDIVIDUALS WITH DISABILITIES. (a) In this section:

(1) "Institutional housing" means:

(A) an ICF-IID;

(B) a nursing facility;

(C) a state hospital, state supported living center, or state center the commission maintains and manages;

(D) a general residential operation for children with an intellectual disability that the commission licenses; or

(E) a general residential operation.

(2) "Integrated housing" means housing in which an individual with a disability resides or may reside that is:

(A) located in the community; and

(B) not exclusively occupied by individuals with disabilities and their care providers.

(b) Subject to the availability of funds, the commission shall coordinate with the Texas Department of Housing and Community Affairs to develop a housing assistance program to assist individuals with disabilities in moving from institutional housing to integrated housing. In developing the program, the agencies shall address:

(1) eligibility requirements for assistance;

(2) the period during which an individual with a disability may receive assistance;

(3) the types of housing expenses the program will cover; and

(4) the locations at which the program will operate.

(c) Subject to the availability of funds, the commission shall administer the housing assistance program. The commission shall coordinate with the Texas Department of Housing and Community Affairs in:

(1) administering the program;

(2) determining the availability of funding from the United States Department of Housing and Urban Development; and

(3) obtaining that funding.

(d) The Texas Department of Housing and Community Affairs shall provide information to the commission as necessary to facilitate the administration of the housing assistance program. (Gov. Code, Sec. 531.059.)

Sec. 546.0057. TRANSITION SERVICES FOR YOUTH WITH DISABILITIES. (a) The executive commissioner shall monitor programs and services offered through health and human services agencies designed to assist youth with disabilities to transition from school-oriented living to:

(1) post-schooling activities;

(2) services for adults; or

(3) community living.

(b) In monitoring the programs and services, the executive commissioner shall:

(1) consider whether the programs or services result in positive outcomes in the employment, community integration,

health, and quality of life of individuals with disabilities; and

(2) collect information regarding the outcomes of the transition process as necessary to assess the programs and services. (Gov. Code, Sec. 531.02445.)

Sec. 546.0058. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES. (a) The commission shall quantify the amount of money the legislature appropriates that would have been spent during the remainder of a state fiscal biennium to care for an individual who resides in a nursing facility but who is leaving that facility before the end of the biennium to reside in the community with the assistance of community-based services.

(b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the executive commissioner shall direct, as appropriate:

(1) the comptroller, at the time an individual described by Subsection (a) leaves a nursing facility, to transfer an amount not to exceed the amount quantified under that subsection among the health and human services agencies and the commission as necessary to comply with this section; or

(2) the commission or a health and human services agency, at the time an individual described by Subsection (a) leaves a nursing facility, to transfer an amount not to exceed the amount quantified under that subsection within the agency's budget as necessary to comply with this section.

(c) The commission shall ensure that the amount transferred under this section is redirected by the commission or a health and human services agency, as applicable, to one or more

community-based programs in the amount necessary to provide community-based services to the individual after the individual leaves a nursing facility. (Gov. Code, Sec. 531.092.)

SUBCHAPTER C. CONSUMER DIRECTION MODELS

Sec. 546.0101. DEFINITIONS. In this subchapter:

(1) "Consumer" means an individual who receives services through a consumer direction model the commission establishes under this subchapter.

(2) "Consumer direction model" means a service delivery model under which a consumer or the consumer's legally authorized representative exercises control over the development and implementation of the consumer's individual service plan or over the persons delivering the services directly to the consumer. The term includes the consumer-directed service option, the service responsibility option, and other types of service delivery models the commission develops under this subchapter.

(3) "Consumer-directed service option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative, as the employer, exercises control over:

(i) recruiting, hiring, managing, or dismissing persons providing services directly to the consumer; or

(ii) retaining contractors or vendors for other authorized program services; and

(B) the consumer-directed services agency serves as fiscal agent and performs employer-related administrative

functions for the consumer or the consumer's legally authorized representative, including payroll and filing tax and related reports.

(4) "Designated representative" means an adult volunteer appointed by a consumer or the consumer's legally authorized representative, as an employer, to perform all or part of the consumer's or the representative's duties as employer as approved by the consumer or the representative.

(5) "Legally authorized representative":

(A) means:

(i) a parent or legal guardian if the individual is a minor;

(ii) a legal guardian if the individual has been adjudicated as incapacitated to manage the individual's personal affairs; or

(iii) any other person authorized or required by law to act on the individual's behalf with regard to the individual's care; and

(B) does not include a designated representative.

(6) "Service responsibility option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative participates in selecting, training, and managing persons providing services directly to the consumer; and

(B) the provider agency, as the employer, performs employer-related administrative functions for the

consumer or the consumer's legally authorized representative, including hiring and dismissing persons providing services directly to the consumer. (Gov. Code, Sec. 531.051(a).)

Sec. 546.0102. IMPLEMENTATION OF CONSUMER DIRECTION MODELS. (a) The commission shall develop and oversee the implementation of consumer direction models under which an individual with a disability or an elderly individual who is receiving certain state-funded or Medicaid-funded services, or the individual's legally authorized representative, exercises control over:

(1) developing and implementing the individual's service plan; or

(2) the persons who directly deliver the services.

(b) The consumer direction models the commission establishes under this subchapter may be implemented in appropriate and suitable commission or health and human services agency programs. (Gov. Code, Secs. 531.051(b), (d).)

Sec. 546.0103. RULES. In adopting rules for consumer direction models, the executive commissioner shall:

(1) determine which services are appropriate and suitable for delivery through a consumer direction model;

(2) ensure that each consumer direction model is designed to comply with applicable federal and state laws;

(3) maintain procedures to ensure that a potential consumer or the consumer's legally authorized representative has adequate and appropriate information, including the responsibilities of a consumer or representative under each service

delivery option, to make an informed choice among the types of consumer direction models;

(4) require each consumer or the consumer's legally authorized representative to sign a statement acknowledging receipt of the information required by Subdivision (3);

(5) maintain procedures to monitor delivery of services through a consumer direction model to ensure:

(A) adherence to existing applicable program standards;

(B) appropriate use of funds; and

(C) consumer satisfaction with the delivery of services;

(6) ensure that authorized program services that are not being delivered to a consumer through a consumer direction model are provided by a provider agency the consumer or the consumer's legally authorized representative chooses; and

(7) set a timetable to complete the implementation of the consumer direction models. (Gov. Code, Sec. 531.051(c).)

Sec. 546.0104. APPLICABILITY OF CERTAIN NURSING LICENSURE REQUIREMENTS. Section 301.251(a), Occupations Code, does not apply to delivery of a service for which payment is provided under the consumer-directed service option developed under this subchapter if:

(1) the individual who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter

301, Occupations Code, that is revoked or suspended; and

(C) performs a service that is not expressly prohibited from delegation by the Texas Board of Nursing; and

(2) the consumer who receives the service:

(A) has a disability and the service would have been performed by the consumer or the consumer's legally authorized representative except for that disability; and

(B) is:

(i) capable of training the individual to properly perform the service and the consumer directs the individual to deliver the service; or

(ii) not capable of training the individual to properly perform the service, the consumer's legally authorized representative is capable of training the individual to properly perform the service, and the legally authorized representative directs the individual to deliver the service. (Gov. Code, Sec. 531.051(e).)

Sec. 546.0105. LEGALLY AUTHORIZED REPRESENTATIVE SERVICE OVERSIGHT REQUIRED. If an individual delivers a service under Section 546.0104(2)(B)(ii), the legally authorized representative must be present when the service is performed or be immediately accessible to the individual who delivers the service. If the individual will perform the service when the representative is not present, the representative must observe the individual performing the service at least once to assure the representative that the individual can competently perform that service. (Gov. Code, Sec. 531.051(f).)

Sec. 546.0106. PROCEDURE TO PROVIDE NOTICE TO MEDICAID RECIPIENTS. The commission shall:

(1) develop a procedure to:

(A) verify that a recipient or the recipient's parent or legal guardian is informed of the consumer direction model and provided the option to choose to receive care under that model; and

(B) if the individual declines to receive care under the consumer direction model, document the decision to decline; and

(2) ensure that each Medicaid managed care organization implements the procedure. (Gov. Code, Sec. 531.0512.)

SUBCHAPTER D. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEM INITIATIVES AND GRANT PROGRAM

Sec. 546.0151. DEFINITION. In this subchapter, "community-based organization" includes:

(1) an area agency on aging;

(2) an independent living center;

(3) a municipality, county, or other local government;

(4) a nonprofit or for-profit organization; or

(5) a community mental health and intellectual disability center. (Gov. Code, Sec. 531.02481(f) (part).)

Sec. 546.0152. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEMS FOR LONG-TERM CARE SERVICES. (a) The commission shall assist communities in this state to develop comprehensive, community-based support and service delivery systems for long-term care services. At a community's request, the commission shall

provide resources and assistance to the community to enable the community to:

(1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers that result from the policies and procedures of state health and human services agencies;

(2) develop a system of blended funds, consistent with federal law and the General Appropriations Act, to allow the community to customize services to fit individual community needs; and

(3) develop a local system of access and assistance to aid clients in accessing the full range of long-term care services.

(b) At the request of a community-based organization or a combination of community-based organizations, the commission may provide a grant to the organization or organizations in accordance with this subchapter.

(c) In implementing this subchapter, the commission shall consider models used in other service delivery systems. (Gov. Code, Secs. 531.02481(a), (d).)

Sec. 546.0153. AREA AGENCIES ON AGING: MINIMUM NUMBER. The executive commissioner shall assure the maintenance of no fewer than 28 area agencies on aging in order to assure the continuation of a local system of access and assistance that is sensitive to the aging population. (Gov. Code, Sec. 531.02481(e).)

Sec. 546.0154. PROPOSALS. A community-based organization or a combination of organizations may make a proposal under this subchapter. (Gov. Code, Sec. 531.02481(f) (part).)

Sec. 546.0155. PROPOSAL REVIEW AND APPROVAL. (a) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval.

(b) The commission shall review the initiative to ensure that the initiative is:

(1) consistent with other similar programs offered in communities; and

(2) not duplicative of other services provided in the community. (Gov. Code, Sec. 531.02481(c).)

Sec. 546.0156. STANDARD AND PRIORITY OF REVIEW. (a) In making a grant to a community-based organization, the commission shall evaluate the organization's proposal based on demonstrated need and the proposal's merit.

(b) The commission shall give priority to proposals that will use the Internet and related information technologies to provide to clients:

(1) referral services;

(2) other information regarding local long-term care services; and

(3) needs assessments. (Gov. Code, Sec. 531.02481(g) (part).)

Sec. 546.0157. COMMUNITY-BASED ORGANIZATION MATCHING CONTRIBUTION REQUIRED. To receive a grant under this subchapter, a community-based organization must at least partially match the state grant with money or other resources obtained from a nongovernmental entity, from a local government, or if the

community-based organization is a local government, from fees or taxes collected by the local government. The community-based organization may then combine the money or resources the organization obtains from a variety of federal, state, local, or private sources to accomplish the proposal's purpose. (Gov. Code, Sec. 531.02481(g) (part).)

Sec. 546.0158. PROPOSALS INVOLVING MULTIPLE COMMUNITY-BASED ORGANIZATIONS. (a) If a combination of community-based organizations makes a proposal, the organizations must designate a single organization to receive and administer the grant.

(b) If a community-based organization receives a grant on behalf of a combination of community-based organizations or if the community-based organization's proposal involves coordination with other entities to accomplish the proposal's purpose, the commission may condition receipt of the grant on the organization's making a good faith effort to coordinate with other entities in the manner indicated in the proposal. (Gov. Code, Sec. 531.02481(g) (part).)

Sec. 546.0159. GUIDELINES. The commission may adopt guidelines for proposals. (Gov. Code, Sec. 531.02481(g) (part).)

Sec. 546.0160. CERTAIN AGENCIES' DUTY TO PROVIDE RESOURCES AND ASSISTANCE. At the commission's request, a health and human services agency shall provide resources and assistance to a community as necessary to perform the commission's duties under Section 546.0152(a). (Gov. Code, Sec. 531.02481(b).)

SUBCHAPTER E. PERMANENCY PLANNING

Sec. 546.0201. DEFINITIONS. In this subchapter:

(1) "Child" means an individual with a developmental disability who is younger than 22 years of age.

(2) "Community resource coordination group" means a coordination group established under the memorandum of understanding adopted under Subchapter D, Chapter 522.

(3) "Department" means the Department of Family and Protective Services.

(4) "Institution" means:

(A) an ICF-IID;

(B) a group home operated under the commission's authority, including a residential service provider under a Section 1915(c) waiver program that provides services at a residence other than the child's home or agency foster home;

(C) a nursing facility;

(D) a general residential operation for children with an intellectual disability that the commission licenses; or

(E) another residential arrangement other than a foster home that provides care to four or more children who are unrelated to each other.

(5) "Permanency planning" means a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship. (Gov. Code, Sec. 531.151; New.)

Sec. 546.0202. POLICY STATEMENT. It is the policy of this state to strive to ensure that the basic needs for safety, security, and stability are met for each child in this state. A successful

family is the most efficient and effective way to meet those needs. This state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible. (Gov. Code, Sec. 531.152.)

Sec. 546.0203. DEVELOPMENT OF PERMANENCY PLAN PROCEDURES. (a) To further the policy stated in Section 546.0202 and except as provided by Subsection (b), the commission and each appropriate health and human services agency shall develop procedures to ensure that a permanency plan is developed for each child:

(1) who resides in an institution in this state on a temporary or long-term basis; or

(2) with respect to whom the commission or appropriate health and human services agency is notified in advance that institutional care is sought.

(b) The department shall develop a permanency plan as required by this subchapter for each child who resides in an institution in this state for whom the department has been appointed permanent managing conservator. The department is not required to develop a permanency plan under this subchapter for a child for whom the department has been appointed temporary managing conservator, but may incorporate the requirements of this subchapter in a permanency plan developed for the child under Section 263.3025, Family Code.

(c) In developing procedures under Subsection (a), the commission and other appropriate health and human services agencies

shall develop to the extent possible uniform procedures applicable to each of the agencies and each child who is the subject of a permanency plan that promote efficiency for the agencies and stability for each child.

(d) In implementing permanency planning procedures, the commission shall:

(1) delegate the commission's duty to develop a permanency plan to a local intellectual and developmental disability authority or enter into a memorandum of understanding with the local intellectual and developmental disability authority to develop the permanency plan for each child who resides in an institution in this state or with respect to whom the commission is notified in advance that institutional care is sought;

(2) contract with a private entity, other than an entity that provides long-term institutional care, to develop a permanency plan for a child who resides in an institution in this state or with respect to whom the commission is notified in advance that institutional care is sought; or

(3) perform the commission's duties regarding permanency planning procedures using commission personnel.

(e) A contract or memorandum of understanding under Subsection (d) must include performance measures by which the commission may evaluate the effectiveness of permanency planning efforts of a local intellectual and developmental disability authority or a private entity.

(f) In implementing permanency planning procedures, the commission shall engage in appropriate activities in addition to

those required by Subsection (d) to minimize the potential conflicts of interest that, in developing the plan, may exist or arise between:

(1) the institution in which the child resides or in which institutional care is sought for the child; and

(2) the best interest of the child.

(g) The commission and the department may solicit and accept gifts, grants, and donations to support the development of permanency plans for children residing in institutions by individuals or organizations not employed by or affiliated with those institutions.

(h) A health and human services agency that contracts with a private entity under Subsection (d) to develop a permanency plan shall ensure that the entity is provided:

(1) training regarding the permanency planning philosophy described by Section 546.0201; and

(2) available resources that will assist a child residing in an institution in making a successful transition to a community-based residence. (Gov. Code, Sec. 531.153.)

Sec. 546.0204. PERMANENCY PLANNING FOR CERTAIN CHILDREN. (a) Notwithstanding Section 546.0201, in this section, "institution" has the meaning assigned by Section 242.002, Health and Safety Code.

(b) The commission and each appropriate health and human services agency shall develop procedures to ensure that permanency planning is provided for each child:

(1) residing in an institution in this state on a

temporary or long-term basis; or

(2) for whom institutional care is sought. (Gov. Code, Secs. 531.0245(a), (b)(1).)

Sec. 546.0205. INSTITUTION TO ASSIST WITH PERMANENCY PLANNING EFFORTS. An institution in which a child resides shall assist with providing effective permanency planning for the child by:

(1) cooperating with the health and human services agency, local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan; and

(2) participating in meetings to review the child's permanency plan as requested by a health and human services agency, local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan. (Gov. Code, Sec. 531.1531.)

Sec. 546.0206. IMPLEMENTATION SYSTEM: LOCAL PERMANENCY PLANNING SITES. The commission shall develop an implementation system that initially consists of four or more local sites and that is designed to coordinate planning for a permanent living arrangement and relationship for a child with a family. In developing the system, the commission shall:

(1) include criteria to identify children who need permanency plans;

(2) require the establishment of a permanency plan for each child who resides outside the child's family or for whom care or protection is sought in an institution;

(3) include a process to determine the agency or entity responsible for developing and overseeing implementation of a child's permanency plan;

(4) identify, blend, and use funds from all available sources to provide customized services and programs to implement a child's permanency plan;

(5) clarify and expand the role of a local community resource coordination group in ensuring accountability for a child who resides in an institution or who is at risk of being placed in an institution;

(6) require reporting of each placement or potential placement of a child in an institution or other living arrangement outside of the child's home; and

(7) assign in each local permanency planning site area a single gatekeeper for all children in the area for whom placement in an institution through a state-funded program is sought with authority to ensure that:

(A) family members of each child are aware of:

(i) intensive services that could prevent placement of the child in an institution; and

(ii) available placement options; and

(B) permanency planning is initiated for each child. (Gov. Code, Sec. 531.158.)

Sec. 546.0207. DESIGNATION OF VOLUNTEER ADVOCATE. (a) The commission shall designate an individual, including a member of a community-based organization, to serve as a volunteer advocate for a child residing in an institution to assist in developing a

permanency plan for the child if:

(1) the child's parent or guardian requests the assistance of an advocate;

(2) the institution in which the child is placed cannot locate the child's parent or guardian; or

(3) the child resides in an institution the commission operates.

(b) The individual designated to serve as the child's volunteer advocate may be:

(1) an individual the child's parent or guardian selects, except that the individual may not be employed by or under a contract with the institution in which the child resides;

(2) an adult relative of the child; or

(3) a child advocacy group representative.

(c) The commission shall provide to each individual designated to serve as a child's volunteer advocate information regarding permanency planning under this subchapter. (Gov. Code, Sec. 531.156.)

Sec. 546.0208. PREADMISSION NOTICE AND INFORMATION. (a) The requirements of this section do not apply to a request to place a child in an institution if the child:

(1) is involved in an emergency situation, as defined by rules the executive commissioner adopts; or

(2) has been committed to an institution under:

(A) Chapter 46B, Code of Criminal Procedure; or

(B) Chapter 55, Family Code.

(b) The executive commissioner by rule shall develop and

implement a system by which the commission ensures that, for each child with respect to whom the commission or a local intellectual and developmental disability authority is notified of a request for placement in an institution, the child's parent or guardian is fully informed before the child is placed in the institution of all community-based services and any other service and support options for which the child may be eligible. The system must be designed to ensure that the commission provides the information through:

(1) a local intellectual and developmental disability authority;

(2) any private entity that has knowledge and expertise regarding the needs of and full spectrum of care options available to children with disabilities as well as the philosophy and purpose of permanency planning; or

(3) a commission employee.

(c) The commission shall develop comprehensive information consistent with the policy stated in Section 546.0202 to explain to a parent or guardian considering placing a child in an institution:

(1) options for community-based services;

(2) the benefits to the child of residing in a family or community setting;

(3) that the child's placement in an institution is considered temporary in accordance with Section 546.0215; and

(4) that an ongoing permanency planning process is required under this subchapter and other state law.

(d) An institution in which a child's parent or guardian is considering placing the child may provide the information required

under Subsection (b), but the information must also be provided by a local intellectual and developmental disability authority, private entity, or employee of the commission as required by that subsection.

(e) Except as otherwise provided by this subsection and Subsection (a), the commission shall ensure that, not later than the 14th working day after the date the commission is notified of a request for a child's placement in an institution, the child's parent or guardian is provided the information described by Subsections (b) and (c). The commission may provide the information after the 14th working day after the date the commission is notified of the request if the child's parent or guardian waives the requirement that the information be provided within the period otherwise required by this subsection. (Gov. Code, Sec. 531.1521.)

Sec. 546.0209. REQUIREMENTS OF PARENT OR GUARDIAN ON CHILD'S ADMISSION TO CERTAIN INSTITUTIONS. On the admission of a child to an institution described by Section 546.0201(4)(A), (B), or (D), the commission shall require the child's parent or guardian to submit:

(1) an admission form that includes:

(A) the parent's or guardian's:

(i) name, address, and telephone number;

(ii) driver's license number and state of issuance or personal identification card number the Department of Public Safety issued; and

(iii) place of employment and the employer's address and telephone number; and

(B) the name, address, and telephone number of a relative of the child or other individual whom the commission or institution may contact in an emergency, a statement indicating the relation between that individual and the child, and at the parent's or guardian's option:

(i) that individual's driver's license number and state of issuance or personal identification card number the Department of Public Safety issued; and

(ii) the name, address, and telephone number of that individual's employer; and

(2) a signed acknowledgment of responsibility stating that the parent or guardian agrees to:

(A) notify the institution in which the child is placed of any changes to the information submitted under Subdivision (1)(A); and

(B) make reasonable efforts to participate in the child's life and in planning activities for the child. (Gov. Code, Sec. 531.1533.)

Sec. 546.0210. DUTIES OF CERTAIN INSTITUTIONS: NOTIFICATION REQUIREMENTS AND PARENT OR GUARDIAN ACCOMMODATIONS. (a) This section applies only to an institution described by Section 546.0201(4)(A), (B), or (D).

(b) An institution described by Section 546.0201(4)(A) or (B) shall notify the local intellectual and developmental disability authority for the region in which the institution is located of a request for a child's placement in the institution. An institution described by Section 546.0201(4)(D) shall notify the

commission of a request for a child's placement in the institution.

(c) An institution must make reasonable accommodations to promote the participation of the parent or guardian of a child residing in the institution in all planning and decision-making regarding the child's care, including participation in:

(1) the initial development of the child's permanency plan and periodic review of the plan;

(2) an annual review and reauthorization of the child's service plan;

(3) routine interdisciplinary team meetings;

(4) decision-making regarding the child's medical care; and

(5) decision-making and other activities involving the child's health and safety.

(d) Reasonable accommodations that an institution must make include:

(1) conducting a meeting in person or by telephone, as mutually agreed upon by the institution and the parent or guardian;

(2) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the institution and the parent or guardian;

(3) if a parent or guardian has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.), including providing an accessible meeting location or a sign language interpreter, as applicable; and

(4) providing a language interpreter, if applicable.

(e) Except as otherwise provided by Subsection (f):

(1) an ICF-IID must:

(A) attempt to notify the parent or guardian of a child who resides in the ICF-IID in writing of a periodic permanency planning meeting or annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian; and

(2) a nursing facility must:

(A) attempt to notify the parent or guardian of a child who resides in the facility in writing of an annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian.

(f) If an emergency situation involving a child residing in an ICF-IID or nursing facility occurs, the ICF-IID or nursing facility, as applicable, must:

(1) attempt to notify the child's parent or guardian as soon as possible; and

(2) request a response from the parent or guardian.

(g) If a child's parent or guardian does not respond to the notice provided under Subsection (e) or (f), the ICF-IID or nursing facility, as applicable, must attempt to locate the parent or guardian by contacting another individual whose information was provided by the parent or guardian under Section 546.0209(1)(B).

(h) Not later than the 30th day after the date an ICF-IID or nursing facility determines that the ICF-IID or nursing facility is unable to locate a child's parent or guardian for participation in activities listed under Subsection (e)(1) or (2), the ICF-IID or nursing facility must notify the commission of that determination and request that the commission initiate a search for the child's parent or guardian. (Gov. Code, Sec. 531.164.)

Sec. 546.0211. NOTIFICATION OF PLACEMENT REQUIRED. (a) Not later than the third day after the date a child is initially placed in an institution, the institution shall notify:

(1) the commission, if the child is placed in a nursing facility;

(2) the local intellectual and developmental disability authority for the region in which the institution is located, if the child:

(A) is placed in an ICF-IID; or

(B) is placed by a child protective services agency in a general residential operation for children with an intellectual disability that the commission licenses;

(3) the community resource coordination group in the county of residence of the child's parent or guardian;

(4) if the child is at least three years of age, the school district for the area in which the institution is located; and

(5) if the child is less than three years of age, the local early childhood intervention program for the area in which the institution is located.

(b) The commission shall notify the local intellectual and developmental disability authority of a child's placement in a nursing facility if the child is known or suspected to have an intellectual disability or another disability for which the child may receive services through the commission. (Gov. Code, Sec. 531.154.)

Sec. 546.0212. NOTICE TO PARENT OR GUARDIAN REGARDING PLACEMENT OPTIONS AND SERVICES. Each entity receiving notice of a child's initial placement in an institution under Section 546.0211 may contact the child's parent or guardian to ensure that the parent or guardian is aware of:

(1) services and support that could provide alternatives to placing the child in the institution;

(2) available placement options; and

(3) opportunities for permanency planning. (Gov. Code, Sec. 531.155.)

Sec. 546.0213. PLACEMENT ON WAIVER PROGRAM WAITING LIST. A state agency that receives notice of a child's placement in an institution shall ensure that, on or before the third day after the date the agency is notified of the child's placement in the institution, the child is also placed on a waiting list for Section 1915(c) waiver program services appropriate to the child's needs. (Gov. Code, Sec. 531.157.)

Sec. 546.0214. INTERFERENCE WITH PERMANENCY PLANNING EFFORTS. An entity that provides information to a child's parent or guardian relating to permanency planning shall refrain from providing the child's parent or guardian with inaccurate or

misleading information regarding the risks of moving the child to another facility or community setting. (Gov. Code, Sec. 531.1532.)

Sec. 546.0215. INITIAL PLACEMENT OF CHILD IN INSTITUTION AND PLACEMENT EXTENSIONS. (a) The chief executive officer of each appropriate health and human services agency or the officer's designee must approve a child's placement in an institution. The child's initial placement in the institution is temporary and may not exceed six months unless the appropriate chief executive officer or the officer's designee approves an extension of an additional six months after conducting a review of documented permanency planning efforts to unite the child with a family in a permanent living arrangement.

(b) After the initial six-month extension of a child's placement in an institution approved under Subsection (a), the chief executive officer or the officer's designee shall conduct a review of the child's placement in the institution at least semiannually to determine whether continuing that placement is warranted. If, based on the review, the chief executive officer or the officer's designee determines that an additional extension is warranted, the officer or the officer's designee shall recommend to the executive commissioner that the child continue residing in the institution.

(c) On receipt of a recommendation made under Subsection (b), the executive commissioner, the executive commissioner's designee, or another person with whom the commission contracts shall conduct a review of the child's placement. Based on the results of the review, the executive commissioner or the executive

commissioner's designee may approve a six-month extension of the child's placement if the extension is appropriate.

(d) A child may continue residing in an institution after the six-month extension approved under Subsection (c) only if the chief executive officer of the appropriate health and human services agency or the officer's designee makes subsequent recommendations as provided by Subsection (b) for each additional six-month extension and the executive commissioner or the executive commissioner's designee approves each extension as provided by Subsection (c). (Gov. Code, Secs. 531.159(b), (c), (d).)

Sec. 546.0216. REVIEW OF CERTAIN PLACEMENT DATA. (a) The executive commissioner or the executive commissioner's designee shall conduct a semiannual review of data received from health and human services agencies regarding all children who reside in institutions in this state.

(b) The executive commissioner, the executive commissioner's designee, or a person with whom the commission contracts shall also review the recommendations of the chief executive officer of each appropriate health and human services agency or the officer's designee if the officer or the officer's designee repeatedly recommends that children continue residing in an institution. (Gov. Code, Sec. 531.159(e).)

Sec. 546.0217. PROCEDURES FOR PLACEMENT REVIEWS. The executive commissioner by rule shall develop procedures for conducting the reviews required by Sections 546.0215(c) and (d) and 546.0216. (Gov. Code, Sec. 531.159(f) (part).)

Sec. 546.0218. ANNUAL REAUTHORIZATION OF PLANS OF CARE FOR

CERTAIN CHILDREN. (a) The executive commissioner shall adopt rules under which the commission requires a nursing facility in which a child resides to request from the child's parent or guardian a written reauthorization of the child's plan of care.

(b) The rules must require that the written reauthorization be requested annually. (Gov. Code, Sec. 531.1591.)

Sec. 546.0219. TRANSFER OF CHILD BETWEEN INSTITUTIONS. (a) This section applies only to an institution described by Section 546.0201(4)(A), (B), or (D) in which a child resides.

(b) Before transferring a child who is 17 years of age or younger, or a child who is at least 18 years of age and for whom a guardian has been appointed, from one institution to another institution, the institution in which the child resides must attempt to obtain consent for the transfer from the child's parent or guardian unless the transfer is in response to an emergency situation, as defined by rules the executive commissioner adopts. (Gov. Code, Sec. 531.166.)

Sec. 546.0220. COMPLIANCE WITH PERMANENCY PLAN REQUIREMENTS AS PART OF INSPECTION, SURVEY, OR INVESTIGATION. As part of each inspection, survey, or investigation of an institution, including a nursing facility, a general residential operation for children with an intellectual disability that the commission licenses, or an ICF-IID, in which a child resides, the agency or the agency's designee shall determine the extent to which the nursing facility, general residential operation, or ICF-IID is complying with the permanency planning requirements under this subchapter. (Gov. Code, Sec. 531.160.)

Sec. 546.0221. SEARCH FOR CHILD'S PARENT OR GUARDIAN. (a) The commission shall develop and implement a process by which the commission, on receipt of notification under Section 546.0210(h) that a child's parent or guardian cannot be located, conducts a search for the parent or guardian. If, on the first anniversary of the date the commission receives the notification under that subsection, the commission has been unsuccessful in locating the parent or guardian, the commission shall refer the case to:

(1) the department's child protective services division if the child is 17 years of age or younger; or

(2) the department's adult protective services division if the child is 18 years of age or older.

(b) On receipt of a referral under Subsection (a)(1), the department's child protective services division shall exercise intense due diligence in attempting to locate the child's parent or guardian. If the division is unable to locate the child's parent or guardian, the department shall file a suit affecting the parent-child relationship requesting an order appointing the department as the child's temporary managing conservator.

(c) A child is considered abandoned for purposes of the Family Code if the child's parent or guardian cannot be located following the department's exercise of intense due diligence in attempting to locate the parent or guardian.

(d) On receipt of a referral under Subsection (a)(2), the department's adult protective services division shall notify the court that appointed the child's guardian that the guardian cannot be located. (Gov. Code, Sec. 531.165.)

Sec. 546.0222. DOCUMENTATION OF ONGOING PERMANENCY PLANNING EFFORTS. The commission and each appropriate health and human services agency shall require a person who develops a permanency plan for a child residing in an institution to identify and document in the child's permanency plan all ongoing permanency planning efforts at least semiannually to ensure that, as soon as possible, the child will benefit from a permanent living arrangement with an enduring and nurturing parental relationship. (Gov. Code, Sec. 531.159(a).)

Sec. 546.0223. ACCESS TO RECORDS. Each institution in which a child resides shall allow the following to have access to the child's records to assist in complying with the requirements of this subchapter:

(1) the commission;

(2) appropriate health and human services agencies; and

(3) to the extent not otherwise prohibited by state or federal confidentiality laws, a local intellectual and developmental disability authority or private entity that enters into a contract or memorandum of understanding under Section 546.0203(d) to develop a permanency plan for the child. (Gov. Code, Sec. 531.161.)

Sec. 546.0224. COLLECTION OF INFORMATION REGARDING INVOLVEMENT OF CERTAIN PARENTS AND GUARDIANS. (a) The commission shall collect and maintain aggregate information regarding the involvement of parents and guardians of children residing in institutions described by Sections 546.0201(4)(A), (B), and (D) in

the lives of and planning activities relating to those children. The commission shall obtain input from stakeholders concerning the types of information most useful in assessing the involvement of those parents and guardians.

(b) The commission shall make the aggregate information available to the public on request. (Gov. Code, Sec. 531.167.)

Sec. 546.0225. REPORTING SYSTEMS: SEMIANNUAL REPORTING. (a) For each of the local permanency planning sites, the commission shall develop a reporting system under which each appropriate health and human services agency responsible for permanency planning under this subchapter is required to semiannually provide to the commission:

(1) the number of permanency plans the agency develops for children residing in institutions or children at risk of being placed in institutions;

(2) progress achieved in implementing permanency plans;

(3) the number of children the agency serves residing in institutions;

(4) the number of children the agency serves at risk of being placed in an institution served by the local permanency planning sites;

(5) the number of children the agency serves reunited with their families or placed with alternate permanent families; and

(6) cost data related to developing and implementing permanency plans.

(b) The executive commissioner shall submit to the governor and the committees of the senate and the house of representatives having primary jurisdiction over health and human services agencies a semiannual report on:

(1) the number of children residing in institutions in this state and the number of those children for whom a recommendation has been made for a transition to a community-based residence but who have not yet made that transition;

(2) the circumstances of each child described by Subdivision (1), including the type of institution and name of the institution in which the child resides, the child's age, the residence of the child's parents or guardians, and the length of time during which the child has resided in the institution;

(3) the number of permanency plans developed for children residing in institutions in this state, progress achieved in implementing those plans, and barriers to implementing those plans;

(4) the number of children who previously resided in an institution in this state and have made the transition to a community-based residence;

(5) the number of children who previously resided in an institution in this state and have been reunited with their families or placed with alternate families;

(6) the community supports that resulted in the successful placement of children described by Subdivision (5) with alternate families; and

(7) the community supports that are unavailable but

necessary to address the needs of children who continue to reside in an institution in this state after being recommended to make a transition from the institution to an alternate family or community-based residence. (Gov. Code, Sec. 531.162.)

Sec. 546.0226. EFFECT ON OTHER LAW. This subchapter does not affect responsibilities imposed by federal or other state law on a physician or other professional. (Gov. Code, Sec. 531.163.)

SUBCHAPTER F. FAMILY-BASED ALTERNATIVES FOR CHILDREN

Sec. 546.0251. DEFINITIONS. In this subchapter:

(1) "Child" means an individual younger than 22 years of age who:

(A) has a physical or developmental disability; or

(B) is medically fragile.

(2) "Family-based alternative" means a family setting in which the family provider or providers are specially trained to provide support and in-home care to children with disabilities or children who are medically fragile.

(3) "Family-based alternatives system" means the system of family-based alternatives required under this subchapter.

(4) "Institution" means any congregate care facility, including:

(A) a nursing facility;

(B) an ICF-IID;

(C) a group home operated by the commission; and

(D) a general residential operation for children

with an intellectual disability that the commission licenses.

(5) "Waiver services" means services provided under:

(A) the medically dependent children (MDCP) waiver program;

(B) the community living assistance and support services (CLASS) waiver program;

(C) the home and community-based services (HCS) waiver program;

(D) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(E) any other Section 1915(c) waiver program that provides long-term care services to children. (Gov. Code, Sec. 531.060(c); New.)

Sec. 546.0252. FAMILY-BASED ALTERNATIVES SYSTEM: PURPOSE, IMPLEMENTATION, AND ADMINISTRATION. (a) The purpose of the family-based alternatives system is to further this state's policy of providing for a child's basic needs for safety, security, and stability by ensuring that a child becomes a part of a successful permanent family as soon as possible.

(b) In achieving the purpose described by Subsection (a), the family-based alternatives system is intended to operate in a manner that recognizes that parents are a valued and integral part of the process established under the system. The system must:

(1) encourage parents to participate in all decisions affecting their children; and

(2) respect the authority of parents, other than parents whose parental rights have been terminated, to make

decisions regarding their children.

(c) The commission shall begin implementing the family-based alternatives system in areas of this state with high numbers of children who reside in institutions.

(d) The family-based alternatives system may be administered in cooperation with public and private entities. (Gov. Code, Secs. 531.060(a), (b), (f), (h).)

Sec. 546.0253. FAMILY-BASED ALTERNATIVES SYSTEM DESIGN REQUIREMENTS. (a) The family-based alternatives system must provide for:

(1) recruiting and training alternative families to provide services for children;

(2) comprehensively assessing each child in need of services and each alternative family available to provide services, as necessary to identify the most appropriate alternative family for the child's placement;

(3) providing to a child's parents or guardian information regarding the availability of a family-based alternative;

(4) identifying each child residing in an institution and offering support services, including waiver services, that would enable the child to return to the child's birth family or be placed in a family-based alternative; and

(5) determining through a child's permanency plan other circumstances in which the child must be offered waiver services, including circumstances in which changes in an institution's status affect the child's placement or the quality of

services the child receives.

(b) In complying with the requirement imposed by Subsection (a)(3), the commission shall ensure that the procedures for providing information to parents or a guardian permit and encourage the participation of an individual who is not affiliated with the institution in which the child resides or with an institution in which the child could be placed.

(c) In designing the family-based alternatives system, the commission shall consider and, when appropriate, incorporate current research and recommendations developed by other public and private entities involved in analyzing public policy relating to children residing in institutions. (Gov. Code, Secs. 531.060(i), (j), (m).)

Sec. 546.0254. MEDICAID WAIVER PROGRAM ALIGNMENT. As necessary to implement this subchapter, the commission shall:

(1) ensure that an appropriate number of openings for waiver services that become available as a result of funding for transferring individuals with disabilities into community-based services are made available to both children and adults;

(2) ensure that service definitions applicable to waiver services are modified as necessary to permit the provision of waiver services through family-based alternatives;

(3) ensure that procedures are implemented for making a level of care determination for each child and identifying the most appropriate waiver service for the child, including procedures under which the commission's director of long-term care, after considering any preference of the child's birth family or

alternative family, resolves disputes among agencies about the most appropriate waiver service; and

(4) require that the health and human services agency responsible for providing a specific waiver service to a child also assume responsibility for identifying any necessary transition activities or services. (Gov. Code, Sec. 531.060(n).)

Sec. 546.0255. COMMUNITY ORGANIZATION ELIGIBILITY; CONTRACT AND REQUIREMENTS. (a) The commission shall contract with a community organization, including a faith-based community organization, or a nonprofit organization to develop and implement a family-based alternatives system under which a child who cannot reside with the child's birth family may receive necessary services in a family-based alternative instead of an institution. For purposes of this subsection, a community organization, including a faith-based community organization, or a nonprofit organization does not include:

(1) a governmental entity; or

(2) a quasi-governmental entity to which a state agency delegates authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

(b) To be eligible for the contract under Subsection (a), an organization must possess knowledge regarding the support needs of children with disabilities and their families.

(c) The contracted organization may subcontract for one or more components of implementing the family-based alternatives system with:

(1) community organizations, including faith-based community organizations;

(2) nonprofit organizations;

(3) governmental entities; or

(4) quasi-governmental entities described by Subsection (a)(2). (Gov. Code, Secs. 531.060(d), (e).)

Sec. 546.0256. PLACEMENT OPTIONS. (a) In placing a child in a family-based alternative, the family-based alternatives system may use a variety of placement options, including a shared parenting arrangement between the alternative family and the child's birth family. Regardless of the option used, a family-based alternative placement must be designed as a long-term arrangement, except in cases in which the child's birth family chooses to return the child to their home.

(b) Adoption of the child by the child's alternative family is an available option in cases in which the child's birth family's parental rights have been terminated. (Gov. Code, Sec. 531.060(k).)

Sec. 546.0257. AGENCY COOPERATION. Each affected health and human services agency shall:

(1) cooperate with the contracted organization and any subcontractors; and

(2) take all action necessary to implement the family-based alternatives system and comply with the requirements of this subchapter. (Gov. Code, Sec. 531.060(g) (part).)

Sec. 546.0258. DISPUTE RESOLUTION. The commission has final authority to make any decisions and resolve any disputes regarding the family-based alternatives system. (Gov. Code, Sec.

531.060(g) (part).)

Sec. 546.0259. GIFTS, GRANTS, AND DONATIONS. The commission or the contracted organization may solicit and accept gifts, grants, and donations to support the family-based alternatives system's functions under this subchapter. (Gov. Code, Sec. 531.060(l).)

Sec. 546.0260. ANNUAL REPORT. Not later than January 1 of each year, the commission shall report to the legislature on the implementation of the family-based alternatives system. The report must include a statement of:

(1) the number of children currently receiving care in an institution;

(2) the number of children placed in a family-based alternative under the system during the preceding year;

(3) the number of children who left an institution during the preceding year under an arrangement other than a family-based alternative under the system or for another reason unrelated to the availability of a family-based alternative under the system;

(4) the number of children waiting for an available placement in a family-based alternative under the system; and

(5) the number of alternative families trained and available to accept placement of a child under the system. (Gov. Code, Sec. 531.060(o).)

SUBCHAPTER G. LONG-TERM CARE INSTITUTIONS AND FACILITIES

Sec. 546.0301. PROCEDURES TO REVIEW CONDUCT RELATED TO CERTAIN INSTITUTIONS AND FACILITIES. The commission shall adopt

procedures to review:

(1) citations or penalties assessed for a violation of a rule or law against an institution or facility licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, considering:

(A) the number of violations by geographic region;

(B) the patterns of violations in each region; and

(C) the outcomes following the assessment of a citation or penalty; and

(2) the performance of duties by employees and agents of a state agency responsible for licensing, inspecting, surveying, or investigating institutions and facilities licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, related to:

(A) complaints the commission receives; or

(B) any standards or rules violated by an employee or agent of a state agency. (Gov. Code, Sec. 531.056.)

Sec. 546.0302. ISSUANCE OF MATERIALS TO CERTAIN LONG-TERM CARE FACILITIES. The executive commissioner shall:

(1) review the commission's methods for issuing informational letters, policy updates, policy clarifications, and other related materials to an entity licensed under Chapter 103, Human Resources Code, or Chapter 242, 247, 248A, or 252, Health and

Safety Code; and

(2) develop and implement more efficient methods to issue those materials, as appropriate. (Gov. Code, Sec. 531.0585.)

SUBCHAPTER H. INCENTIVE PAYMENT PROGRAM FOR CERTAIN NURSING FACILITIES

Sec. 546.0351. DEFINITIONS. In this subchapter:

(1) "Incentive payment program" means the program established under this subchapter.

(2) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term care services, as defined by Section 22.0011, Human Resources Code, to recipients. (Gov. Code, Sec. 531.912(a); New.)

Sec. 546.0352. INCENTIVE PAYMENT PROGRAM. (a) If feasible, the executive commissioner by rule may establish an incentive payment program for nursing facilities that choose to participate. The program must be designed to improve the quality of care and services provided to recipients.

(b) Subject to Section 546.0354, the incentive payment program may provide incentive payments in accordance with this section to encourage facilities to participate in the program.

(c) The executive commissioner may:

(1) determine the amount of any incentive payment under the incentive payment program; and

(2) enter into a contract with a qualified person, as the executive commissioner determines, for the following services related to the program:

(A) data collection;

(B) data analysis; and

(C) technical support. (Gov. Code, Secs. 531.912(b), (e).)

Sec. 546.0353. COMMON PERFORMANCE MEASURES. (a) In establishing an incentive payment program, the executive commissioner shall adopt common performance measures to be used in evaluating nursing facilities that are related to structure, process, and outcomes that positively correlate to nursing facility quality and improvement. The common performance measures:

(1) must be:

(A) recognized by the executive commissioner as valid indicators of the overall quality of care recipients receive; and

(B) designed to encourage and reward evidence-based practices among nursing facilities; and

(2) may include measures of:

(A) quality of care, as determined by clinical performance ratings published by the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency;

(B) direct-care staff retention and turnover;

(C) recipient satisfaction, including the satisfaction of recipients who are short-term and long-term facility residents, and family satisfaction, as determined by the Consumer Assessment of Healthcare Providers and Systems Nursing Home Surveys relied on by the Centers for Medicare and Medicaid

Services;

(D) employee satisfaction and engagement;

(E) the incidence of preventable acute care emergency room services use;

(F) regulatory compliance;

(G) level of person-centered care; and

(H) direct-care staff training, including a facility's use of independent distance learning programs for continuously training direct-care staff.

(b) The executive commissioner shall maximize the use of available information technology and limit the number of performance measures adopted under this section to achieve administrative cost efficiency and avoid an unreasonable administrative burden on participating nursing facilities. (Gov. Code, Secs. 531.912(c), (d).)

Sec. 546.0354. SUBJECT TO APPROPRIATIONS. The commission may make incentive payments under an incentive payment program only if money is appropriated for that purpose. (Gov. Code, Sec. 531.912(f).)

SUBCHAPTER I. MEDICAID GENERALLY

Sec. 546.0401. MEDICAID LONG-TERM CARE SYSTEM. (a) The commission shall ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds.

(b) The commission shall also make every effort to improve the quality of care for recipients of Medicaid long-term care

services by:

(1) evaluating the need for expanding the provider base for consumer-directed services and, if the commission identifies a demand for that expansion, encouraging area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with the commission;

(2) ensuring that all recipients who reside in a nursing facility are provided information about end-of-life care options and the importance of planning for end-of-life care; and

(3) developing policies to encourage a recipient who resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an appropriate continuum of care. (Gov. Code, Sec. 531.083.)

Sec. 546.0402. ADMINISTRATION AND DELIVERY OF CERTAIN WAIVER PROGRAMS; PUBLIC INPUT. (a) To the extent authorized by law, the commission shall make uniform the functions relating to the administration and delivery of Section 1915(c) waiver programs, including:

(1) rate-setting;

(2) the applicability and use of service definitions;

(3) quality assurance; and

(4) intake data elements.

(b) Subsection (a) does not apply to functions of a Section 1915(c) waiver program that is operated in conjunction with a federally funded state Medicaid program that is authorized under Section 1915(b) of the Social Security Act (42 U.S.C. Section

1396n(b)).

(c) The commission shall ensure that information on individuals seeking to obtain services from Section 1915(c) waiver programs is maintained in a single computerized database that is accessible to staff of each of the state agencies administering those programs.

(d) In complying with the requirements of this section, the commission shall regularly consult with and obtain input from:

(1) consumers and family members;

(2) providers;

(3) advocacy groups;

(4) state agencies that administer a Section 1915(c) waiver program; and

(5) other interested persons. (Gov. Code, Secs. 531.0218, 531.02191.)

Sec. 546.0403. RECOVERY OF CERTAIN ASSISTANCE; MEDICAID ACCOUNT. (a) The executive commissioner shall ensure that Section 1917(b)(1) of the Social Security Act (42 U.S.C. Section 1396p(b)(1)) is implemented under Medicaid.

(b) The Medicaid account is an account in the general revenue fund. Any funds recovered by implementing the provisions of Section 1917(b)(1) of the Social Security Act (42 U.S.C. Section 1396p(b)(1)) must be deposited in the Medicaid account. Money in the account may be appropriated only to fund long-term care, including community-based care and facility-based care. (Gov. Code, Sec. 531.077.)

SUBCHAPTER J. MEDICAID WAIVER PROGRAMS

Sec. 546.0451. COMPETITIVE AND INTEGRATED EMPLOYMENT INITIATIVE FOR CERTAIN RECIPIENTS; BIENNIAL REPORT. (a) This section applies to an individual receiving services under:

(1) any of the following Section 1915(c) waiver programs:

(A) the home and community-based services (HCS) waiver program;

(B) the Texas home living (TxHmL) waiver program;

(C) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) the community living assistance and support services (CLASS) waiver program; and

(2) the STAR+PLUS home and community-based services (HCBS) waiver program established under Section 1115, Social Security Act (42 U.S.C. Section 1315).

(b) The executive commissioner by rule shall develop a uniform process that complies with the policy adopted under Section 546.0003 to:

(1) assess the goals of and competitive and integrated employment opportunities and related employment services available to an individual to whom this section applies; and

(2) use the identified goals and available opportunities and services to direct the individual's plan of care at the time the plan is developed or renewed.

(c) The entity responsible for developing and renewing the plan of care for an individual to whom this section applies shall

use the uniform process developed under Subsection (b) to assess the individual's goals, opportunities, and services described by that subsection and incorporate those goals, opportunities, and services into the individual's plan of care.

(d) The executive commissioner by rule shall:

(1) identify strategies to increase the number of individuals receiving employment services from the Texas Workforce Commission or through the waiver program in which an individual is enrolled;

(2) determine a reasonable number of individuals who indicate a desire to work to receive employment services and ensure those individuals:

(A) have received employment services during the state fiscal biennium ending August 31, 2023, or during the period beginning September 1, 2023, and ending December 31, 2023, from the Texas Workforce Commission or through the waiver program in which an individual is enrolled; or

(B) are receiving employment services on December 31, 2023, from the Texas Workforce Commission or through the waiver program in which an individual is enrolled; and

(3) ensure each individual who indicates a desire to work is referred to receive employment services from the Texas Workforce Commission or through the waiver program in which the individual is enrolled.

(e) Not later than December 31 of each even-numbered year, the executive commissioner shall prepare and submit to the governor, lieutenant governor, speaker of the house of

representatives, and legislature a written report that outlines:

(1) the number of individuals to whom this section applies who are receiving employment services in accordance with rules adopted under this section;

(2) whether the employment services described by Subdivision (1) are provided by the Texas Workforce Commission, through the waiver program in which an individual is enrolled, or both; and

(3) the number of individuals to whom this section applies who have obtained competitive and integrated employment, categorized by waiver program and, if applicable, an individual's level of care. (Gov. Code, Sec. 531.02448.)

Sec. 546.0452. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER PROGRAMS. (a) In this section, "legally authorized representative" has the meaning assigned by Section 546.0101.

(b) The commission shall consider developing risk management criteria under home and community-based services waiver programs designed to allow individuals eligible to receive services under the programs to assume greater choice and responsibility over the services and supports the individuals receive.

(c) The commission shall ensure that any risk management criteria developed include:

(1) a requirement that if an individual who will be provided services and supports has a legally authorized representative, the representative is involved in determining which services and supports the individual will receive; and

(2) a requirement that if services or supports are

declined, the decision to decline is clearly documented. (Gov. Code, Sec. 531.0515.)

Sec. 546.0453. PROTOCOL FOR MAINTAINING CONTACT INFORMATION OF INDIVIDUALS INTERESTED IN MEDICAID WAIVER PROGRAMS. The commission shall develop a protocol in the office of the ombudsman to improve the capture and updating of contact information for an individual who contacts the office of the ombudsman regarding Medicaid waiver programs or services. (Gov. Code, Sec. 531.0501(d).)

Sec. 546.0454. INTEREST LIST MANAGEMENT FOR CERTAIN MEDICAID WAIVER PROGRAMS. (a) This section applies only to the following waiver programs:

(1) the community living assistance and support services (CLASS) waiver program;

(2) the home and community-based services (HCS) waiver program;

(3) the deaf-blind with multiple disabilities (DBMD) waiver program;

(4) the Texas home living (TxHmL) waiver program;

(5) the medically dependent children (MDCP) waiver program; and

(6) the STAR+PLUS home and community-based services (HCBS) program.

(b) The commission, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052, the state Medicaid managed care advisory committee, and interested stakeholders, shall develop a

questionnaire to be completed by or on behalf of an individual who requests to be placed on or is currently on an interest list for a waiver program.

(c) The questionnaire developed under Subsection (b) must, at a minimum, request the following information about an individual seeking or receiving services under a waiver program:

(1) contact information for the individual or the individual's parent or other legally authorized representative;

(2) the individual's general demographic information;

(3) the individual's living arrangement;

(4) the types of assistance the individual requires;

(5) the individual's current caregiver supports and circumstances that may cause the individual to lose those supports; and

(6) when the delivery of services under a waiver program should begin to ensure the individual's health and welfare and that the individual receives services and supports in the least restrictive setting possible.

(d) If an individual is on a waiver program's interest list and the individual or the individual's parent or other legally authorized representative does not respond to a written or verbal request made by the commission to update information concerning the individual or otherwise fails to maintain contact with the commission, the commission:

(1) shall designate the individual's status on the interest list as inactive until the individual or the individual's parent or other legally authorized representative notifies the

commission that the individual is still interested in receiving services under the waiver program; and

(2) at the time the individual or the individual's parent or other legally authorized representative provides notice to the commission under Subdivision (1), shall designate the individual's status on the interest list as active and restore the individual to the position on the list that corresponds with the date the individual was initially placed on the list.

(e) The commission's designation of an individual's status on an interest list as inactive under Subsection (d) may not result in the removal of the individual from that list or any other waiver program interest list.

(f) Not later than September 1 of each year, the commission shall provide to the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052, or, if that advisory committee is abolished, an appropriate stakeholder advisory committee, as determined by the executive commissioner, the number of individuals, including individuals whose status is designated as inactive by the commission, who are on an interest list to receive services under a waiver program. (Gov. Code, Sec. 531.06011.)

Sec. 546.0455. INTEREST LIST MANAGEMENT FOR CERTAIN CHILDREN ENROLLED IN MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM. (a) This section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) A legally authorized representative of a child who is notified by the commission that the child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forgo the hearing, may request that the commission:

(1) return the child to the interest list for the program unless the child is ineligible due to the child's age; or

(2) place the child on the interest list for another Section 1915(c) waiver program.

(c) At the time a child's legally authorized representative makes a request under Subsection (b), the commission shall:

(1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other individuals on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection

(a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other individuals on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other individuals on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date the child was initially placed on the interest list for the other waiver program.

(d) Notwithstanding Subsection (c)(1)(B) or (c)(2), a child may be placed on an interest list for a Section 1915(c) waiver program in the position described by those subsections only if the child has previously been placed on the interest list for that waiver program.

(e) At the time the commission provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forgo the hearing, the commission shall inform the representative in writing about:

(1) the options under this section for placing the child on an interest list; and

(2) the process for applying for the Medicaid buy-in

program for children with disabilities implemented under Section 532.0353. (Gov. Code, Sec. 531.0601.)

Sec. 546.0456. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM; INTEREST LIST PLACEMENT. (a) Notwithstanding any other law and to the extent allowed by federal law, in determining a child's eligibility for the medically dependent children (MDCP) waiver program, the deaf-blind with multiple disabilities (DBMD) waiver program, or a "Money Follows the Person" demonstration project, the commission shall consider whether the child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or

(2) receives Medicaid hospice or palliative care services.

(b) If the commission determines a child is eligible for a waiver program under Subsection (a), the child's enrollment in the applicable program is contingent on the availability of a slot in the program. If a slot is not immediately available, the commission shall place the child in the first position on the interest list for the medically dependent children (MDCP) waiver program or deaf-blind with multiple disabilities (DBMD) waiver program, as applicable. (Gov. Code, Sec. 531.0603.)

SUBCHAPTER K. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM

Sec. 546.0501. LIMITATION ON NURSING FACILITY LEVEL OF CARE REQUIREMENT. To the extent allowed by federal law, the commission

may not require that a child reside in a nursing facility for an extended period of time to meet the nursing facility level of care required for the child to be determined eligible for the medically dependent children (MDCP) waiver program. (Gov. Code, Sec. 531.0604.)

Sec. 546.0502. CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections 546.0102(b) and 546.0103(1), a consumer direction model implemented under Subchapter C, including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program must allow for the delivery of all services and supports available under that program through consumer direction. (Gov. Code, Sec. 531.0511.)

Sec. 546.0503. ASSESSMENTS AND REASSESSMENTS. (a) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides for review the results of the initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall ensure that providing the results does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services.

(b) The commission shall require the signature of a parent or legally authorized representative to verify the parent's or representative's receipt of the results of the initial assessment or reassessment from the care coordinator. A Medicaid managed care

organization may not delay the delivery of care pending the signature.

(c) The commission shall provide to a parent or legally authorized representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.

(d) This section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal process, the Medicaid fair hearing process, or the external medical review process. (Gov. Code, Sec. 531.0602.)

Sec. 546.0504. QUALITY MONITORING BY EXTERNAL QUALITY REVIEW ORGANIZATION. The commission, based on the state's external quality review organization's initial report on the STAR Kids managed care program, shall determine whether the findings of the report necessitate additional data and research to improve the program. If the commission determines additional data and research are needed, the commission, through the external quality review organization, may:

(1) conduct annual surveys of recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;

(2) conduct annual focus groups with recipients described by Subdivision (1) or their representatives on issues

identified through:

(A) the Consumer Assessment of Healthcare Providers and Systems;

(B) other external quality review organization activities; or

(C) stakeholders; and

(3) in consultation with the STAR Kids Managed Care Advisory Committee and as frequently as feasible, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as the collaborative innovation improvement network. (Gov. Code, Sec. 531.06021(a).)

Sec. 546.0505. QUARTERLY REPORT. Not later than the 30th day after the last day of each state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for recipients receiving benefits under the medically dependent children (MDCP) waiver program:

(1) enrollment in the Medicaid buy-in for children program implemented under Section 532.0353;

(2) requests relating to interest list placements under Section 546.0455;

(3) use of the Medicaid escalation help line established under Subchapter R, Chapter 540, if the help line was operational during the applicable state fiscal quarter;

(4) use of, requests for, and outcomes of the external medical review procedure established under Section 532.0404; and

(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition. (Gov. Code, Sec. 531.06021(b).)

SUBCHAPTER L. QUALITY ASSURANCE FEE PROGRAM

Sec. 546.0551. QUALITY ASSURANCE FEE FOR CERTAIN MEDICAID WAIVER PROGRAM SERVICES. (a) In this section, "gross receipts" means money received as compensation for services under an intermediate care facility for individuals with an intellectual disability waiver program, such as a home and community services waiver or a community living assistance and support services waiver. The term does not include:

(1) a charitable contribution;

(2) revenues received for services or goods other than waivers; or

(3) any money received from consumers or their families as reimbursement for services or goods not normally covered under a waiver program.

(b) The executive commissioner by rule shall modify the quality assurance fee program under Subchapter H, Chapter 252, Health and Safety Code, by providing for a quality assurance fee program that imposes a quality assurance fee on persons providing services under a home and community services waiver or a community living assistance and support services waiver.

(c) The executive commissioner shall establish the fee at an amount that will produce annual revenues of not more than six

percent of the total annual gross receipts in this state.

(d) The executive commissioner shall adopt rules governing:

(1) the reporting required to compute and collect the fee and the manner and times of collecting the fee; and

(2) the administration of the fee, including the imposition of penalties for a violation of the rules.

(e) Fees collected under this section must be deposited in the waiver program quality assurance fee account. (Gov. Code, Sec. 531.078.)

Sec. 546.0552. WAIVER PROGRAM QUALITY ASSURANCE FEE ACCOUNT. (a) The waiver program quality assurance fee account is a dedicated account in the general revenue fund. The account is exempt from the application of Section 403.095.

(b) The account consists of fees collected under Section 546.0551.

(c) Subject to legislative appropriation and state and federal law, money in the account may be appropriated only to the commission to:

(1) increase reimbursement rates paid under:

(A) the home and community services waiver program; or

(B) the community living assistance and support services (CLASS) waiver program; or

(2) offset allowable expenses under Medicaid. (Gov. Code, Sec. 531.079.)

Sec. 546.0553. REIMBURSEMENT UNDER CERTAIN MEDICAID WAIVER PROGRAMS. Subject to legislative appropriation and state and

federal law, the commission shall use money from the waiver program quality assurance fee account, together with any federal money available to match money from the account, to increase reimbursement rates paid under:

(1) the home and community services waiver program; or

(2) the community living assistance and support services (CLASS) waiver program. (Gov. Code, Sec. 531.080.)

Sec. 546.0554. INVALIDITY; FEDERAL MONEY. If any portion of Section 546.0551, 546.0552, or 546.0553 is held invalid by a final order of a court that is not subject to appeal, or if the commission determines that the imposition of the quality assurance fee and the expenditure of the money collected as provided by those sections will not entitle this state to receive additional federal money under Medicaid, the commission shall:

(1) stop collecting the quality assurance fee; and

(2) not later than the 30th day after the date the commission stops collecting the quality assurance fee, return any money collected under Section 546.0551, but not spent under Section 546.0553, to the persons who paid the fees in proportion to the total amount paid by those persons. (Gov. Code, Sec. 531.081.)

Sec. 546.0555. EXPIRATION OF QUALITY ASSURANCE FEE PROGRAM. If Subchapter H, Chapter 252, Health and Safety Code, expires, this subchapter expires on the same date. (Gov. Code, Sec. 531.082.)

SUBCHAPTER M. VOLUNTEER ADVOCATE PROGRAM FOR CERTAIN ELDERLY INDIVIDUALS

Sec. 546.0601. DEFINITIONS. In this subchapter:

(1) "Designated caregiver" means:

(A) a person designated as a caregiver by an elderly individual receiving services from or under the direction of the commission or a health and human services agency; or

(B) a court-appointed guardian of an elderly individual receiving services from or under the direction of the commission or a health and human services agency.

(2) "Elderly individual" means an individual who is at least 60 years of age.

(3) "Program" means the volunteer advocate program created under this subchapter for elderly individuals receiving services from or under the direction of the commission or a health and human services agency.

(4) "Volunteer advocate" means a person who successfully completes the volunteer advocate curriculum described by Section 546.0602(2). (Gov. Code, Sec. 531.057(a).)

Sec. 546.0602. PROGRAM PRINCIPLES. The program must adhere to the following principles:

(1) the intent of the program is to evaluate, through the operation of pilot projects, whether providing the services of a trained volunteer advocate selected by an elderly individual or the individual's designated caregiver is effective in achieving the following goals:

(A) extend the time the elderly individual can remain in an appropriate home setting;

(B) maximize the efficiency of services delivered to the elderly individual by focusing on services needed to sustain family caregiving;

(C) protect the elderly individual by providing a knowledgeable third party to review the quality of care and services delivered to the individual and the care options available to the individual and the individual's family; and

(D) facilitate communication between the elderly individual or the individual's designated caregiver and providers of health care and other services;

(2) a volunteer advocate curriculum must be maintained that incorporates best practices as determined and recognized by a professional organization recognized in the elder health care field;

(3) the use of pro bono assistance from qualified professionals must be maximized in modifying the volunteer advocate curriculum and the program;

(4) trainers must be certified on the ability to deliver training;

(5) training shall be offered through multiple community-based organizations; and

(6) participation in the program is voluntary and must be initiated by an elderly individual or the individual's designated caregiver. (Gov. Code, Sec. 531.057(c).)

Sec. 546.0603. AGREEMENTS WITH NONPROFIT ORGANIZATIONS; ORGANIZATION ELIGIBILITY. The executive commissioner may enter into agreements with appropriate nonprofit organizations to provide services under the program. A nonprofit organization is eligible to provide services under the program if the organization:

(1) has significant experience in providing services

to elderly individuals;

(2) has the capacity to provide training and supervision for individuals interested in serving as volunteer advocates; and

(3) meets any other criteria prescribed by the executive commissioner. (Gov. Code, Sec. 531.057(d).)

Sec. 546.0604. FUNDING. (a) The commission shall fund the program, including the design and evaluation of pilot projects, modification of the volunteer advocate curriculum, and training of volunteers, through existing appropriations to the commission.

(b) Notwithstanding Subsection (a), the commission may accept gifts, grants, or donations for the program from any source to:

(1) carry out the design of the program;

(2) develop criteria for evaluating any proposed pilot projects operated under the program;

(3) modify a volunteer advocate training curriculum;

(4) conduct training for volunteer advocates; and

(5) develop a request for offers to conduct any proposed pilot projects under the program. (Gov. Code, Secs. 531.057(e), (f).)

Sec. 546.0605. RULES. The executive commissioner may adopt rules as necessary to implement the program. (Gov. Code, Sec. 531.057(g).)

SUBCHAPTER N. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT PROGRAM

Sec. 546.0651. DEFINITION. In this subchapter, "pilot program" means the pilot program established under this subchapter.

(New.)

Sec. 546.0652. PILOT PROGRAM. The commission shall collaborate with the STAR Kids Managed Care Advisory Committee, recipients, family members of children with complex medical conditions, children's health care advocates, Medicaid managed care organizations, and other stakeholders to develop and implement a pilot program that is substantially similar to the program described by Section 3, Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), to provide coordinated care through a health home to children with complex medical conditions. (Gov. Code, Sec. 531.0605(a).)

Sec. 546.0653. FEDERAL GUIDANCE AND FUNDING. The commission shall seek guidance from the Centers for Medicare and Medicaid Services and the United States Department of Health and Human Services regarding the design of the program and, based on the guidance, may actively seek and apply for federal funding to implement the program. (Gov. Code, Sec. 531.0605(b).)

Sec. 546.0654. REPORT. Not later than December 31, 2024, the commission shall prepare and submit to the legislature a report that includes:

(1) a summary of the commission's implementation of the pilot program; and

(2) if the pilot program has been operating for a period sufficient to obtain necessary data:

(A) a summary of the commission's evaluation of the effect of the pilot program on the coordination of care for children with complex medical conditions; and

(B) a recommendation as to whether the pilot program should be continued, expanded, or terminated. (Gov. Code, Sec. 531.0605(c).)

Sec. 546.0655. EXPIRATION. The pilot program terminates and this subchapter expires September 1, 2025. (Gov. Code, Sec. 531.0605(d).)

SUBCHAPTER O. MORTALITY REVIEW FOR CERTAIN INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITY

Sec. 546.0701. DEFINITION. In this subchapter, "contracted organization" means an entity that contracts with the commission to provide the services described by Section 546.0702(b). (Gov. Code, Sec. 531.8501.)

Sec. 546.0702. MORTALITY REVIEW SYSTEM. (a) The executive commissioner shall establish an independent mortality review system to review the death of an individual with an intellectual or developmental disability who, at the time of the individual's death or at any time during the 24-hour period preceding the individual's death:

(1) resided in or received services from:

(A) an ICF-IID operated or licensed by the commission or a community center; or

(B) the ICF-IID component of the Rio Grande State Center; or

(2) received services through a Section 1915(c) waiver program for individuals who are eligible for ICF-IID services.

(b) The executive commissioner shall contract with an institution of higher education or a health care organization or

association with experience in conducting research-based mortality studies to conduct independent mortality reviews of individuals with an intellectual or developmental disability. The contract must require the contracted organization to form a review team consisting of:

(1) a physician with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(2) a registered nurse with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(3) a clinician or other professional with expertise in the delivery of services and supports for individuals with an intellectual or developmental disability; and

(4) any other appropriate individual as the executive commissioner provides.

(c) A review under this subchapter must be conducted:

(1) in addition to any review conducted by the facility in which the individual resided or the facility, agency, or provider from which the individual received services; and

(2) after any investigation of alleged or suspected abuse, neglect, or exploitation is completed.

(d) To ensure consistency across mortality review systems, a review under this subchapter must collect information consistent with the information required to be collected by another independent mortality review process established specifically for individuals with an intellectual or developmental disability.

(e) The executive commissioner shall adopt rules regarding the manner in which the death of an individual described by Subsection (a) must be reported to the contracted organization by a facility or waiver program provider described by that subsection. (Gov. Code, Sec. 531.851.)

Sec. 546.0703. ACCESS TO INFORMATION AND RECORDS. (a) A contracted organization may request information and records regarding a deceased individual as necessary to carry out the organization's duties. The requested information and records may include:

(1) medical, dental, and mental health care information; and

(2) information and records maintained by any state or local government agency, including:

(A) a birth certificate;

(B) law enforcement investigative data;

(C) medical examiner investigative data;

(D) juvenile court records;

(E) parole and probation information and records; and

(F) adult or child protective services information and records.

(b) On request of the contracted organization, the custodian of the relevant information and records relating to a deceased individual shall provide those records to the organization at no charge. (Gov. Code, Sec. 531.852.)

Sec. 546.0704. MORTALITY REVIEW REPORTS. Subject to

Section 546.0705, a contracted organization shall submit:

(1) to the commission, the Department of Family and Protective Services, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report of the findings of the mortality review; and

(2) semiannually to the governor, the lieutenant governor, the speaker of the house of representatives, and the standing committees of the senate and house of representatives with primary jurisdiction over the commission, the department, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report that contains:

(A) aggregate information regarding the deaths for which the organization performed an independent mortality review;

(B) trends in the causes of death the organization identifies; and

(C) any suggestions for system-wide improvements to address conditions that contributed to deaths reviewed by the organization. (Gov. Code, Sec. 531.853.)

Sec. 546.0705. USE AND PUBLICATION RESTRICTIONS; CONFIDENTIALITY. (a) The commission may use or publish information under this subchapter only to advance statewide practices regarding the treatment and care of individuals with an intellectual or developmental disability. A summary of the data in the contracted organization's reports or a statistical compilation of data reports may be released by the commission for general

publication if the summary or statistical compilation does not contain any information that would permit the identification of an individual or that is confidential or privileged under this subchapter or other state or federal law.

(b) Information and records acquired by the contracted organization in the exercise of the organization's duties under this subchapter:

(1) are confidential and exempt from disclosure under Chapter 552; and

(2) may be disclosed only as necessary to carry out the organization's duties.

(c) The identity of:

(1) an individual whose death was reviewed in accordance with this subchapter is confidential and may not be revealed; and

(2) a health care provider or the name of a facility or agency that provided services to or was the residence of an individual whose death was reviewed in accordance with this subchapter is confidential and may not be revealed.

(d) Reports, information, statements, memoranda, and other information furnished under this subchapter to the contracted organization and any findings or conclusions resulting from a review by the organization are privileged.

(e) A contracted organization's report of the findings of the independent mortality review conducted under this subchapter and any records the organization develops relating to the review:

(1) are confidential and privileged;

(2) are not subject to discovery or subpoena; and

(3) may not be introduced into evidence in any civil, criminal, or administrative proceeding.

(f) A member of the contracted organization's review team may not testify or be required to testify in a civil, criminal, or administrative proceeding as to observations, factual findings, or conclusions that were made in conducting a review under this subchapter. (Gov. Code, Sec. 531.854.)

Sec. 546.0706. LIMITATION ON LIABILITY. A health care provider or other person is not civilly or criminally liable for furnishing information to the contracted organization or to the commission for use by the organization in accordance with this subchapter unless the person acted in bad faith or knowingly provided false information to the organization or the commission. (Gov. Code, Sec. 531.855.)

CHAPTER 547. MENTAL HEALTH AND SUBSTANCE USE SERVICES

SUBCHAPTER A. DELIVERY OF MENTAL HEALTH AND SUBSTANCE USE SERVICES

SUBCHAPTER B. TEXAS SYSTEM OF CARE FRAMEWORK

CHAPTER 547. MENTAL HEALTH AND SUBSTANCE USE SERVICES

SUBCHAPTER A. DELIVERY OF MENTAL HEALTH AND SUBSTANCE USE SERVICES

Sec. 547.0001. EVALUATION OF CERTAIN CONTRACTORS AND SUBCONTRACTORS. (a) To ensure the appropriate delivery of mental health and substance use services, the commission shall regularly evaluate program contractors and subcontractors that provide or arrange services for individuals enrolled in:

(1) the Medicaid managed care program; and

(2) the child health plan program.

(b) The commission shall monitor:

(1) penetration rates as those rates relate to mental health and substance use services provided by or through contractors and subcontractors;

(2) utilization rates as those rates relate to mental health and substance use services provided by or through contractors and subcontractors; and

(3) provider networks used by contractors and subcontractors to provide mental health or substance use services. (Gov. Code, Sec. 531.0225.)

Sec. 547.0002. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE. (a) In this section, "ombudsman" means the individual designated under this section by the executive commissioner as the ombudsman for behavioral health access to care unless the context requires otherwise.

(b) The executive commissioner shall designate an ombudsman for behavioral health access to care.

(c) The ombudsman is administratively attached to the

commission's office of the ombudsman established under Section 523.0255.

(d) The commission may use an alternate title for the ombudsman in consumer-facing materials if the commission determines that an alternate title would benefit consumer understanding or access.

(e) The ombudsman serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

(f) The ombudsman shall:

(1) interact with consumers and behavioral health care providers regarding concerns or complaints to help the consumers and providers resolve behavioral health care access issues;

(2) identify, track, and help report potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to quantitative and nonquantitative treatment limitations;

(3) report concerns, complaints, and potential violations described by Subdivision (2) to the appropriate regulatory or oversight agency;

(4) receive and report concerns and complaints relating to inappropriate care or mental health commitment;

(5) provide appropriate information to help consumers obtain behavioral health care;

(6) develop appropriate points of contact for referrals to other state and federal agencies; and

(7) provide appropriate information to help consumers or providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies.

(g) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive the reports of concerns, complaints, and potential violations described by Subsection (f)(2) from the ombudsman, consumers, or behavioral health care providers. (Gov. Code, Sec. 531.02251.)

Sec. 547.0003. RULES GOVERNING PEER SPECIALISTS. (a) With input from mental health and substance use peer specialists, the commission shall develop and the executive commissioner shall adopt:

(1) rules establishing training requirements for peer specialists to provide services to individuals with mental illness or individuals with substance use conditions;

(2) rules establishing certification and supervision requirements for peer specialists;

(3) rules defining the scope of services that peer specialists may provide;

(4) rules distinguishing peer services from other services that a person must hold a license to provide; and

(5) any other rules necessary to protect the health and safety of individuals receiving peer services.

(b) The executive commissioner may not adopt rules under this section that preclude the provision of mental health rehabilitative services under 25 T.A.C. Chapter 416, Subchapter A, as that subchapter existed on January 1, 2017. (Gov. Code, Secs. 531.0999(a), (f).)

Sec. 547.0004. VETERAN SUICIDE PREVENTION ACTION PLAN. (a) The commission, in collaboration with the Texas Coordinating Council for Veterans Services, the United States Department of Veterans Affairs, the Service Members, Veterans, and their Families Technical Assistance Center Implementation Academy of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, veteran advocacy groups, health care providers, and any other organization or interested party the commission considers appropriate, shall develop a comprehensive action plan to increase access to and availability of professional veteran health services to prevent veteran suicides.

(b) The action plan must:

(1) identify opportunities for raising awareness of and providing resources for veteran suicide prevention;

(2) identify opportunities to increase access to veteran mental health services;

(3) identify funding resources to provide accessible, affordable veteran mental health services;

(4) provide measures to expand public-private partnerships to ensure access to quality, timely mental health services;

(5) provide for proactive outreach measures to reach veterans needing care;

(6) provide for peer-to-peer service coordination, including training, certification, recertification, and continuing education for peer coordinators; and

(7) address suicide prevention awareness, measures, and training regarding veterans involved in the justice system.

(c) The commission shall make specific long-term statutory, administrative, and budget-related recommendations to the legislature and the governor regarding the policy initiatives and reforms necessary to implement the action plan developed under this section. The initiatives and reforms in the long-term plan must be fully implemented by September 1, 2027.

(d) The commission shall include in the commission's strategic plan under Chapter 2056 the plans for implementing the long-term recommendations under Subsection (c).

(e) This section expires September 1, 2027. (Gov. Code, Secs. 531.0925(a), (b), (c) (part), (d), (e).)

Sec. 547.0005. LOCAL MENTAL HEALTH AUTHORITY GROUP REGIONAL STRATEGIES; ANNUAL REPORT. (a) In this section, "local mental health authority group" means a group of local mental health authorities established by the commission under Chapter 963 (S.B. 633), Acts of the 86th Legislature, Regular Session, 2019.

(b) The commission shall require each local mental health authority group to meet at least quarterly to collaborate on planning and implementing regional strategies to reduce:

(1) costs to local governments of providing services

to individuals experiencing a mental health crisis;

(2) transportation to mental health facilities of individuals served by an authority that is a member of the group;

(3) incarceration of individuals with mental illness in county jails located in an area served by an authority that is a member of the group; and

(4) visits by individuals with mental illness at hospital emergency rooms located in an area served by an authority that is a member of the group.

(c) The commission shall use federal funds in accordance with state and federal guidelines to implement this section.

(d) The commission, in coordination with each local mental health authority group, shall annually update the mental health services development plan that was initially developed by the commission and each local mental health authority group under Chapter 963 (S.B. 633), Acts of the 86th Legislature, Regular Session, 2019. The commission and each group's updated plan must include a description of:

(1) actions taken by the group to implement regional strategies in the plan; and

(2) new regional strategies identified by the group to reduce the circumstances described by Subsection (b), including the estimated number of outpatient and inpatient beds necessary to meet the goals of each group's regional strategy.

(e) Not later than December 1 of each year, the commission shall produce and publish on the commission's Internet website a report containing the most recent version of each mental health

services development plan developed by the commission and a local mental health authority group. (Gov. Code, Sec. 531.0222.)

SUBCHAPTER B. TEXAS SYSTEM OF CARE FRAMEWORK

Sec. 547.0051. DEFINITIONS. In this subchapter:

(1) "Minor" means an individual younger than 18 years of age.

(2) "Serious emotional disturbance" means a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment that substantially interferes with or limits an individual's role or ability to function in family, school, or community activities.

(3) "System of care framework" means a framework for collaboration among state agencies, minors who have a serious emotional disturbance or are at risk of developing a serious emotional disturbance, and the families of those minors that improves access to services and delivers effective community-based services that are family-driven, youth- or young adult-guided, and culturally and linguistically competent. (Gov. Code, Sec. 531.251(a).)

Sec. 547.0052. TEXAS SYSTEM OF CARE FRAMEWORK. (a) The commission shall implement a system of care framework to develop local mental health systems of care in communities for minors who:

(1) have or are at risk of developing a serious emotional disturbance;

(2) are receiving residential mental health services and supports or inpatient mental health hospitalization; or

(3) are at risk of being removed from the minor's home

and placed in a more restrictive environment to receive mental health services and supports, including:

(A) an inpatient mental health hospital;

(B) a residential treatment facility; or

(C) a facility or program operated by the Department of Family and Protective Services or an agency that is part of the juvenile justice system.

(b) The commission shall:

(1) maintain a comprehensive plan for the delivery of mental health services and supports to a minor and a minor's family using a system of care framework, including best practices in the financing, administration, governance, and delivery of those services;

(2) enter into memoranda of understanding with the Department of State Health Services, the Department of Family and Protective Services, the Texas Education Agency, the Texas Juvenile Justice Department, and the Texas Correctional Office on Offenders with Medical or Mental Impairments that specify the roles and responsibilities of each agency in implementing the comprehensive plan;

(3) identify appropriate local, state, and federal funding sources to finance infrastructure and mental health services and supports necessary to support state and local system of care framework efforts; and

(4) develop an evaluation system to measure cross-system performance and outcomes of state and local system of care framework efforts.

(c) In implementing this section, the commission shall consult with stakeholders, including:

(1) minors who have or are at risk of developing a serious emotional disturbance or young adults who received mental health services and supports as a minor with or at risk of developing a serious emotional disturbance; and

(2) family members of those minors or young adults. (Gov. Code, Secs. 531.251(b), (c).)

Sec. 547.0053. IMPLEMENTATION. The commission shall:

(1) monitor the implementation of a system of care framework under Section 547.0052; and

(2) adopt rules necessary to facilitate or adjust that implementation. (Gov. Code, Sec. 531.255.)

Sec. 547.0054. TECHNICAL ASSISTANCE FOR LOCAL SYSTEMS OF CARE. The commission may provide technical assistance to a community that implements a local system of care. (Gov. Code, Sec. 531.257.)

SUBCHAPTER C. SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCES

Sec. 547.0101. DEFINITIONS. In this subchapter:

(1) "Children with severe emotional disturbances" includes children:

(A) who are at risk of incarceration or placement in a residential mental health facility;

(B) who are students in a special education program under Subchapter A, Chapter 29, Education Code;

(C) with a substance use disorder or a

developmental disability; and

(D) for whom a court may appoint the Department of Family and Protective Services as managing conservator.

(2) "Community resource coordination group" means a coordination group established under a memorandum of understanding adopted under Subchapter D, Chapter 522.

(3) "Systems of care services" means a comprehensive state system of mental health services and other necessary and related services that is organized as a coordinated network to meet the multiple and changing needs of children with severe emotional disturbances and their families. (Gov. Code, Sec. 531.421.)

Sec. 547.0102. EVALUATIONS BY COMMUNITY RESOURCE COORDINATION GROUPS. (a) Each community resource coordination group shall evaluate the provision of systems of care services in the community that the group serves. The evaluation must:

(1) describe and prioritize services needed by children with severe emotional disturbances in the community;

(2) review and assess the available systems of care services in the community to meet those needs;

(3) assess the integration of the provision of those services; and

(4) identify barriers to the effective provision of those services.

(b) Each community resource coordination group shall create a report that includes the evaluation described by Subsection (a) and related recommendations, including:

(1) suggested policy and statutory changes for

agencies providing systems of care services; and

(2) recommendations for overcoming barriers to the provision of systems of care services and improving the integration of those services.

(c) Each community resource coordination group shall submit the report described by Subsection (b) to the commission. The commission shall provide to each group a deadline for submitting the report that is coordinated with any regional reviews by the commission of the delivery of related services. (Gov. Code, Sec. 531.422.)

Sec. 547.0103. SUMMARY REPORT BY COMMISSION. (a) The commission shall create a summary report based on the evaluations in the reports submitted to the commission by community resource coordination groups under Section 547.0102. The commission's report must include:

(1) recommendations for policy and statutory changes at each agency involved in providing systems of care services; and

(2) the outcome expected from implementing each recommendation.

(b) The commission may include in the report created under this section recommendations for:

(1) the statewide expansion of sites participating in the Texas System of Care; and

(2) the integration of services provided at those sites with services provided by community resource coordination groups.

(c) The commission shall coordinate, where appropriate, the

recommendations in the report created under this section with:

(1) recommendations in the assessment developed under Chapter 23 (S.B. 491), Acts of the 78th Legislature, Regular Session, 2003; and

(2) the continuum of care developed under Section 533.040(d), Health and Safety Code.

(d) The commission shall provide a copy of the report created under this section to each agency for which the report makes a recommendation and to other agencies as appropriate. (Gov. Code, Sec. 531.423.)

Sec. 547.0104. AGENCY IMPLEMENTATION OF RECOMMENDATIONS. As appropriate, the person responsible for adopting rules for an agency described by Section 547.0103(a) shall implement the recommendations in the report created under Section 547.0103 by:

(1) adopting rules;

(2) implementing policy changes; and

(3) entering into memoranda of understanding with other agencies. (Gov. Code, Sec. 531.424.)

SUBCHAPTER D. STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL

Sec. 547.0151. DEFINITION. In this subchapter, "council" means the statewide behavioral health coordinating council. (Gov. Code, Sec. 531.471.)

Sec. 547.0152. PURPOSE. The council is established to ensure a strategic statewide approach to behavioral health services. (Gov. Code, Sec. 531.472.)

Sec. 547.0153. COMPOSITION OF COUNCIL. (a) The council is composed of at least one representative designated by each of the

following entities:

(1) the governor's office;

(2) the Texas Veterans Commission;

(3) the commission;

(4) the Department of State Health Services;

(5) the Department of Family and Protective Services;

(6) the Texas Civil Commitment Office;

(7) The University of Texas Health Science Center at Houston;

(8) The University of Texas Health Science Center at Tyler;

(9) the Texas Tech University Health Sciences Center;

(10) the Texas Department of Criminal Justice;

(11) the Texas Correctional Office on Offenders with Medical or Mental Impairments;

(12) the Commission on Jail Standards;

(13) the Texas Indigent Defense Commission;

(14) the court of criminal appeals;

(15) the Texas Juvenile Justice Department;

(16) the Texas Military Department;

(17) the Texas Education Agency;

(18) the Texas Workforce Commission;

(19) the Health Professions Council, representing:

(A) the State Board of Dental Examiners;

(B) the Texas State Board of Pharmacy;

(C) the State Board of Veterinary Medical Examiners;

(D) the Texas Optometry Board;

(E) the Texas Board of Nursing; and

(F) the Texas Medical Board; and

(20) the Texas Department of Housing and Community Affairs.

(b) The executive commissioner shall determine the number of representatives that each entity may designate to serve on the council.

(c) The council may authorize another state agency or institution that provides specific behavioral health services with the use of appropriated money to designate a representative to the council.

(d) A council member serves at the pleasure of the designating entity. (Gov. Code, Sec. 531.473.)

Sec. 547.0154. PRESIDING OFFICER. The mental health statewide coordinator shall serve as the presiding officer of the council. (Gov. Code, Sec. 531.474.)

Sec. 547.0155. MEETINGS. The council shall meet at least once quarterly or more frequently at the call of the presiding officer. (Gov. Code, Sec. 531.475.)

Sec. 547.0156. POWERS AND DUTIES. (a) The council:

(1) shall develop and monitor the implementation of a five-year statewide behavioral health strategic plan;

(2) shall develop a biennial coordinated statewide behavioral health expenditure proposal;

(3) shall annually publish an updated inventory of behavioral health programs and services that this state funds that

includes a description of how those programs and services further the purpose of the statewide behavioral health strategic plan;

(4) may create subcommittees to carry out the council's duties under this subchapter; and

(5) may facilitate opportunities to increase collaboration for the effective expenditure of available federal and state funds for behavioral and mental health services in this state.

(b) The council shall include statewide suicide prevention efforts in the five-year statewide behavioral health strategic plan the council develops under Subsection (a). (Gov. Code, Sec. 531.476.)

Sec. 547.0157. SUICIDE PREVENTION SUBCOMMITTEE; SUICIDE DATA REPORTS. (a) The council shall create a suicide prevention subcommittee to focus on statewide suicide prevention efforts using information collected by the council from available sources of suicide data reports. The suicide prevention subcommittee shall establish guidelines for the frequent use of those reports in carrying out the council's purpose under this subchapter.

(b) The suicide prevention subcommittee shall establish a method for identifying how suicide data reports are used to make policy.

(c) Public or private entities that collect information regarding suicide and suicide prevention may provide suicide data reports to commission staff the executive commissioner designates to receive those reports. (Gov. Code, Sec. 531.477.)

SUBCHAPTER E. BEHAVIORAL HEALTH GRANT PROGRAMS GENERALLY

Sec. 547.0201. STREAMLINING PROCESS FOR AWARDING BEHAVIORAL HEALTH GRANTS. (a) The commission shall implement a process to better coordinate behavioral health grants the commission administers. The process must:

(1) streamline the administrative processes at the commission; and

(2) decrease the administrative burden on applicants applying for multiple grants.

(b) The process may include developing a standard application for multiple behavioral health grants. (Gov. Code, Sec. 531.0991(m).)

SUBCHAPTER F. MATCHING GRANT PROGRAM FOR CERTAIN COMMUNITY MENTAL HEALTH PROGRAMS ASSISTING INDIVIDUALS EXPERIENCING MENTAL ILLNESS

Sec. 547.0251. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Sec. 547.0252. MATCHING GRANT PROGRAM. To the extent money is appropriated to the commission for that purpose, the commission shall establish a matching grant program to support community mental health programs providing services and treatment to individuals experiencing mental illness. (Gov. Code, Sec. 531.0991(a).)

Sec. 547.0253. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS. (a) The commission shall:

(1) condition each grant awarded under this subchapter on the grant recipient obtaining and securing funds to match the

grant from non-state sources in amounts of money or other consideration as required by Subsection (c); and

(2) ensure that each grant recipient obtains or secures contributions to match a grant awarded to the recipient in an amount of money or other consideration as required by Subsection (c).

(b) The matching contributions obtained or secured by the grant recipient, as the executive commissioner determines, may include cash or in-kind contributions from any person but may not include money from state or federal funds.

(c) A grant recipient must leverage funds in an amount equal to:

(1) 25 percent of the grant amount if the community mental health program is located in a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the community mental health program is located in a county with a population of 100,000 or more but less than 250,000;

(3) 100 percent of the grant amount if the community mental health program is located in a county with a population of at least 250,000; and

(4) the percentage of the grant amount otherwise required by this subsection for the largest county in which a community mental health program is located if the community mental health program is located in more than one county. (Gov. Code, Secs. 531.0991(b), (g), (h).)

Sec. 547.0254. SELECTION OF RECIPIENTS; APPLICATIONS AND

PROPOSALS. The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and governmental entities. The executive commissioner shall develop criteria for evaluating those applications or proposals and the selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address whether the services proposed in the application or proposal would duplicate services already available in the applicant's service area;

(3) address the possibility of and method for making multiple awards; and

(4) include other factors that the executive commissioner considers relevant. (Gov. Code, Sec. 531.0991(e).)

Sec. 547.0255. LOCAL MENTAL HEALTH AUTHORITY INVOLVEMENT. (a) A nonprofit or governmental entity that applies for a grant under this subchapter must:

(1) notify each local mental health authority with a local service area covered wholly or partly by the entity's proposed community mental health program; and

(2) provide in the entity's application a letter of support from each of those local mental health authorities.

(b) The commission shall consider a local mental health

authority's written input before awarding a grant under this subchapter and may take any recommendations made by the authority. (Gov. Code, Sec. 531.0991(f).)

Sec. 547.0256. USE OF GRANTS AND MATCHING AMOUNTS. A grant awarded under the matching grant program and matching amounts must be used for the sole purpose of supporting community mental health programs that:

(1) provide mental health services and treatment to individuals with a mental illness; and

(2) coordinate mental health services for individuals with a mental illness with other transition support services. (Gov. Code, Sec. 531.0991(d).)

Sec. 547.0257. DISTRIBUTING AND ALLOCATING APPROPRIATED MONEY. (a) The commission shall disburse money appropriated to or obtained by the commission for the matching grant program directly to a grant recipient, as the executive commissioner authorizes.

(b) Except as provided by Subsection (c), from money appropriated to the commission for each fiscal year to implement this subchapter, the commission shall reserve 50 percent of that total to be awarded only as grants to a community mental health program located in a county with a population not greater than 250,000.

(c) Without regard to the limitation provided by Subsection (b) and to the extent money appropriated to the commission to implement this subchapter for a fiscal year remains available to the commission after the commission selects grant recipients for the fiscal year, the commission shall make grants available through

a competitive request for proposal process using the remaining money for the fiscal year.

(d) The commission may use a reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this subchapter to pay the administrative costs of implementing this subchapter. (Gov. Code, Secs. 531.0991(c), (i), (j), (n).)

Sec. 547.0258. RULES. The executive commissioner shall adopt rules necessary to implement the matching grant program under this subchapter. (Gov. Code, Sec. 531.0991(l).)

Sec. 547.0259. BIENNIAL REPORT. Not later than December 1 of each even-numbered year, the executive commissioner shall submit to the governor, the lieutenant governor, and each member of the legislature a report evaluating the success of the matching grant program. (Gov. Code, Sec. 531.0991(k).)

SUBCHAPTER G. MATCHING GRANT PROGRAM FOR COMMUNITY MENTAL HEALTH PROGRAMS ASSISTING VETERANS AND THEIR FAMILIES

Sec. 547.0301. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Sec. 547.0302. MATCHING GRANT PROGRAM. To the extent funds are appropriated to the commission for that purpose, the commission shall establish a matching grant program to support community mental health programs that provide services and treatment to veterans and their families. (Gov. Code, Sec. 531.0992(a).)

Sec. 547.0303. MATCHING CONTRIBUTIONS REQUIRED. (a) The commission shall ensure that each grant recipient obtains or

secures contributions to match a grant awarded to the recipient in amounts of money or other consideration as required by Section 547.0304 or 547.0305.

(b) The money or other consideration obtained or secured by the commission may, as the executive commissioner determines, include cash or in-kind contributions from private contributors or local governments but may not include state or federal funds. (Gov. Code, Sec. 531.0992(c).)

Sec. 547.0304. MATCHING GRANT CONDITIONS: SINGLE COUNTIES. For services and treatment provided in a single county, the commission shall condition each grant provided under this subchapter on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of 100,000 or more but less than 250,000; or

(3) 100 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of 250,000 or more. (Gov. Code, Sec. 531.0992(d-1).)

Sec. 547.0305. MATCHING GRANT CONDITIONS: MULTIPLE COUNTIES. For a community mental health program that provides

services and treatment in more than one county, the commission shall condition each grant provided under this subchapter on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of less than 100,000;

(2) 50 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of 100,000 or more but less than 250,000; or

(3) 100 percent of the grant amount if the county with the largest population in which the community mental health program to be supported by the grant provides services and treatment has a population of 250,000 or more. (Gov. Code, Sec. 531.0992(d-2).)

Sec. 547.0306. SELECTION OF RECIPIENTS; APPLICATIONS AND PROPOSALS. (a) The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and governmental entities.

(b) The executive commissioner shall develop criteria for evaluating the applications or proposals and the selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address the possibility of and method for making multiple awards; and

(3) include other factors that the executive commissioner considers relevant. (Gov. Code, Sec. 531.0992(f).)

Sec. 547.0307. USE OF GRANTS AND MATCHING AMOUNTS. A grant awarded under the matching grant program must be used for the sole purpose of supporting community mental health programs that:

(1) provide mental health services and treatment to veterans and their families; and

(2) coordinate mental health services for veterans and their families with other transition support services. (Gov. Code, Sec. 531.0992(e).)

Sec. 547.0308. DISTRIBUTING AND ALLOCATING APPROPRIATED MONEY. (a) As the executive commissioner authorizes, the commission shall disburse money appropriated to or obtained by the commission for the matching grant program directly to grant recipients.

(b) The commission may use a reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this subchapter to pay the administrative costs of implementing this subchapter. (Gov. Code, Secs. 531.0992(d), (g).)

Sec. 547.0309. RULES. The executive commissioner shall adopt rules necessary to implement the matching grant program. (Gov. Code, Sec. 531.0992(h).)

SUBCHAPTER H. MATCHING GRANT PROGRAM FOR CERTAIN COMMUNITY COLLABORATIVES TO REDUCE INVOLVEMENT OF INDIVIDUALS WITH MENTAL ILLNESS IN CRIMINAL JUSTICE SYSTEM

Sec. 547.0351. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Sec. 547.0352. MATCHING GRANT PROGRAM. The commission shall establish a matching grant program to provide grants to county-based community collaboratives to reduce:

(1) recidivism by, the frequency of arrests of, and incarceration of individuals with mental illness; and

(2) the total wait time for forensic commitment of individuals with mental illness to a state hospital. (Gov. Code, Sec. 531.0993(a).)

Sec. 547.0353. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS. (a) The commission shall condition each grant provided to a community collaborative under this subchapter on the collaborative providing funds from non-state sources in a total amount at least equal to:

(1) 25 percent of the grant amount if the collaborative includes a county with a population of less than 100,000;

(2) 50 percent of the grant amount if the collaborative includes a county with a population of 100,000 or more but less than 250,000;

(3) 100 percent of the grant amount if the collaborative includes a county with a population of 250,000 or

more; and

(4) the percentage of the grant amount otherwise required by this subsection for the largest county included in the collaborative, if the collaborative includes more than one county.

(b) A community collaborative may seek and receive gifts, grants, or donations from any person to raise the required funds from non-state sources. (Gov. Code, Secs. 531.0993(c), (c-1).)

Sec. 547.0354. COMMUNITY COLLABORATIVE ELIGIBILITY; CERTAIN GRANTS PROHIBITED. (a) A community collaborative may petition the commission to receive a grant under the matching grant program only if the collaborative includes:

(1) a county;

(2) a local mental health authority that operates in the county; and

(3) each hospital district, if any, located in the county.

(b) A collaborative may include other local entities designated by the collaborative's members.

(c) The commission may not award a grant under this subchapter for a fiscal year to a community collaborative that includes a county with a population greater than four million if the legislature appropriates money for a mental health jail diversion program in the county for that fiscal year. (Gov. Code, Secs. 531.0993(b), (i).)

Sec. 547.0355. PETITION REQUIRED; CONTENTS. In each state fiscal year for which a community collaborative seeks a grant, the collaborative must submit a petition to the commission not later

than the 30th day of that fiscal year. The collaborative must include with a petition:

(1) a statement indicating the amount of funds from non-state sources that the collaborative is able to provide; and

(2) a plan that:

(A) is endorsed by each of the collaborative's member entities;

(B) identifies a target population;

(C) describes how the grant money and the funds from non-state sources will be used;

(D) includes outcome measures to evaluate the success of the plan; and

(E) describes how the success of the plan, in accordance with the outcome measures, would further the state's interest in the grant program's purposes. (Gov. Code, Sec. 531.0993(d).)

Sec. 547.0356. REVIEW OF PETITION BY COMMISSION. The commission must review plans submitted with a petition under Section 547.0355 before the commission provides a grant under this subchapter. The commission must fulfill this requirement not later than the 60th day of each fiscal year. (Gov. Code, Sec. 531.0993(e).)

Sec. 547.0357. USE OF GRANT MONEY AND MATCHING FUNDS. Acceptable uses of the grant money and matching funds include:

(1) continuing a mental health jail diversion program;

(2) establishing or expanding a mental health jail diversion program;

(3) establishing alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) providing assertive community treatment or forensic assertive community treatment with an outreach component;

(5) providing intensive mental health services and substance use treatment not readily available in the county;

(6) providing continuity of care services for an individual being released from a state hospital;

(7) establishing interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) providing local community hospital, crisis, respite, or residential beds. (Gov. Code, Sec. 531.0993(f).)

Sec. 547.0358. REPORT BY COMMUNITY COLLABORATIVE. Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this subchapter, each grant recipient shall prepare and submit a report to the commission describing the effect of the grant money and matching funds in achieving the standard defined by the outcome measures in the plan submitted with a petition under Section 547.0355. (Gov. Code, Sec. 531.0993(g).)

Sec. 547.0359. INSPECTIONS. The commission may inspect the operation and provision of mental health services provided by a community collaborative to ensure state money appropriated for the matching grant program is used effectively. (Gov. Code, Sec.

531.0993(h).)

Sec. 547.0360. ALLOCATING APPROPRIATED MONEY. (a) Except as provided by Subsection (b), the commission shall reserve at least 20 percent of money appropriated to the commission for each fiscal year to implement the matching grant program to be awarded only as grants to a community collaborative that includes a county with a population of less than 250,000.

(b) Without regard to the limitation provided by Subsection (a) and to the extent money appropriated to the commission for a fiscal year to implement this subchapter remains available to the commission after the commission has selected grant recipients for the fiscal year, the commission shall make grants available through a competitive request for proposal process using the remaining money for the fiscal year.

(c) The commission may use a reasonable amount not to exceed five percent of the money appropriated by the legislature for the purposes of this subchapter to pay the administrative costs of implementing this subchapter. (Gov. Code, Secs. 531.0993(c-2), (f-1), (j).)

SUBCHAPTER I. MATCHING GRANT PROGRAM FOR COMMUNITY COLLABORATIVE IN MOST POPULOUS COUNTY TO REDUCE INVOLVEMENT OF INDIVIDUALS WITH MENTAL ILLNESS IN CRIMINAL JUSTICE SYSTEM

Sec. 547.0401. DEFINITION. In this subchapter, "matching grant program" means the matching grant program established under this subchapter. (New.)

Sec. 547.0402. MATCHING GRANT PROGRAM. The commission shall establish a matching grant program to provide a grant to a

county-based community collaborative in the most populous county in this state to reduce:

(1) recidivism by, the frequency of arrests of, and incarceration of individuals with mental illness; and

(2) the total wait time for forensic commitment of individuals with mental illness to a state hospital. (Gov. Code, Sec. 531.09935(a).)

Sec. 547.0403. MATCHING CONTRIBUTIONS REQUIRED; GRANT CONDITIONS. (a) The commission shall condition a grant provided to the community collaborative under this subchapter on the collaborative providing funds from non-state sources in a total amount at least equal to the grant amount.

(b) A community collaborative may seek and receive gifts, grants, or donations from any person to raise the required funds from non-state sources. (Gov. Code, Secs. 531.09935(d), (e).)

Sec. 547.0404. COMMUNITY COLLABORATIVE ELIGIBILITY. (a) A community collaborative may receive a grant under the matching grant program only if the collaborative includes:

(1) the county;

(2) a local mental health authority operating in the county; and

(3) each hospital district located in the county.

(b) A collaborative may include other local entities designated by the collaborative's members. (Gov. Code, Sec. 531.09935(b).)

Sec. 547.0405. DISTRIBUTION OF GRANT. Not later than the 30th day of each fiscal year, the commission shall make available to

the community collaborative established in the county described by Section 547.0402 a grant in an amount equal to the lesser of:

(1) the amount appropriated to the commission for that fiscal year for a mental health jail diversion pilot program in that county; or

(2) the collaborative's available matching funds. (Gov. Code, Sec. 531.09935(c).)

Sec. 547.0406. USE OF GRANT MONEY AND MATCHING FUNDS. Acceptable uses of the grant money and matching funds include:

(1) continuing a mental health jail diversion program;

(2) establishing or expanding a mental health jail diversion program;

(3) establishing alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) providing assertive community treatment or forensic assertive community treatment with an outreach component;

(5) providing intensive mental health services and substance use treatment not readily available in the county;

(6) providing continuity of care services for an individual being released from a state hospital;

(7) establishing interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) providing local community hospital, crisis, respite, or residential beds. (Gov. Code, Sec. 531.09935(f).)

Sec. 547.0407. REPORT BY COMMUNITY COLLABORATIVE. Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this subchapter, the grant recipient shall prepare and submit a report to the commission describing the effect of the grant money and matching funds in fulfilling the purpose described by Section 547.0402. (Gov. Code, Sec. 531.09935(g).)

Sec. 547.0408. INSPECTIONS. The commission may inspect the operation and provision of mental health services provided by the community collaborative to ensure state money appropriated for the matching grant program is used effectively. (Gov. Code, Sec. 531.09935(h).)

CHAPTER 547A. COMMUNITY COLLABORATIVES

CHAPTER 547A. COMMUNITY COLLABORATIVES

Sec. 547A.0001. GRANTS FOR ESTABLISHING AND EXPANDING

COMMUNITY COLLABORATIVES. (a) To the extent funds are appropriated to the commission for that purpose, the commission shall make grants to entities, including local governmental entities, nonprofit community organizations, and faith-based community organizations, to establish or expand community collaboratives that bring the public and private sectors together to provide services to individuals experiencing homelessness, substance use issues, or mental illness. In awarding grants, the commission shall give special consideration to entities:

(1) establishing new collaboratives; or

(2) establishing or expanding collaboratives that serve two or more counties, each with a population of less than 100,000.

(b) Except as provided by Subsection (c), the commission shall require each entity awarded a grant under this section to:

(1) leverage additional funding or in-kind contributions from private contributors or local governments, excluding state or federal funds, in an amount that is at least equal to the amount of the grant awarded under this section;

(2) provide evidence of significant coordination and collaboration between the entity, local mental health authorities, municipalities, local law enforcement agencies, and other community stakeholders in establishing or expanding a community collaborative funded by a grant awarded under this section; and

(3) provide evidence of a local law enforcement policy to divert appropriate individuals from jails or other detention facilities to an entity affiliated with a community collaborative

for the purpose of providing services to those individuals.

(c) The commission may award a grant under this section to an entity for the purpose of establishing a community mental health program in a county with a population of less than 250,000, if the entity leverages additional funding or in-kind contributions from private contributors or local governments, excluding state or federal funds, in an amount equal to one-quarter of the grant amount to be awarded under this section, and the entity otherwise meets the requirements of Subsections (b)(2) and (3). (Gov. Code, Sec. 539.002.)

Sec. 547A.0002. ACCEPTABLE USES OF GRANT MONEY. An entity shall use money received from a grant made by the commission and private funding sources to establish or expand a community collaborative. Acceptable uses for the money include:

(1) developing the infrastructure of the collaborative and the start-up costs of the collaborative;

(2) establishing, operating, or maintaining other community service providers in the community the collaborative serves, including intake centers, detoxification units, sheltering centers for food, workforce training centers, microbusinesses, and educational centers;

(3) providing clothing, hygiene products, and medical services to and arranging transitional and permanent residential housing for individuals the collaborative serves;

(4) providing mental health services and substance use treatment not readily available in the community the collaborative serves;

(5) providing information, tools, and resource referrals to assist individuals the collaborative serves in addressing the needs of their children; and

(6) establishing and operating coordinated intake processes, including triage procedures, to protect public safety in the community the collaborative serves. (Gov. Code, Sec. 539.003.)

Sec. 547A.0003. ELEMENTS OF COMMUNITY COLLABORATIVES. (a) If appropriate, an entity may incorporate into the community collaborative the entity operates the use of the homeless management information system, transportation plans, and case managers. An entity may also consider incorporating into a collaborative mentoring and volunteering opportunities, strategies to assist homeless youth and homeless families with children, strategies to reintegrate individuals who were recently incarcerated into the community, services for veterans, and strategies for individuals the collaborative serves to participate in the planning, governance, and oversight of the collaborative.

(b) The focus of a community collaborative shall be the eventual successful transition of individuals from receiving services from the collaborative to becoming integrated into the community the collaborative serves through community relationships and family supports. (Gov. Code, Sec. 539.004.)

Sec. 547A.0004. OUTCOME MEASURES FOR COMMUNITY COLLABORATIVES. Each entity that receives a grant from the commission to establish or expand a community collaborative shall select at least four of the following outcome measures that the entity will focus on meeting through implementing and operating the

collaborative:

(1) individuals the collaborative serves finding employment that results in those individuals having incomes that are at or above 100 percent of the federal poverty level;

(2) individuals the collaborative serves finding permanent housing;

(3) individuals the collaborative serves completing alcohol or substance use programs;

(4) the collaborative helping to start social businesses in the community or engaging in job creation, job training, or other workforce development activities;

(5) a decrease in the use of jail beds by individuals the collaborative serves;

(6) a decrease in the need for emergency care by individuals the collaborative serves;

(7) a decrease in the number of children whose families lack adequate housing referred to the Department of Family and Protective Services or a local entity responsible for child welfare; and

(8) any other appropriate outcome measure the commission approves that measures whether a collaborative is meeting a specific need of the community the collaborative serves. (Gov. Code, Sec. 539.005.)

Sec. 547A.0005. PLAN REQUIRED FOR CERTAIN COMMUNITY COLLABORATIVES. (a) The governing body of a county shall develop and make public a plan detailing the method by which:

(1) local mental health authorities, municipalities,

local law enforcement agencies, and other community stakeholders in the county may coordinate to establish or expand a community collaborative to accomplish the goals of Section 547A.0001;

(2) entities in the county may leverage funding from private sources to accomplish the goals of Section 547A.0001 through the formation or expansion of a community collaborative; and

(3) the formation or expansion of a community collaborative may establish or support resources or services to help local law enforcement agencies to divert individuals who have been arrested to appropriate mental health care or substance use treatment.

(b) The governing body of a county in which an entity that received a grant under former Section 539.002 before September 1, 2017, is located is not required to develop a plan under Subsection (a).

(c) Two or more counties, each with a population of less than 100,000, may form a joint plan under Subsection (a). (Gov. Code, Sec. 539.0051.)

Sec. 547A.0006. ANNUAL REVIEW OF OUTCOME MEASURES. The commission shall contract with an independent third party to verify annually whether a community collaborative is meeting the outcome measures the entity that operates the collaborative selects under Section 547A.0004. (Gov. Code, Sec. 539.006.)

Sec. 547A.0007. REDUCTION AND CESSATION OF FUNDING. The commission shall establish processes by which the commission may reduce or cease providing funding to an entity if the community

collaborative the entity operates does not meet the outcome measures the entity for the collaborative selects under Section 547A.0004. The commission shall redistribute on a competitive basis any funds withheld from an entity under this section to other entities operating high-performing collaboratives. (Gov. Code, Sec. 539.007.)

Sec. 547A.0008. RULES. The executive commissioner shall adopt any rules necessary to implement the community collaborative grant program established under this chapter, including rules establishing:

(1) the requirements for an entity to be eligible to receive a grant;

(2) the required elements of a community collaborative an entity operates; and

(3) permissible and prohibited uses of money an entity receives from a grant the commission makes. (Gov. Code, Sec. 539.008.)

Sec. 547A.0009. ADMINISTRATIVE COSTS. The commission may use a reasonable amount not to exceed five percent of the money the legislature appropriates for the purposes of this chapter to pay administrative costs of implementing this chapter. (Gov. Code, Sec. 539.009.)

CHAPTER 548. HEALTH CARE SERVICES PROVIDED THROUGH TELE-CONNECTIVE MEANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 548.0001. PROVISION OF SERVICES THROUGH TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY UNDER MEDICAID AND OTHER PUBLIC BENEFITS PROGRAMS

Sec. 548.0002. RULES AND PROCEDURES REGARDING REIMBURSING CERTAIN TELEMEDICINE MEDICAL SERVICES

SUBCHAPTER B. TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, TELEHEALTH, AND HOME TELEMONITORING SERVICES PROVIDED UNDER MEDICAID IN GENERAL

Sec. 548.0051. MEDICAID REIMBURSEMENT SYSTEM FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES

Sec. 548.0052. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE BY MEDICAID MANAGED CARE ORGANIZATION

Sec. 548.0053. REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE

Sec. 548.0054. PROVIDER AND FACILITY PARTICIPATION

Sec. 548.0055. PROMOTION AND SUPPORT OF MEDICAL HOME AND CARE COORDINATION

CHAPTER 548. HEALTH CARE SERVICES PROVIDED THROUGH TELE-CONNECTIVE MEANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 548.0001. PROVISION OF SERVICES THROUGH TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY UNDER MEDICAID AND OTHER PUBLIC BENEFITS PROGRAMS. (a) In this section:

(1) "Behavioral health services" has the meaning assigned by Section 540.0703.

(2) "Case management services" includes service coordination, service management, and care coordination.

(b) To the extent permitted by federal law and to the extent it is cost-effective and clinically effective, as the commission determines, the commission shall ensure that Medicaid recipients, child health plan program enrollees, and other individuals receiving benefits under a public benefits program the commission or a health and human services agency administers, regardless of whether receiving benefits through a managed care delivery model or another delivery model, have the option to receive services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, including the following services:

(1) preventive health and wellness services;

(2) case management services, including targeted case management services;

(3) subject to Subsection (c), behavioral health services;

(4) occupational, physical, and speech therapy

services;

(5) nutritional counseling services; and

(6) assessment services, including nursing assessments under the following Section 1915(c) waiver programs:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the deaf-blind with multiple disabilities (DBMD) waiver program;

(C) the home and community-based services (HCS) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(c) To the extent permitted by state and federal law and to the extent it is cost-effective and clinically effective, as the commission determines, the executive commissioner by rule shall develop and implement a system that ensures behavioral health services may be provided using an audio-only platform consistent with Section 111.008, Occupations Code, to a Medicaid recipient, a child health plan program enrollee, or another individual receiving those services under another public benefits program the commission or a health and human services agency administers.

(d) If the executive commissioner determines that providing services other than behavioral health services is appropriate using an audio-only platform under a public benefits program the commission or a health and human services agency administers, in accordance with applicable federal and state law, the executive commissioner may by rule authorize the provision of those services under the applicable program using the audio-only platform. In

determining whether the use of an audio-only platform in a program is appropriate under this subsection, the executive commissioner shall consider whether using the platform would be cost-effective and clinically effective. (Gov. Code, Sec. 531.02161.)

Sec. 548.0002. RULES AND PROCEDURES REGARDING REIMBURSING CERTAIN TELEMEDICINE MEDICAL SERVICES. (a) In addition to the authority granted by other law regarding telemedicine medical services, the executive commissioner may review rules and procedures applicable to reimbursement of a telemedicine medical service provided through any government-funded health program subject to the commission's oversight. The executive commissioner may modify the rules and procedures as necessary to ensure that reimbursement for a telemedicine medical service is provided:

(1) in a cost-effective manner; and

(2) only in circumstances in which providing the service is clinically effective.

(b) This section does not affect the commission's authority or duties under other law regarding reimbursing a telemedicine medical service under Medicaid. (Gov. Code, Sec. 531.02174.)

SUBCHAPTER B. TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, TELEHEALTH, AND HOME TELEMONITORING SERVICES PROVIDED UNDER MEDICAID IN GENERAL

Sec. 548.0051. MEDICAID REIMBURSEMENT SYSTEM FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES. The executive commissioner by rule shall develop and implement a system to reimburse Medicaid providers for telemedicine medical services, teledentistry dental services, or telehealth

services performed. (Gov. Code, Sec. 531.0216(a).)

Sec. 548.0052. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE BY MEDICAID MANAGED CARE ORGANIZATION. (a) The commission shall ensure that a Medicaid managed care organization does not:

(1) deny reimbursement for a covered health care service or procedure delivered by a health care provider with whom the organization contracts to a Medicaid recipient as a telemedicine medical service, teledentistry dental service, or telehealth service solely because the covered service or procedure is not provided through an in-person consultation; or

(2) limit, deny, or reduce reimbursement for a covered health care service or procedure delivered by a health care provider with whom the organization contracts to a Medicaid recipient as a telemedicine medical service, teledentistry dental service, or telehealth service based on the provider's choice of platform for providing the health care service or procedure.

(b) In complying with state and federal requirements to provide access to medically necessary services under the Medicaid managed care program, a Medicaid managed care organization determining whether reimbursement for a telemedicine medical service, teledentistry dental service, or telehealth service is appropriate shall continue to consider other factors, including whether:

(1) reimbursement is cost-effective; and

(2) providing the service is clinically effective. (Gov. Code, Secs. 531.0216(g) (part), (j).)

Sec. 548.0053. REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, OR TELEHEALTH SERVICE. (a) Subject to Subsection (b), the executive commissioner by rule shall ensure that a rural health clinic as defined by 42 U.S.C. Section 1396d(l)(1) and a federally qualified health center as defined by 42 U.S.C. Section 1396d(l)(2)(B) may be reimbursed for the originating site facility fee or the distant site practitioner fee or both, as appropriate, for a covered telemedicine medical service, teledentistry dental service, or telehealth service delivered by a health care provider to a Medicaid recipient.

(b) The commission is required to implement this section only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement this section using other money available to the commission for that purpose. (Gov. Code, Sec. 531.0216(i).)

Sec. 548.0054. PROVIDER AND FACILITY PARTICIPATION. (a) The commission shall encourage health care providers and health care facilities to provide telemedicine medical services, teledentistry dental services, and telehealth services in the health care delivery system. The commission may not require that a service be provided to a patient through telemedicine medical services, teledentistry dental services, or telehealth services.

(b) The commission shall explore opportunities to increase STAR Health program providers' use of telemedicine medical services in medically underserved areas of this state. (Gov. Code, Secs.

531.0216(c), (c-1).)

Sec. 548.0055. PROMOTION AND SUPPORT OF MEDICAL HOME AND CARE COORDINATION. (a) The commission shall ensure that a Medicaid managed care organization ensures that using telemedicine medical services, teledentistry dental services, or telehealth services promotes and supports patient-centered medical homes by allowing a Medicaid recipient to receive a telemedicine medical service, teledentistry dental service, or telehealth service from a provider other than the recipient's primary care physician or provider, except as provided by Section 548.0202(b), only if:

(1) the service is provided in accordance with the law and contract requirements applicable to providing the same health care service in an in-person setting, including requirements regarding care coordination; and

(2) subject to Subsection (b), the provider of the service gives notice to the Medicaid recipient's primary care physician or provider regarding the service, including a summary of the service, exam findings, a list of prescribed or administered medications, and patient instructions, for the purpose of sharing medical information.

(b) A provider of a telemedicine medical service, teledentistry dental service, or telehealth service is required to provide notice under Subsection (a)(2) only if:

(1) the recipient has a primary care physician or provider; and

(2) the recipient or, if appropriate, the recipient's parent or legal guardian, consents to the notice.

(c) The commission shall develop, document, and implement a monitoring process to ensure that a Medicaid managed care organization ensures that using telemedicine medical services, teledentistry dental services, or telehealth services promotes and supports patient-centered medical homes and care coordination in accordance with Subsection (a). The process must include monitoring of the rate at which a telemedicine medical service, teledentistry dental service, or telehealth service provider gives notice in accordance with Subsection (a)(2). (Gov. Code, Secs. 531.0216(g) (part), (h).)

Sec. 548.0056. BIENNIAL REPORT. Not later than December 1 of each even-numbered year, the commission shall report to the speaker of the house of representatives and the lieutenant governor on the effects of telemedicine medical services, teledentistry dental services, telehealth services, and home telemonitoring services on Medicaid in this state, including:

(1) the number of physicians, dentists, health professionals, and licensed health care facilities using the services;

(2) the geographic and demographic disposition of the physicians, dentists, and health professionals;

(3) the number of patients receiving the services;

(4) the types of services being provided;

(5) the utilization cost; and

(6) the cost savings to Medicaid from using the services. (Gov. Code, Sec. 531.0216(f).)

Sec. 548.0057. RULES. Subject to Sections 111.004 and

153.004, Occupations Code, the executive commissioner may adopt rules as necessary to implement this subchapter. In the rules adopted under this subchapter, the executive commissioner shall refer to:

(1) the site where the patient is physically located as the patient site; and

(2) the site where the physician, dentist, or health professional providing the telemedicine medical service, teledentistry dental service, or telehealth service is physically located as the distant site. (Gov. Code, Sec. 531.0216(d).)

SUBCHAPTER C. PROVISION OF AND REIMBURSEMENT FOR TELEMEDICINE MEDICAL AND TELEHEALTH SERVICES IN GENERAL

Sec. 548.0101. DEFINITIONS. In this subchapter:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec. 531.0217(a).)

Sec. 548.0102. MEDICAID REIMBURSEMENT REQUIREMENTS: TELEMEDICINE MEDICAL SERVICES. (a) The executive commissioner by rule shall require each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a telemedicine medical service initiated or provided by a physician.

(b) The commission shall ensure that reimbursement is provided only for a telemedicine medical service a physician initiates or provides.

(c) The commission shall require reimbursement for a telemedicine medical service at the same rate Medicaid reimburses for the same in-person medical service. (Gov. Code, Secs. 531.0217(b), (c), (d) (part).)

Sec. 548.0103. PHYSICIAN'S CHOICE OF PLATFORM. The commission may not limit a physician's choice of platform for providing a telemedicine medical service or telehealth service by requiring that the physician use a particular platform to receive Medicaid reimbursement for the service. (Gov. Code, Sec. 531.0217(d) (part).)

Sec. 548.0104. CERTAIN TELEMEDICINE MEDICAL SERVICE REIMBURSEMENT DENIALS PROHIBITED. A request for Medicaid reimbursement for a telemedicine medical service may not be denied solely because an in-person medical service between a physician and a patient did not occur. (Gov. Code, Sec. 531.0217(d) (part).)

Sec. 548.0105. PROTOCOLS AND GUIDELINES. A health care facility that receives reimbursement under this subchapter for a telemedicine medical service provided by a physician who practices

in that facility or a health professional who participates in a telemedicine medical service under this subchapter shall establish quality of care protocols and patient confidentiality guidelines to ensure that the telemedicine medical service meets legal requirements and acceptable patient care standards. (Gov. Code, Sec. 531.0217(e).)

Sec. 548.0106. PROVIDER COORDINATION. If a patient receiving a telemedicine medical service has a primary care physician or provider and the patient or, if appropriate, the patient's parent or legal guardian consents to the notification, the commission shall require that the primary care physician or provider be notified of the telemedicine medical service for the purpose of sharing medical information. (Gov. Code, Sec. 531.0217(g) (part).)

Sec. 548.0107. COMPLIANCE. The commission in consultation with the Texas Medical Board shall monitor and regulate the use of telemedicine medical services to ensure compliance with this subchapter. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this subchapter. (Gov. Code, Sec. 531.0217(h).)

Sec. 548.0108. TEXAS MEDICAL BOARD RULES. The Texas Medical Board, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services; and

(2) prevent abuse and fraud through the use of

telemedicine medical services, including rules relating to filing claims and records required to be maintained in connection with telemedicine. (Gov. Code, Sec. 531.0217(i).)

Sec. 548.0109. EFFECT ON OTHER REQUIREMENTS. This subchapter does not affect any requirement relating to:

(1) a rural health clinic; or

(2) physician delegation to an advanced practice nurse or physician assistant of the authority to carry out or sign prescription drug orders. (Gov. Code, Sec. 531.0217(k).)

SUBCHAPTER D. PROVISION OF AND REIMBURSEMENT FOR TELEDENTISTRY DENTAL SERVICES IN GENERAL

Sec. 548.0151. MEDICAID REIMBURSEMENT REQUIREMENTS. (a) The executive commissioner by rule shall require each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for teledentistry dental services provided by a dentist licensed to practice dentistry in this state.

(b) The commission shall require reimbursement for a teledentistry dental service at the same rate as the Medicaid program reimburses for the same in-person dental service. (Gov. Code, Secs. 531.02172(a), (b) (part).)

Sec. 548.0152. DENTIST'S CHOICE OF PLATFORM. The commission may not limit a dentist's choice of platform for providing a teledentistry dental service by requiring that the dentist use a particular platform to receive reimbursement for the service. (Gov. Code, Sec. 531.02172(b) (part).)

Sec. 548.0153. CERTAIN TELEDENTISTRY DENTAL SERVICES REIMBURSEMENT DENIALS PROHIBITED. A request for reimbursement may

not be denied solely because an in-person dental service between a dentist and a patient did not occur. (Gov. Code, Sec. 531.02172(b) (part).)

Sec. 548.0154. STATE BOARD OF DENTAL EXAMINERS RULES. The State Board of Dental Examiners, in consultation with the commission and the commission's office of inspector general, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive teledentistry dental services; and

(2) prevent abuse and fraud through the use of teledentistry dental services, including rules relating to filing claims and the records required to be maintained in connection with teledentistry dental services. (Gov. Code, Sec. 531.02172(c).)

SUBCHAPTER E. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES PROVIDED TO CERTAIN CHILDREN

Sec. 548.0201. REIMBURSEMENT FOR TELEMEDICINE MEDICAL, TELEDENTISTRY DENTAL, AND TELEHEALTH SERVICES PROVIDED TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS. (a) In this section, "child with special health care needs" has the meaning assigned by Section 35.0022, Health and Safety Code.

(b) The executive commissioner by rule shall establish policies that permit reimbursement under Medicaid and the child health plan program for services provided through telemedicine medical services, teledentistry dental services, and telehealth services to children with special health care needs.

(c) The policies required under this section must:

(1) be designed to:

(A) prevent unnecessary travel and encourage efficient use of telemedicine medical services, teledentistry dental services, and telehealth services for children with special health care needs in all suitable circumstances; and

(B) ensure in a cost-effective manner the availability to a child with special health care needs of services appropriately performed using telemedicine medical services, teledentistry dental services, and telehealth services that are comparable to the same types of services available to that child without using telemedicine medical services, teledentistry dental services, and telehealth services; and

(2) provide for reimbursement of multiple providers of different services who participate in a single session of telemedicine medical services, teledentistry dental services, telehealth services, or any combination of those services for a child with special health care needs, if the commission determines that reimbursing each provider for the session is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without using telemedicine medical services, teledentistry dental services, and telehealth services, including the costs of transportation and lodging and other direct costs. (Gov. Code, Sec. 531.02162.)

Sec. 548.0202. MEDICAID REIMBURSEMENT FOR TELEMEDICINE MEDICAL SERVICES PROVIDED IN SCHOOL-BASED SETTING. (a) In this section, "physician" means an individual licensed to practice

medicine in this state under Subtitle B, Title 3, Occupations Code.

(b) The commission shall ensure that Medicaid reimbursement is provided to a physician for a telemedicine medical service provided by the physician, even if the physician is not the patient's primary care physician or provider, if:

(1) the physician is an authorized Medicaid health care provider;

(2) the patient is a child who receives the service in a primary or secondary school-based setting; and

(3) the parent or legal guardian of the patient provides consent before the service is provided.

(c) In the case of a telemedicine medical service provided to a child in a school-based setting as described by Subsection (b), the notification under Section 548.0106, if any, must include a summary of the service, including exam findings, prescribed or administered medications, and patient instructions.

(d) If a patient receiving a telemedicine medical service in a school-based setting as described by Subsection (b) does not have a primary care physician or provider, the commission shall require that the patient's parent or legal guardian receive:

(1) the notification required under Section 548.0106; and

(2) a list of primary care physicians or providers from which the patient may select the patient's primary care physician or provider.

(e) The commission in consultation with the Texas Medical Board shall monitor and regulate the use of telemedicine medical

services to ensure compliance with this section. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this section.

(f) The Texas Medical Board, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services; and

(2) prevent abuse and fraud through the use of telemedicine medical services, including rules relating to filing of claims and records required to be maintained in connection with telemedicine.

(g) This section does not affect any requirement relating to:

(1) a rural health clinic; or

(2) physician delegation to an advanced practice nurse or physician assistant of the authority to carry out or sign prescription drug orders. (Gov. Code, Secs. 531.0217(a)(2), (c-4), (g) (part), (g-1), (h), (i), (k).)

Sec. 548.0203. MEDICAID REIMBURSEMENT FOR TELEHEALTH SERVICES PROVIDED THROUGH SCHOOL DISTRICT OR CHARTER SCHOOL. (a) In this section, "health professional" means an individual who is:

(1) licensed, registered, certified, or otherwise authorized by this state to practice as a social worker, occupational therapist, or speech-language pathologist;

(2) a licensed professional counselor;

(3) a licensed marriage and family therapist; or

(4) a licensed specialist in school psychology.

(b) The commission shall ensure that Medicaid reimbursement is provided to a school district or open-enrollment charter school for telehealth services provided through the school district or charter school by a health professional, even if the health professional is not the patient's primary care provider, if:

(1) the school district or charter school is an authorized Medicaid health care provider; and

(2) the parent or legal guardian of the patient provides consent before the service is provided. (Gov. Code, Sec. 531.02171.)

SUBCHAPTER F. MEDICAID REIMBURSEMENT FOR HOME TELEMONITORING SERVICES

Sec. 548.0251. DEFINITIONS. In this subchapter:

(1) "Home and community support services agency" means a person licensed under Chapter 142, Health and Safety Code, to provide home health, hospice, or personal assistance services as those terms are defined by Section 142.001, Health and Safety Code.

(2) "Hospital" means a hospital licensed under Chapter 241, Health and Safety Code. (Gov. Code, Sec. 531.02164(a).)

Sec. 548.0252. MEDICAID REIMBURSEMENT PROGRAM FOR HOME TELEMONITORING SERVICES AUTHORIZED. If the commission determines that establishing a statewide program that permits Medicaid reimbursement for home telemonitoring services would be cost-effective and feasible, the executive commissioner by rule shall establish the program as provided by this subchapter. (Gov. Code, Sec. 531.02164(b).)

Sec. 548.0253. REIMBURSEMENT PROGRAM REQUIREMENTS. (a) A program established under this subchapter must:

(1) provide that home telemonitoring services are available only to an individual who:

(A) is diagnosed with one or more of the following conditions:

(i) pregnancy;

(ii) diabetes;

(iii) heart disease;

(iv) cancer;

(v) chronic obstructive pulmonary disease;

(vi) hypertension;

(vii) congestive heart failure;

(viii) mental illness or serious emotional disturbance;

(ix) asthma;

(x) myocardial infarction; or

(xi) stroke; and

(B) exhibits two or more of the following risk factors:

(i) two or more hospitalizations in the prior 12-month period;

(ii) frequent or recurrent emergency room admissions;

(iii) a documented history of poor adherence to ordered medication regimens;

(iv) a documented history of falls in the

prior six-month period;

(v) limited or absent informal support systems;

(vi) living alone or being home alone for extended periods; and

(vii) a documented history of care access challenges;

(2) ensure that clinical information gathered by a home and community support services agency or hospital while providing home telemonitoring services is shared with the patient's physician; and

(3) ensure that the program does not duplicate disease management program services provided under Section 32.057, Human Resources Code.

(b) Notwithstanding Subsection (a)(1), a program established under this subchapter must also provide that home telemonitoring services are available to pediatric individuals who:

(1) are diagnosed with end-stage solid organ disease;

(2) have received an organ transplant; or

(3) require mechanical ventilation. (Gov. Code, Secs. 531.02164(c), (c-1).)

Sec. 548.0254. DISCONTINUATION OF REIMBURSEMENT PROGRAM UNDER CERTAIN CIRCUMSTANCES. If, after implementation, the commission determines that the program established under this subchapter is not cost-effective, the commission may discontinue the program and stop providing Medicaid reimbursement for home

telemonitoring services, notwithstanding Subchapter B or any other law. (Gov. Code, Sec. 531.02164(d).)

Sec. 548.0255. DETERMINATION OF COST SAVINGS FOR MEDICARE PROGRAM. The commission shall determine whether providing home telemonitoring services to individuals who are eligible to receive benefits under both Medicaid and the Medicare program achieves cost savings for the Medicare program. (Gov. Code, Sec. 531.02164(e).)

Sec. 548.0256. REIMBURSEMENT FOR OTHER CONDITIONS AND RISK FACTORS. (a) To comply with state and federal requirements to provide access to medically necessary services under the Medicaid managed care program, a Medicaid managed care organization may reimburse providers for home telemonitoring services provided to individuals who have conditions and exhibit risk factors other than those expressly authorized by this subchapter.

(b) In determining whether the Medicaid managed care organization should provide reimbursement for services under this section, the organization shall consider whether reimbursement for the service is cost-effective and providing the service is clinically effective. (Gov. Code, Sec. 531.02164(f).)

SUBCHAPTER G. MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATIONS

Sec. 548.0301. DEFINITION. In this subchapter, "physician" means an individual licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec. 531.02175(a).)

Sec. 548.0302. MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATION AUTHORIZED. (a) The executive commissioner by rule

may require the commission and each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a medical consultation that a physician or other health care professional provides using the Internet as a cost-effective alternative to an in-person consultation.

(b) The executive commissioner may require the commission or a health and human services agency to provide the reimbursement described by this section only if the Centers for Medicare and Medicaid Services develops an appropriate Current Procedural Terminology code for medical services provided using the Internet. (Gov. Code, Sec. 531.02175(b).)

Sec. 548.0303. PILOT PROGRAM FOR MEDICAID REIMBURSEMENT FOR INTERNET MEDICAL CONSULTATION. (a) The executive commissioner may develop and implement a pilot program in one or more sites the executive commissioner chooses under which Medicaid reimbursements are paid for medical consultations provided by physicians or other health care professionals using the Internet. The pilot program must be designed to test whether an Internet medical consultation is a cost-effective alternative to an in-person consultation under Medicaid.

(b) The executive commissioner may modify the pilot program as necessary throughout the program's implementation to maximize the potential cost-effectiveness of Internet medical consultations.

(c) If the executive commissioner determines from the pilot program that Internet medical consultations are cost-effective, the executive commissioner may expand the pilot program to

additional sites or implement Medicaid reimbursements for Internet medical consultations statewide.

(d) The executive commissioner is not required to implement the pilot program authorized under Subsection (a) as a prerequisite to providing Medicaid reimbursement authorized by Section 548.0302 on a statewide basis. (Gov. Code, Secs. 531.02175(c), (d).)

SUBCHAPTER H. PEDIATRIC TELE-CONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS

Sec. 548.0351. DEFINITIONS. In this subchapter:

(1) "Nonurban health care facility" means a hospital licensed under Chapter 241, Health and Safety Code, or other licensed health care facility in this state that is located in a rural area as defined by Section 845.002, Insurance Code.

(2) "Pediatric specialist" means a physician who is certified in general pediatrics by the American Board of Pediatrics or American Osteopathic Board of Pediatrics.

(3) "Pediatric subspecialist" means a physician who is certified in a pediatric subspecialty by a member board of the American Board of Medical Specialties or American Osteopathic Board of Pediatrics.

(4) "Pediatric tele-specialty provider" means a pediatric health care facility in this state that offers continuous access to telemedicine medical services provided by pediatric subspecialists.

(5) "Physician" means an individual licensed to practice medicine in this state.

(6) "Program" means the pediatric tele-connectivity

resource program for rural Texas established under this subchapter.

(7) Notwithstanding Section 521.0001, "telemedicine medical service" means a health care service delivered to a patient:

(A) by a physician acting within the scope of the physician's license or a health professional acting under the delegation and supervision of a physician and within the scope of the health professional's license;

(B) from a physical location that is different from the patient's location; and

(C) using telecommunications or information technology. (Gov. Code, Sec. 541.001.)

Sec. 548.0352. ESTABLISHMENT OF PEDIATRIC TELE-CONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS. The commission with any necessary assistance of pediatric tele-specialty providers shall establish a pediatric tele-connectivity resource program for rural Texas to award grants to nonurban health care facilities to connect the facilities with pediatric specialists and pediatric subspecialists who provide telemedicine medical services. (Gov. Code, Sec. 541.002.)

Sec. 548.0353. USE OF PROGRAM GRANT. A nonurban health care facility awarded a grant under this subchapter may use grant money to:

(1) purchase equipment necessary for implementing a telemedicine medical service;

(2) modernize the facility's information technology infrastructure and secure information technology support to ensure

an uninterrupted two-way video signal that is compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(3) pay a service fee to a pediatric tele-specialty provider under an annual contract with the provider; or

(4) pay for other activities, services, supplies, facilities, resources, and equipment the commission determines necessary for the facility to use a telemedicine medical service. (Gov. Code, Sec. 541.003.)

Sec. 548.0354. SELECTION OF PROGRAM GRANT RECIPIENTS. (a) The commission with any necessary assistance of pediatric tele-specialty providers may select an eligible nonurban health care facility to receive a grant under this subchapter.

(b) To be eligible for a grant, a nonurban health care facility must have:

(1) a quality assurance program that measures the compliance of the facility's health care providers with the facility's medical protocols;

(2) on staff at least one full-time equivalent physician who has training and experience in pediatrics and one individual who is responsible for ongoing nursery and neonatal support and care;

(3) a designated neonatal intensive care unit or an emergency department;

(4) a commitment to obtaining neonatal or pediatric education from a tertiary facility to expand the facility's depth and breadth of telemedicine medical service capabilities; and

(5) the capability of maintaining records and producing reports that measure the effectiveness of the grant the facility would receive. (Gov. Code, Sec. 541.004.)

Sec. 548.0355. GIFTS, GRANTS, AND DONATIONS. (a) The commission may solicit and accept gifts, grants, and donations from any public or private source for the purposes of this subchapter.

(b) A political subdivision that participates in the program may pay part of the costs of the program. (Gov. Code, Sec. 541.005.)

Sec. 548.0356. WORK GROUP. (a) The commission may establish a program work group to:

(1) assist the commission with developing, implementing, or evaluating the program; and

(2) prepare a report on the results and outcomes of the grants awarded under this subchapter.

(b) A program work group member is not entitled to compensation for serving on the program work group and may not be reimbursed for travel or other expenses incurred while conducting the business of the program work group.

(c) A program work group is not subject to Chapter 2110. (Gov. Code, Sec. 541.006.)

Sec. 548.0357. BIENNIAL REPORT. Not later than December 1 of each even-numbered year, the commission shall submit a report to the governor and members of the legislature regarding the activities of the program and grant recipients under the program, including the results and outcomes of grants awarded under this subchapter. (Gov. Code, Sec. 541.007.)

Sec. 548.0358. RULES. The executive commissioner may adopt rules necessary to implement this subchapter. (Gov. Code, Sec. 541.008.)

Sec. 548.0359. APPROPRIATION REQUIRED. The commission may not spend state funds to accomplish the purposes of this subchapter and is not required to award a grant under this subchapter unless money is appropriated for the purposes of this subchapter. (Gov. Code, Sec. 541.009.)

SUBCHAPTER I. TELEHEALTH TREATMENT PROGRAM FOR SUBSTANCE USE DISORDERS

Sec. 548.0401. TELEHEALTH TREATMENT PROGRAM FOR SUBSTANCE USE DISORDERS. The executive commissioner by rule shall establish a program to increase opportunities and expand access to telehealth treatment for substance use disorders in this state. (Gov. Code, Sec. 531.02253.)

CHAPTER 549. PROVISION OF DRUGS AND DRUG INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS APPLICABLE TO PROVISION OF DRUGS UNDER VENDOR DRUG PROGRAM AND CERTAIN OTHER PROGRAMS

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Sec. 549.0001. BULK PURCHASING WITH ANOTHER STATE OF PRESCRIPTION DRUGS AND OTHER MEDICATIONS. (a) Subject to Subsection (b), the commission and each health and human services agency the executive commissioner authorizes may enter into an agreement with one or more other states for the joint bulk purchasing of prescription drugs and other medications to be used in Medicaid, the child health plan program, or another program under the commission's authority.

(b) A joint bulk purchasing agreement may not be entered into until:

(1) the commission determines that entering into the agreement would be feasible and cost-effective; and

(2) if appropriated money would be spent under the proposed agreement, the governor and the Legislative Budget Board

grant prior approval to spend appropriated money under the proposed agreement.

(c) In determining the feasibility and cost-effectiveness of entering into a joint bulk purchasing agreement, the commission shall identify:

(1) the most cost-effective existing joint bulk purchasing agreement; and

(2) any potential groups of states with which this state could enter into a new cost-effective joint bulk purchasing agreement.

(d) If a joint bulk purchasing agreement is entered into, the commission shall adopt procedures applicable to an agreement and joint purchase described by this section. The procedures must ensure that this state receives:

(1) all prescription drugs and other medications purchased with money provided by this state; and

(2) an equitable share of any price benefits resulting from the joint bulk purchase. (Gov. Code, Sec. 531.090.)

Sec. 549.0002. VALUE-BASED ARRANGEMENT IN MEDICAID VENDOR DRUG PROGRAM. (a) In this section, "manufacturer" has the meaning assigned by Section 549.0101.

(b) Subject to Subchapter D, the commission may enter into a value-based arrangement for the Medicaid vendor drug program by written agreement with a manufacturer based on outcome data or other metrics to which this state and the manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a

reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus, or any other thing of value. (Gov. Code, Sec. 531.0701.)

Sec. 549.0003. PERIOD OF VALIDITY OF PRESCRIPTIONS UNDER MEDICAID. (a) This section does not apply to a prescription for a controlled substance, as defined by Chapter 481, Health and Safety Code.

(b) In the rules and standards governing the vendor drug program, the executive commissioner, to the extent allowed by federal law and laws regulating the writing of prescriptions and dispensing of prescription medications, shall ensure that a prescription written by an authorized health care provider under Medicaid is valid for the lesser of:

(1) the period for which the prescription is written; or

(2) one year. (Gov. Code, Sec. 531.0694.)

Sec. 549.0004. CERTAIN MEDICATIONS FOR SEX OFFENDERS PROHIBITED. (a) To the maximum extent allowed under federal law, the commission may not provide a sexual performance enhancing medication under the vendor drug program or any other health and human services program to an individual required to register as a sex offender under Chapter 62, Code of Criminal Procedure.

(b) The executive commissioner may adopt rules as necessary to implement this section. (Gov. Code, Sec. 531.089.)

Sec. 549.0005. PRIOR APPROVAL OF AND PHARMACY PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS AND ENROLLEES. (a) This section applies to:

(1) the vendor drug program for Medicaid and the child health plan program;

(2) the kidney health care program;

(3) the children with special health care needs program; and

(4) any other state program the commission administers that provides prescription drug benefits.

(b) A managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that administers claims for prescription drug benefits under a program to which this section applies shall, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients or enrollees collectively under a program:

(1) submit a copy of the communication to the commission for approval; and

(2) if applicable, allow the pharmacy providers of the recipients or enrollees who are to receive the communication access to the communication. (Gov. Code, Sec. 531.0697.)

SUBCHAPTER B. REVIEW AND ANALYSIS OF CERTAIN PRESCRIPTION DRUG PURCHASES AND PATTERNS

Sec. 549.0051. PERIODIC REVIEW OF VENDOR DRUG PROGRAM PURCHASES. (a) The commission shall periodically review all purchases made under the vendor drug program to determine the cost-effectiveness of including a component for prescription drug benefits in any capitation rate paid by this state under a Medicaid managed care program or the child health plan program.

(b) In making the determination required by Subsection (a), the commission shall consider the value of any prescription drug rebates this state receives. (Gov. Code, Sec. 531.069.)

Sec. 549.0052. MEDICAID PRESCRIPTION DRUG USE AND EXPENDITURE PATTERNS. The commission shall:

(1) monitor and analyze Medicaid prescription drug use and expenditure patterns;

(2) identify the therapeutic prescription drug classes and individual prescription drugs that are most often prescribed to patients or that represent the greatest expenditures; and

(3) post the data the commission identifies under this section on the commission's Internet website and update the information on a quarterly basis. (Gov. Code, Sec. 531.0693.)

SUBCHAPTER C. SUPPLEMENTAL REBATES OR PROGRAM BENEFITS FOR PRESCRIPTION DRUGS

Sec. 549.0101. DEFINITIONS. In this subchapter:

(1) "Labeler" means a person that:

(A) has a labeler code from the United States Food and Drug Administration under 21 C.F.R. Section 207.33; and

(B) receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

(2) "Manufacturer" means a manufacturer of prescription drugs as defined by 42 U.S.C. Section 1396r-8(k)(5), including a subsidiary or affiliate of a manufacturer.

(3) "Supplemental rebate" means a cash rebate a

manufacturer pays to this state:

(A) on the basis of appropriate quarterly health and human services program utilization data relating to the manufacturer's products; and

(B) in accordance with a state supplemental rebate agreement negotiated with the manufacturer and, if necessary, approved by the federal government under 42 U.S.C. Section 1396r-8.

(4) "Wholesaler" means a person licensed under Subchapter I, Chapter 431, Health and Safety Code. (Gov. Code, Secs. 531.070(a), (b).)

Sec. 549.0102. REQUIREMENT TO NEGOTIATE FOR SUPPLEMENTAL REBATES FOR CERTAIN PROGRAMS. (a) Subject to Subsection (b), the commission shall negotiate with manufacturers and labelers, including generic manufacturers and labelers, to obtain supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8;

(2) the child health plan program; and

(3) any other state program the commission or a health and human services agency administers, including a community mental health center or state mental health hospital.

(b) The commission may by contract authorize a private entity to negotiate with manufacturers and labelers on the commission's behalf. (Gov. Code, Secs. 531.070(h), (i).)

Sec. 549.0103. VOLUNTARY NEGOTIATION FOR MANUFACTURER AND LABELER SUPPLEMENTAL REBATES. A manufacturer or labeler that sells

prescription drugs in this state may voluntarily negotiate with the commission and enter into an agreement to provide supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8;

(2) the child health plan program; and

(3) any other state program the commission or a health and human services agency administers, including a community mental health center or state mental health hospital. (Gov. Code, Sec. 531.070(j).)

Sec. 549.0104. CONSIDERATIONS IN SUPPLEMENTAL REBATE NEGOTIATIONS. (a) In negotiating terms for a supplemental rebate amount, the commission shall consider:

(1) rebates calculated under the Medicaid rebate program in accordance with 42 U.S.C. Section 1396r-8;

(2) any other available information on prescription drug prices or rebates; and

(3) other program benefits as specified in Section 549.0106(b).

(b) In negotiating terms for a supplemental rebate, the commission shall use the average manufacturer price as defined in 42 U.S.C. Section 1396r-8(k)(1) as the cost basis for the product. (Gov. Code, Secs. 531.070(k), (m).)

Sec. 549.0105. REQUIRED DISCLOSURES IN NEGOTIATIONS FOR SUPPLEMENTAL REBATES. Before or during supplemental rebate agreement negotiations for a prescription drug being considered for the preferred drug list, the commission shall disclose to

pharmaceutical manufacturers any clinical edits or clinical protocols that may be imposed on drugs within a particular drug category that are placed on the preferred drug list during the contract period. Clinical edits may not be imposed for a preferred drug during the contract period unless the disclosure is made. (Gov. Code, Sec. 531.070(n).)

Sec. 549.0106. PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES; MONETARY CONTRIBUTION OR DONATION. (a) For purposes of this section, a program benefit may mean a disease management program authorized under this title, a drug product donation program, a drug utilization control program, prescriber and beneficiary counseling and education, a fraud or abuse initiative, and another service or administrative investment with guaranteed savings to a program a health and human services agency operates.

(b) The commission may enter into a written agreement with a manufacturer to accept a program benefit instead of a supplemental rebate only if:

(1) the program benefit yields savings that are at least equal to the amount the manufacturer would have provided under a state supplemental rebate agreement during the current biennium as determined by the written agreement;

(2) the manufacturer:

(A) posts a performance bond guaranteeing savings to this state; and

(B) agrees that if the savings are not achieved in accordance with the written agreement, the manufacturer will forfeit the bond to this state, less any savings that were achieved;

and

(3) the program benefit is in addition to other program benefits the manufacturer currently offers to recipients of Medicaid or related programs.

(c) For purposes of this subchapter, the commission may consider a monetary contribution or donation to the arrangements described in Subsection (b) for the purpose of offsetting expenditures to other state health care programs, but that funding may not be used to offset expenditures for covered outpatient drugs as defined by 42 U.S.C. Section 1396r-8(k)(2) under the vendor drug program. An arrangement under this subsection may not yield less than the amount this state would have benefited under a supplemental rebate. The commission may consider an arrangement under this subchapter as satisfying the requirements of Section 549.0204(a). (Gov. Code, Secs. 531.070(c), (d), (g).)

Sec. 549.0107. LIMITATIONS ON AGREEMENT TO ACCEPT PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES. (a) A commission agreement to accept a program benefit described by Section 549.0106:

(1) may not prohibit the commission from entering into a similar agreement with another entity that relates to a different drug class;

(2) must be limited to a period the commission expressly determines; and

(3) subject to Subsection (b), may cover only a product that has received United States Food and Drug Administration approval as of the date the commission enters into

the agreement.

(b) A new product the United States Food and Drug Administration approves after the commission enters into the agreement may be incorporated into the agreement only under an amendment to the agreement. (Gov. Code, Sec. 531.070(f).)

Sec. 549.0108. TREATMENT OF PROGRAM BENEFITS FOR CERTAIN PURPOSES. Other than as required to satisfy the provisions of this subchapter, a program benefit described by Section 549.0106 is considered an alternative to, and not the equivalent of, a supplemental rebate. A program benefit must be treated in this state's submissions to the federal government, including, as appropriate, waiver requests and quarterly Medicaid claims, so as to maximize the availability of federal matching payments. (Gov. Code, Sec. 531.070(e).)

SUBCHAPTER D. CONFIDENTIALITY OF INFORMATION RELATING TO PRESCRIPTION DRUG REBATE NEGOTIATIONS AND AGREEMENTS

Sec. 549.0151. CERTAIN PRESCRIPTION DRUG INFORMATION CONFIDENTIAL. (a) Notwithstanding any other state law other than Sections 549.0152 and 549.0153, information the commission obtains or maintains regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure under Chapter 552.

(b) Information that is confidential under Subsection (a) includes information described by that subsection that the commission obtains or maintains in connection with:

(1) the vendor drug program;

(2) the child health plan program;

(3) the kidney health care program;

(4) the children with special health care needs program; or

(5) another state program the commission or a health and human services agency administers. (Gov. Code, Secs. 531.071(a), (b).)

Sec. 549.0152. GENERAL PRESCRIPTION DRUG INFORMATION NOT CONFIDENTIAL; EXCEPTION. General information about the aggregate costs of different classes of prescription drugs is not confidential under Section 549.0151(a), except that a drug name or information that could reveal a drug name is confidential. (Gov. Code, Sec. 531.071(c).)

Sec. 549.0153. EXISTENCE OR NONEXISTENCE OF SUPPLEMENTAL REBATE AGREEMENT NOT CONFIDENTIAL. Information about whether the commission and a manufacturer or labeler reached or did not reach a supplemental rebate agreement under Subchapter C for a particular prescription drug is not confidential under Section 549.0151(a). (Gov. Code, Sec. 531.071(d).)

SUBCHAPTER E. PREFERRED DRUG LISTS

Sec. 549.0201. DEFINITION. In this subchapter, "board" means the Drug Utilization Review Board. (New.)

Sec. 549.0202. PREFERRED DRUG LISTS REQUIRED FOR MEDICAID VENDOR DRUG AND CHILD HEALTH PLAN PROGRAMS. In a manner that complies with state and federal law, the commission shall adopt preferred drug lists for:

(1) the Medicaid vendor drug program; and

(2) prescription drugs purchased through the child health plan program. (Gov. Code, Sec. 531.072(a) (part).)

Sec. 549.0203. PREFERRED DRUG LISTS AUTHORIZED FOR CERTAIN PROGRAMS. The commission may adopt preferred drug lists for:

(1) community mental health centers;

(2) state mental health hospitals; and

(3) any state program the commission or a state health and human services agency administers other than a program for which Section 549.0202 requires the adoption of preferred drug lists. (Gov. Code, Sec. 531.072(a) (part).)

Sec. 549.0204. LIMITATION ON DRUGS INCLUDED ON PREFERRED DRUG LISTS; EXCEPTIONS. (a) The preferred drug lists adopted under this subchapter may contain only drugs provided by a manufacturer or labeler that reaches an agreement with the commission on supplemental rebates under Subchapter C.

(b) Notwithstanding Subsection (a), the preferred drug lists may contain:

(1) a drug provided by a manufacturer or labeler that has not reached a supplemental rebate agreement with the commission if the commission determines that including the drug on the preferred drug lists will not have a negative cost impact to this state; or

(2) a drug provided by a manufacturer or labeler that has reached an agreement with the commission to provide program benefits instead of supplemental rebates as described by Subchapter C. (Gov. Code, Secs. 531.072(b), (b-1).)

Sec. 549.0205. CONSIDERATIONS FOR INCLUDING DRUG ON PREFERRED DRUG LISTS. (a) In making a decision regarding the placement of a drug on each of the preferred drug lists adopted under this subchapter, the commission shall consider:

(1) the board's recommendations under Section 549.0309;

(2) the drug's clinical efficacy;

(3) the price of competing drugs after deducting any federal and state rebate amounts; and

(4) program benefit offerings solely or in conjunction with rebates and other pricing information.

(b) The commission shall consider including on a preferred drug list:

(1) multiple methods of delivery within each drug class, including liquid, capsule, and tablet, including an orally disintegrating tablet; and

(2) all strengths and dosage forms of a drug. (Gov. Code, Secs. 531.072(b-2), (c), (c-1).)

Sec. 549.0206. SUBMISSION OF EVIDENCE TO SUPPORT INCLUDING DRUG ON PREFERRED DRUG LISTS. (a) In this section, "labeler" and "manufacturer" have the meanings assigned by Section 549.0101.

(b) The commission shall ensure that a manufacturer or labeler may submit written evidence that supports including a drug on the preferred drug lists before a supplemental rebate agreement is reached with the commission. (Gov. Code, Sec. 531.072(e) (part).)

Sec. 549.0207. PUBLICATION OF INFORMATION RELATING TO AND

DISTRIBUTION OF PREFERRED DRUG LISTS. (a) The commission shall publish on the commission's Internet website any decisions on preferred drug list placement, including:

(1) a list of drugs reviewed and the commission's decision for or against placement on a preferred drug list of each reviewed drug;

(2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Subchapter C; and

(3) the rationale for any departure from a board recommendation under Section 549.0309.

(b) The commission shall:

(1) provide for the distribution of current copies of the preferred drug lists adopted under this subchapter by posting the lists on the Internet; and

(2) mail copies of the lists to a health care provider on the provider's request. (Gov. Code, Secs. 531.072(d), 531.0741.)

SUBCHAPTER F. PRIOR AUTHORIZATION FOR CERTAIN DRUGS

Sec. 549.0251. DRUGS SUBJECT TO PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program and the child health plan program, shall require prior authorization for the reimbursement of a drug that is not included in the appropriate preferred drug list adopted under Subchapter E unless:

(1) the drug is exempt from prior authorization requirements by federal law; or

(2) the executive commissioner is prohibited under Sections 549.0252 and 549.0253(a) from requiring prior authorization for the drug.

(b) The executive commissioner may require prior authorization for the reimbursement of a drug provided through any state program, other than a program described by Subsection (a), that the commission or a state health and human services agency administers, including a community mental health center and a state mental health hospital if the commission adopts a preferred drug list under Subchapter E that applies to that facility and the drug is not included in the appropriate list.

(c) The executive commissioner shall require that the prior authorization be obtained by the prescribing physician or prescribing practitioner. (Gov. Code, Sec. 531.073(a).)

Sec. 549.0252. PRIOR AUTHORIZATION AND CERTAIN PROTOCOL REQUIREMENTS PROHIBITED FOR CERTAIN ANTIRETROVIRAL DRUGS. (a) In this section, "antiretroviral drug" means a drug that treats human immunodeficiency virus infection or prevents acquired immune deficiency syndrome. The term includes:

(1) protease inhibitors;

(2) non-nucleoside reverse transcriptase inhibitors;

(3) nucleoside reverse transcriptase inhibitors;

(4) integrase inhibitors;

(5) fusion inhibitors;

(6) attachment inhibitors;

(7) CD4 post-attachment inhibitors;

(8) CCR5 receptor antagonists; and

(9) other antiretroviral drugs used to treat human immunodeficiency virus infection or prevent acquired immune deficiency syndrome.

(b) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program, may not require a clinical, nonpreferred, or other prior authorization for an antiretroviral drug, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse. (Gov. Code, Sec. 531.073(j).)

Sec. 549.0253. PRIOR AUTHORIZATION PROHIBITED FOR CERTAIN NONPREFERRED ANTIPSYCHOTIC DRUGS. (a) The executive commissioner, in the rules and standards governing the vendor drug program, may not require prior authorization for a nonpreferred antipsychotic drug that is included on the vendor drug formulary and prescribed to an adult patient if:

(1) during the preceding year, the patient was prescribed and unsuccessfully treated with a 14-day treatment trial of an antipsychotic drug that is included on the appropriate preferred drug list adopted under Subchapter E and for which a single claim was paid;

(2) the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription is for the purpose of drug dosage titration; or

(3) subject to federal law on maximum dosage limits and commission rules on drug quantity limits, the patient has previously been prescribed and obtained prior authorization for the

nonpreferred antipsychotic drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.

(b) Subsection (a) does not affect:

(1) a pharmacist's authority to dispense the generic equivalent or interchangeable biological product of a prescription drug in accordance with Subchapter A, Chapter 562, Occupations Code;

(2) any drug utilization review requirements prescribed by state or federal law; or

(3) clinical prior authorization edits to preferred and nonpreferred antipsychotic drug prescriptions. (Gov. Code, Secs. 531.073(a-3), (a-4).)

Sec. 549.0254. ADMINISTRATION OF PRIOR AUTHORIZATION REQUIREMENTS. (a) The commission may by contract authorize a private entity to administer the prior authorization requirements imposed by Sections 549.0251 and 549.0255 through 549.0259 on the commission's behalf.

(b) The commission shall ensure that the prior authorization requirements are implemented in a manner that minimizes the cost to this state and any administrative burden placed on providers. (Gov. Code, Secs. 531.073(e), (f).)

Sec. 549.0255. PREREQUISITE TO IMPLEMENTING PRIOR AUTHORIZATION REQUIREMENT FOR CERTAIN DRUGS. Until the commission completes a study evaluating the impact of a prior authorization requirement on recipients of certain drugs, the executive commissioner shall delay requiring prior authorization for drugs

that are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies. (Gov. Code, Sec. 531.073(a-1).)

Sec. 549.0256. NOTICE OF PRIOR AUTHORIZATION REQUIREMENT IMPLEMENTATION AND PROCEDURES. Not later than the 30th day before the date a prior authorization requirement is implemented, the commission shall post on the Internet for consumers and providers:

(1) notice of the implementation date; and

(2) a detailed description of the procedures to be used in obtaining prior authorization. (Gov. Code, Sec. 531.073(a-2).)

Sec. 549.0257. PRIOR AUTHORIZATION PROCEDURES. (a) The commission shall establish procedures for the prior authorization requirement under the Medicaid vendor drug program to ensure that the requirements of 42 U.S.C. Section 1396r-8(d)(5) are met. The procedures must ensure that:

(1) a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Drug Utilization Review Board under Subchapter G;

(2) a response to a request for prior authorization is provided by telephone or other telecommunications device within 24 hours after receipt of the request; and

(3) a 72-hour supply of the drug prescribed is provided in an emergency or if the commission does not provide a response within the period required by Subdivision (2).

(b) The commission shall implement procedures to ensure that a recipient or enrollee under Medicaid, the child health plan program, or another state program the commission administers, or an individual who becomes eligible under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, receives continuity of care in relation to certain prescriptions the commission identifies.

(c) The commission shall ensure that requests for prior authorization may be submitted by telephone, facsimile, or electronic communications through the Internet.

(d) The commission shall provide an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request. (Gov. Code, Secs. 531.073(b), (d), (g), (h).)

Sec. 549.0258. PRIOR AUTHORIZATION AUTOMATION AND POINT-OF-SALE REQUIREMENTS. The executive commissioner, in the rules and standards governing the vendor drug program and as part of the requirements under a contract between the commission and a Medicaid managed care organization, shall:

(1) require, to the maximum extent possible based on a pharmacy benefit manager's claim system, automation of clinical prior authorization for each drug in the antipsychotic drug class; and

(2) ensure that, at the time a nonpreferred or clinical prior authorization edit is denied, a pharmacist is

immediately provided a point-of-sale return message that:

(A) clearly specifies the contact and other information necessary for the pharmacist to submit a prior authorization request for the prescription; and

(B) instructs the pharmacist to dispense, only if clinically appropriate under federal or state law, a 72-hour supply of the prescription. (Gov. Code, Sec. 531.073(a-5).)

Sec. 549.0259. APPLICABILITY OF PRIOR AUTHORIZATION REQUIREMENTS TO PRIOR PRESCRIPTIONS. The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient or enrollee under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, or for an individual who becomes eligible under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, is not subject to any prior authorization requirement under this subchapter until the earlier of:

(1) the date the recipient or enrollee exhausts all the prescription, including any authorized refills; or

(2) the expiration of a period the commission prescribes. (Gov. Code, Sec. 531.073(c).)

Sec. 549.0260. APPEAL OF PRIOR AUTHORIZATION DENIAL UNDER MEDICAID VENDOR DRUG PROGRAM. A recipient of drug benefits under the Medicaid vendor drug program may appeal through the Medicaid fair hearing process a denial of prior authorization under this subchapter for a covered drug or covered dosage. (Gov. Code, Sec.

531.072(f).)

SUBCHAPTER G. DRUG UTILIZATION REVIEW BOARD

Sec. 549.0301. DEFINITION. In this subchapter, "board" means the Drug Utilization Review Board. (Gov. Code, Sec. 531.0736(a).)

Sec. 549.0302. BOARD COMPOSITION; APPLICATION PROCESS. (a) The composition of the board must comply with federal law, including 42 C.F.R. Section 456.716. The executive commissioner shall determine the board's composition, which must include:

(1) two representatives of managed care organizations, one of whom must be a physician and one of whom must be a pharmacist, as nonvoting members;

(2) at least 17 physicians and pharmacists who:

(A) provide services across the entire population of Medicaid recipients and represent different specialties, including at least one of each of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist; and

(v) an adult psychiatrist; and

(B) have experience in either developing or practicing under a preferred drug list; and

(3) a consumer advocate who represents Medicaid recipients.

(b) The executive commissioner by rule shall develop and implement a process by which an individual may apply to become a board member and shall post the application and information regarding the application process on the commission's Internet website. (Gov. Code, Secs. 531.0736(c), (c-1).)

Sec. 549.0303. CONFLICTS OF INTEREST. (a) A voting board member may not have a contractual relationship with, ownership interest in, or other conflict of interest with:

(1) a pharmaceutical manufacturer or labeler; or

(2) an entity the commission engages to assist in developing preferred drug lists or administering the Medicaid Drug Utilization Review Program.

(b) The executive commissioner may implement this section by:

(1) adopting rules that identify prohibited relationships and conflicts; or

(2) requiring the board to develop a conflict-of-interest policy that applies to the board. (Gov. Code, Sec. 531.0737.)

Sec. 549.0304. BOARD MEMBER TERMS. Board members serve staggered four-year terms. (Gov. Code, Sec. 531.0736(e).)

Sec. 549.0305. PRESIDING OFFICER. The voting board members shall elect from among the voting members a presiding officer. The presiding officer must be a physician. (Gov. Code, Sec. 531.0736(f).)

Sec. 549.0306. INAPPLICABILITY OF OTHER LAW TO BOARD. Chapter 2110 does not apply to the board. (Gov. Code, Sec.

531.0736(m).)

Sec. 549.0307. ADMINISTRATIVE SUPPORT FOR BOARD. The commission shall provide administrative support and resources as necessary for the board to perform the board's duties. (Gov. Code, Sec. 531.0736(l).)

Sec. 549.0308. RULES FOR BOARD OPERATION. (a) The executive commissioner shall adopt rules governing the board's operation, including:

(1) rules governing the procedures the board uses to provide notice of a meeting; and

(2) rules prohibiting the board from discussing confidential information described by Subchapter D in a public meeting.

(b) The board shall comply with the rules adopted under this section and Section 549.0311. (Gov. Code, Sec. 531.0736(i).)

Sec. 549.0309. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to performing any other duties required by federal law, the board shall:

(1) develop and submit to the commission recommendations for the preferred drug lists the commission adopts under Subchapter E;

(2) suggest to the commission restrictions or clinical edits on prescription drugs;

(3) recommend to the commission educational interventions for Medicaid providers;

(4) review drug utilization across Medicaid; and

(5) perform other duties that may be specified by law

and otherwise make recommendations to the commission.

(b) In developing recommendations for the preferred drug lists, the board shall consider the clinical efficacy, safety, and cost-effectiveness of, and any program benefit associated with, a product.

(c) To the extent feasible, the board:

(1) shall review all drug classes included in the preferred drug lists at least once every 12 months; and

(2) may recommend inclusions in and exclusions from the lists to ensure that the lists provide for a range of clinically effective, safe, cost-effective, and medically appropriate drug therapies for the diverse segments of the Medicaid population, children receiving health benefits coverage under the child health plan program, and any other affected individuals. (Gov. Code, Secs. 531.0736(b), (h), (k).)

Sec. 549.0310. BOARD MEETINGS; REVIEW OF CERTAIN PRODUCTS. (a) The board shall hold a public meeting quarterly at the call of the presiding officer and shall permit public comment before voting on any changes in the preferred drug lists the commission adopts under Subchapter E, the adoption of or changes to drug use criteria, or the adoption of prior authorization or drug utilization review proposals. The location of the quarterly public meeting may rotate among different geographic areas across this state, or allow for public input through teleconferencing centers in various geographic areas across this state.

(b) The board shall hold public meetings at other times at the call of the presiding officer.

(c) Minutes of each meeting shall be made available to the public not later than the 10th business day after the date the minutes are approved.

(d) The board may meet in executive session to discuss confidential information as described by Section 549.0308.

(e) Board members appointed under Section 549.0302(a)(1) may attend quarterly and other regularly scheduled meetings, but may not:

(1) attend executive sessions; or

(2) access confidential drug pricing information.

(f) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 549.0101. The commission shall ensure that a drug that has been approved or had any of the drug's particular uses approved by the United States Food and Drug Administration under a priority review classification is reviewed by the board at the next regularly scheduled board meeting. On receiving notice from a manufacturer or labeler of the availability of a new product, the commission, to the extent possible, shall schedule a review for the product at the next regularly scheduled board meeting. (Gov. Code, Secs. 531.072(e) (part), 531.0736(b) (part), (d), (g).)

Sec. 549.0311. BOARD SUMMARY OF CERTAIN INFORMATION REQUIRED. (a) The executive commissioner by rule shall require the board or the board's designee to present a summary of any clinical efficacy and safety information or analyses regarding a drug under consideration for a preferred drug list the commission adopts under Subchapter E that is provided to the board by a private entity that

contracted with the commission to provide the information. Confidential information described by Subchapter D must be omitted from the summary.

(b) The board or the board's designee shall provide the summary in electronic form before the public meeting at which consideration of the drug occurs.

(c) The summary must be posted on the commission's Internet website. (Gov. Code, Secs. 531.0736(b) (part), (j).)

Sec. 549.0312. PUBLIC DISCLOSURE OF CERTAIN BOARD RECOMMENDATIONS REQUIRED. (a) The commission or the commission's agent shall publicly disclose, immediately after the board's deliberations conclude, each specific drug recommended for or against preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The disclosure must include:

(1) the general basis for the recommendation for each drug class; and

(2) for each recommendation, whether a supplemental rebate agreement or program benefit agreement was reached under Subchapter C.

(b) The disclosure must be posted on the commission's Internet website not later than the 10th business day after the date of conclusion of board deliberations that result in recommendations made to the executive commissioner regarding the placement of drugs on the preferred drug list. (Gov. Code, Sec. 531.0736(n).)

SUBCHAPTER H. MEDICAID DRUG UTILIZATION REVIEW PROGRAM

Sec. 549.0351. DEFINITIONS. In this subchapter:

(1) "Medicaid Drug Utilization Review Program" means the program the vendor drug program operates to improve the quality of pharmaceutical care under Medicaid.

(2) "Prospective drug use review" means the review of a patient's drug therapy and prescription drug order or medication order before dispensing or distributing a drug to the patient.

(3) "Retrospective drug use review" means the review of prescription drug claims data to identify patterns of prescribing. (Gov. Code, Sec. 531.0735(a).)

Sec. 549.0352. DRUG USE REVIEWS. (a) The commission shall provide for an increase in the number and types of retrospective drug use reviews performed each year under the Medicaid Drug Utilization Review Program in comparison to the number and types of reviews performed in the state fiscal year ending August 31, 2009.

(b) In determining the number and types of drug use reviews to be performed, the commission shall:

(1) allow for the repeat of retrospective drug use reviews that address ongoing drug therapy problems and that, in previous years, improved client outcomes and reduced Medicaid spending;

(2) consider implementing disease-specific retrospective drug use reviews that:

(A) address ongoing drug therapy problems in this state; and

(B) reduced Medicaid prescription drug use expenditures in another state; and

(3) regularly examine Medicaid prescription drug

claims data to identify occurrences of potential drug therapy problems that may be addressed by repeating successful retrospective drug use reviews performed in this state or another state. (Gov. Code, Secs. 531.0735(b), (c).)

Sec. 549.0353. ANNUAL REPORT. (a) In addition to any other information required by federal law, the commission shall include the following information in the annual report regarding the Medicaid Drug Utilization Review Program:

(1) a detailed description of the program's activities; and

(2) estimates of cost savings anticipated to result from the program's performance of prospective and retrospective drug use reviews.

(b) The cost-saving estimates for prospective drug use reviews under Subsection (a) must include savings attributed to drug use reviews performed through the vendor drug program's electronic claims processing system and clinical edits screened through the prior authorization system implemented under Subchapter F.

(c) The commission shall post the annual report regarding the Medicaid Drug Utilization Review Program on the commission's Internet website. (Gov. Code, Secs. 531.0735(d), (e), (f).)

SUBCHAPTER I. PHARMACEUTICAL PATIENT ASSISTANCE PROGRAM INFORMATION

Sec. 549.0401. DEFINITION. In this subchapter, "patient assistance program" means a program a pharmaceutical company offers under which the company provides a drug to individuals in need of

assistance at no charge or at a substantially reduced cost. The term does not include the provision of a drug as part of a clinical trial. (Gov. Code, Sec. 531.351.)

Sec. 549.0402. PROVISION OF PROGRAM INFORMATION BY PHARMACEUTICAL COMPANY. Each pharmaceutical company that does business in this state and that offers a patient assistance program shall inform the commission of:

(1) the existence of the program;

(2) the eligibility requirements for the program;

(3) the drugs covered by the program; and

(4) information used for applying for the program, such as a telephone number. (Gov. Code, Sec. 531.352.)

Sec. 549.0403. PUBLIC ACCESS TO PROGRAM INFORMATION. (a) The commission shall establish a system under which members of the public can call a toll-free telephone number to obtain information about available patient assistance programs. The commission shall ensure that the system is staffed at least during normal business hours with individuals who can:

(1) determine whether a patient assistance program is offered for a particular drug;

(2) determine whether an individual may be eligible to participate in a program; and

(3) assist an individual who wishes to apply for a program.

(b) The commission shall publicize the telephone number to pharmacies and drug prescribers. (Gov. Code, Sec. 531.353.)

SUBCHAPTER J. STATE PRESCRIPTION DRUG PROGRAM

Sec. 549.0451. DEVELOPMENT AND IMPLEMENTATION OF STATE PRESCRIPTION DRUG PROGRAM. The commission shall develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to Medicaid recipients. (Gov. Code, Sec. 531.301(a).)

Sec. 549.0452. PROGRAM ELIGIBILITY. An individual is eligible for prescription drug benefits under the state prescription drug program if the individual is:

(1) a qualified Medicare beneficiary, as defined by 42 U.S.C. Section 1396d(p)(1);

(2) a specified low-income Medicare beneficiary who is eligible for assistance under Medicaid for Medicare cost-sharing payments under 42 U.S.C. Section 1396a(a)(10)(E)(iii);

(3) a qualified disabled and working individual, as defined by 42 U.S.C. Section 1396d(s); or

(4) a qualifying individual who is eligible for assistance under Medicaid under 42 U.S.C. Section 1396a(a)(10)(E)(iv). (Gov. Code, Sec. 531.301(b).)

Sec. 549.0453. RULES. (a) The executive commissioner shall adopt rules necessary for implementing the state prescription drug program.

(b) In adopting rules for the state prescription drug program, the executive commissioner:

(1) shall consult with an advisory panel composed of an equal number of physicians, pharmacists, and pharmacologists the

executive commissioner appoints; and

(2) may:

(A) require an individual who is eligible for prescription drug benefits to pay a cost-sharing payment;

(B) authorize the use of a prescription drug formulary to specify which prescription drugs the state prescription drug program will cover;

(C) to the extent possible, require clinically appropriate prior authorization for prescription drug benefits in the same manner as prior authorization is required under the vendor drug program; and

(D) establish a drug utilization review program to ensure the appropriate use of prescription drugs under the state prescription drug program. (Gov. Code, Sec. 531.302.)

Sec. 549.0454. GENERIC EQUIVALENT AUTHORIZED. In rules adopted for the state prescription drug program, the executive commissioner may require that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, a pharmacist may select a generic equivalent of the prescribed drug. (Gov. Code, Sec. 531.303.)

Sec. 549.0455. PROGRAM FUNDING AND FUNDING PRIORITIES. (a) Prescription drugs under the state prescription drug program may be funded only with state money unless funds are available under federal law to fund all or part of the program.

(b) If money available for the state prescription drug program is insufficient to provide prescription drug benefits to all individuals who are eligible under Section 549.0452, the

commission shall:

(1) limit the number of enrollees based on available funding; and

(2) provide the prescription drug benefits to eligible individuals in the following order of priority:

(A) individuals eligible under Section 549.0452(1);

(B) individuals eligible under Section 549.0452(2); and

(C) individuals eligible under Sections 549.0452(3) and (4). (Gov. Code, Secs. 531.301(c), 531.304.)

CHAPTER 550. HUMAN SERVICES AND OTHER SOCIAL SERVICES PROVIDED THROUGH FAITH- AND COMMUNITY-BASED ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

SUBCHAPTER B. GOVERNMENTAL LIAISONS FOR FAITH- AND COMMUNITY-BASED ORGANIZATIONS

CHAPTER 550. HUMAN SERVICES AND OTHER SOCIAL SERVICES PROVIDED THROUGH FAITH- AND COMMUNITY-BASED ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 550.0001. DEFINITIONS. In this chapter:

(1) "Community-based initiative" includes a social, health, human services, or volunteer income tax assistance initiative a community-based organization operates.

(2) "Community-based organization" means a nonprofit corporation or association that is located in close proximity to

the population the organization serves.

(3) "Faith-based initiative" means a social, health, or human services initiative a faith-based organization operates.

(4) "Faith-based organization" means a nonprofit corporation or association that:

(A) operates through a religious or denominational organization, including an organization that is:

(i) operated for a religious, educational, or charitable purpose; and

(ii) operated, supervised, or controlled, wholly or partly, by or in connection with a religious organization; or

(B) clearly demonstrates through the organization's mission statement, policies, or practices that the organization is guided or motivated by religion.

(5) "Interagency coordinating group" means the interagency coordinating group for faith- and community-based initiatives established under Section 550.0054.

(6) "State Commission on National and Community Service" means the entity used as authorized by 42 U.S.C. Section 12638(a) to carry out a state commission's duties under the National and Community Service Act of 1990 (42 U.S.C. Section 12501 et seq.). (Gov. Code, Sec. 535.001; New.)

Sec. 550.0002. PURPOSE OF CHAPTER. The purpose of this chapter is to strengthen the capacity of faith- and community-based organizations and forge stronger partnerships between those organizations and state government for the legitimate public

purpose of providing charitable and social services to persons in this state. (Gov. Code, Sec. 535.002.)

Sec. 550.0003. CONSTRUCTION OF CHAPTER. This chapter may not be construed to:

(1) exempt a faith- or community-based organization from any applicable state or federal law; or

(2) be an endorsement or sponsorship by this state of a faith-based organization's religious character, expression, beliefs, doctrines, or practices. (Gov. Code, Sec. 535.003.)

Sec. 550.0004. CONSISTENT APPLICATION WITH FEDERAL LAW. A power authorized or duty imposed under this chapter must be performed in a manner consistent with 42 U.S.C. Section 604a. (Gov. Code, Sec. 535.004.)

SUBCHAPTER B. GOVERNMENTAL LIAISONS FOR FAITH- AND COMMUNITY-BASED ORGANIZATIONS

Sec. 550.0051. DEFINITION. In this subchapter, "council" means the Texas Nonprofit Council. (New.)

Sec. 550.0052. DESIGNATION OF FAITH- AND COMMUNITY-BASED LIAISONS. (a) The executive commissioner, in consultation with the governor, shall designate one employee from the commission and from each health and human services agency to serve as a liaison for faith- and community-based organizations.

(b) The chief administrative officer of each of the following state agencies, in consultation with the governor, shall designate one employee from the agency to serve as a liaison for faith- and community-based organizations:

(1) the Department of Agriculture;

(2) the Department of Information Resources;

(3) the Department of Public Safety;

(4) the office of the attorney general;

(5) the office of the comptroller;

(6) the office of the governor;

(7) the office of the secretary of state;

(8) the Office of State-Federal Relations;

(9) the Public Utility Commission of Texas;

(10) the Texas Commission on Environmental Quality;

(11) the Texas Department of Criminal Justice;

(12) the Texas Department of Housing and Community Affairs;

(13) the Texas Department of Insurance;

(14) the Texas Juvenile Justice Department;

(15) the Texas Veterans Commission;

(16) the Texas Workforce Commission; and

(17) other state agencies as the governor determines.

(c) The commissioner of higher education, in consultation with the presiding officer of the interagency coordinating group, shall designate one employee from an institution of higher education, as defined by Section 61.003, Education Code, to serve as a liaison for faith- and community-based organizations. (Gov. Code, Sec. 535.051.)

Sec. 550.0053. GENERAL POWERS AND DUTIES OF LIAISONS. (a) A faith- and community-based liaison designated under Section 550.0052 shall:

(1) identify and remove unnecessary barriers to

partnerships between the state agency the liaison represents and faith- and community-based organizations;

(2) provide any necessary information and training for employees of the represented state agency regarding equal opportunity standards for faith- and community-based organizations seeking to partner with state government;

(3) facilitate the identification of practices with demonstrated effectiveness for faith- and community-based organizations that partner with the represented state agency;

(4) work with the appropriate departments and programs of the represented state agency to conduct outreach efforts to inform and welcome faith- and community-based organizations that have not traditionally formed partnerships with the agency;

(5) coordinate all efforts with the governor's office of faith- and community-based initiatives and provide any requested information, support, and assistance to that office to the extent permitted by law and as feasible; and

(6) attend conferences sponsored by federal agencies and offices and other relevant entities to become and remain informed of issues and developments regarding faith- and community-based initiatives.

(b) A designated faith- and community-based liaison may coordinate and interact with statewide organizations that represent faith- or community-based organizations as necessary to accomplish the purposes of this subchapter and Subchapters A and C. (Gov. Code, Sec. 535.052.)

Sec. 550.0054. INTERAGENCY COORDINATING GROUP. (a) The

interagency coordinating group for faith- and community-based initiatives is composed of:

(1) each faith- and community-based liaison designated under Section 550.0052; and

(2) a liaison from the State Commission on National and Community Service.

(b) Service on the interagency coordinating group is an additional duty of the office or position held by each liaison designated under Section 550.0052(b).

(c) The liaison from the State Commission on National and Community Service is the presiding officer of the interagency coordinating group. If the State Commission on National and Community Service is abolished, the liaison from the office of the governor is the presiding officer of the group.

(d) The state agencies described by Section 550.0052(b) shall provide administrative support for the interagency coordinating group as coordinated by the presiding officer. (Gov. Code, Secs. 535.053(a), (a-1), (b).)

Sec. 550.0055. DUTIES OF INTERAGENCY COORDINATING GROUP. The interagency coordinating group shall:

(1) meet periodically at the call of the presiding officer;

(2) work across state agencies and with the State Commission on National and Community Service to facilitate the removal of unnecessary interagency barriers to partnerships between state agencies and faith- and community-based organizations; and

(3) operate in a manner that promotes effective partnerships between those agencies and organizations to serve residents of this state who need assistance. (Gov. Code, Sec. 535.053(c).)

Sec. 550.0056. INTERAGENCY COORDINATING GROUP ANNUAL REPORT. Not later than December 1 of each year, the interagency coordinating group shall submit to the legislature a report describing in detail the activities, goals, and progress of the group. The report must be made available to the public on the office of the governor's Internet website. (Gov. Code, Sec. 535.054.)

Sec. 550.0057. TEXAS NONPROFIT COUNCIL. (a) The Texas Nonprofit Council is established to help direct the interagency coordinating group in carrying out the group's duties under this subchapter.

(b) The governor, in consultation with the presiding officer of the interagency coordinating group, shall appoint as council members two representatives from each of the following groups and entities to represent each group's and entity's appropriate sector:

(1) community-based groups;

(2) consultants to nonprofit corporations;

(3) faith-based groups, at least one of which must be a statewide interfaith group;

(4) local governments;

(5) statewide associations of nonprofit organizations; and

(6) statewide nonprofit organizations.

(c) A council member serves a three-year term expiring October 1. A council member may not serve more than two consecutive terms.

(d) The council shall:

(1) elect a presiding officer or presiding officers and a secretary from among the council members; and

(2) assist the executive commissioner in identifying an individual to fill a vacancy on the council.

(e) The state agencies described by Section 550.0052(b) shall provide administrative support to the council as coordinated by the presiding officer of the interagency coordinating group.

(f) Chapter 2110 does not apply to the council. (Gov. Code, Secs. 535.055(a), (b), (c-1), (c-2), (e).)

Sec. 550.0058. DUTIES OF TEXAS NONPROFIT COUNCIL. The council, in coordination with the interagency coordinating group, shall:

(1) make recommendations for improving contracting relationships between state agencies and faith- and community-based organizations;

(2) develop best practices for cooperating and collaborating with faith- and community-based organizations; and

(3) identify and address:

(A) duplication of services provided by this state and faith- and community-based organizations; and

(B) gaps in state services that faith- and community-based organizations could fill. (Gov. Code, Sec.

535.055(c).)

Sec. 550.0059. TEXAS NONPROFIT COUNCIL BIENNIAL REPORT. (a) The council shall prepare a biennial report detailing the council's work. The report must include any recommendations relating to legislation necessary to address an issue identified under Section 550.0058.

(b) Not later than December 1 of each even-numbered year, the council shall present the report to:

(1) the House Committee on Human Services or its successor;

(2) the House Committee on Public Health or its successor; and

(3) the Senate Health and Human Services Committee or its successor. (Gov. Code, Sec. 535.055(d).)

SUBCHAPTER C. RENEWING OUR COMMUNITIES ACCOUNT

Sec. 550.0101. DEFINITION. In this subchapter, "account" means the renewing our communities account established under Section 550.0103. (Gov. Code, Sec. 535.101.)

Sec. 550.0102. PURPOSES OF SUBCHAPTER. Recognizing that faith- and community-based organizations provide a range of vital charitable services to persons in this state, the purposes of this subchapter are to:

(1) increase the impact and effectiveness of those organizations;

(2) forge stronger partnerships between those organizations and state government so that:

(A) communities are empowered to serve

individuals in need; and

(B) community capacity for providing services is strengthened; and

(3) create a funding mechanism that:

(A) builds on the established efforts of those organizations; and

(B) operates to create new partnerships in local communities for the benefit of this state. (Gov. Code, Sec. 535.102.)

Sec. 550.0103. RENEWING OUR COMMUNITIES ACCOUNT. (a) The renewing our communities account is an account in the general revenue fund that may be appropriated only to the commission for:

(1) the purposes and activities authorized by this subchapter; and

(2) reasonable administrative expenses under this subchapter.

(b) The purposes of the account are to:

(1) increase the capacity of faith- and community-based organizations to provide charitable services and to manage human resources and funds;

(2) assist local governmental entities in establishing local offices to promote faith- and community-based initiatives; and

(3) foster better partnerships between state government and faith- and community-based organizations.

(c) The account consists of:

(1) all money appropriated for the purposes of this

subchapter; and

(2) any gifts, grants, or donations received for the purposes of this subchapter.

(d) The account is exempt from the application of Section 403.095. (Gov. Code, Sec. 535.103.)

Sec. 550.0104. COMMISSION POWERS AND DUTIES REGARDING ACCOUNT. (a) The commission shall:

(1) contract with the State Commission on National and Community Service to administer funds appropriated from the account in a manner that:

(A) consolidates the capacity of and strengthens national service and community and faith- and community-based initiatives; and

(B) leverages public and private funds to benefit this state;

(2) develop a competitive process for awarding grants from funds in the account that is consistent with state law and includes objective selection criteria;

(3) oversee the delivery of training and other assistance activities under this subchapter;

(4) develop criteria limiting grant awards under Section 550.0106(a)(1)(A) to small and medium-sized faith- and community-based organizations that provide charitable services to persons in this state;

(5) establish general state priorities for the account;

(6) establish and monitor performance and outcome

measures for persons who are awarded grants under this subchapter; and

(7) establish policies and procedures to ensure that any money appropriated from the account to the commission that is allocated to build the capacity of a faith-based organization or for a faith-based initiative is not used to advance a sectarian purpose or to engage in any form of proselytization.

(b) The commission may award money in the account appropriated to the commission to the State Commission on National and Community Service in the form of a grant instead of contracting with that entity under Subsection (a)(1). (Gov. Code, Secs. 535.104(a), (b).)

Sec. 550.0105. ACCEPTABLE USES OF ACCOUNT FUNDS. The commission or the State Commission on National and Community Service, in accordance with the terms of a contract or grant, as applicable, may:

(1) directly, or through agreements with one or more entities serving faith- and community-based organizations that provide charitable services to persons in this state:

(A) assist the organizations with:

(i) writing or managing grants through workshops or other forms of guidance;

(ii) obtaining legal assistance related to forming a corporation or obtaining an exemption from taxation under the Internal Revenue Code; and

(iii) obtaining information about or referrals to entities that provide expertise in accounting, legal,

or tax issues, program development matters, or other organizational topics;

(B) provide to the organizations information or assistance related to building the organizations' capacity for providing services;

(C) facilitate the formation of networks, the coordination of services, and the sharing of resources among the organizations;

(D) in cooperation with existing efforts, if possible, conduct needs assessments to identify gaps in services in a community that present a need for developing or expanding services;

(E) work with the organizations to identify the organizations' needs for improvements in their internal capacity for providing services;

(F) provide the organizations with information on and assistance in identifying or using practices with demonstrated effectiveness for delivering charitable services to persons, families, and communities and in replicating charitable services programs that have demonstrated effectiveness; and

(G) encourage research into the impact of organizational capacity on program delivery for the organizations;

(2) assist a local governmental entity in creating a better partnership between government and faith- and community-based organizations to provide charitable services to persons in this state; and

(3) use funds appropriated from the account to provide

matching money for federal or private grant programs that further the purposes of the account as described by Section 550.0103(b). (Gov. Code, Sec. 535.104(d).)

Sec. 550.0106. ADMINISTRATION OF ACCOUNT FUNDS. (a) If under Section 550.0104 the commission contracts with or awards a grant to the State Commission on National and Community Service, that entity:

(1) may award grants from funds appropriated from the account to:

(A) faith- and community-based organizations that provide charitable services to persons in this state for capacity-building purposes; and

(B) local governmental entities to provide seed money for local offices for faith- and community-based initiatives; and

(2) shall monitor performance and outcome measures for persons to whom that entity awards grants using the measures the commission establishes under Section 550.0104(a)(6).

(b) Any funds awarded to the State Commission on National and Community Service under a contract or through a grant under Section 550.0104 must be administered in the manner required by this subchapter. (Gov. Code, Secs. 535.104(c), 535.105.)

Sec. 550.0107. ACCOUNT MONITORING. The commission shall monitor the use of the funds administered by the State Commission on National and Community Service under a contract or through a grant under Section 550.0104 to ensure that the funds are used in a manner consistent with the requirements of this subchapter. (Gov. Code,

Sec. 535.104(e) (part).)

Sec. 550.0108. PUBLIC INFORMATION; INTERNET POSTING REQUIREMENT. (a) Records relating to the award of a contract or grant to the State Commission on National and Community Service, or to grants that entity awards, and records relating to other uses of the awarded funds are public information subject to Chapter 552.

(b) If the commission contracts with or awards a grant to the State Commission on National and Community Service under Section 550.0104, the commission shall provide a link on the commission's Internet website to that entity's Internet website. The entity's Internet website must provide:

(1) a list of the names of each person to whom the entity awards a grant from money appropriated from the account and the amount and purpose of the grant; and

(2) information regarding the methods by which the public may request information about those grants. (Gov. Code, Secs. 535.104(e) (part), 535.106(a).)

Sec. 550.0109. REPORTS. (a) If the State Commission on National and Community Service is awarded a contract or grant under Section 550.0104, that entity must provide to the commission periodic reports on a schedule the executive commissioner determines. The schedule of periodic reports must include an annual report that provides:

(1) a specific accounting of that entity's use of money appropriated from the account, including the names of persons to whom grants have been awarded and the purposes of those grants; and

(2) a summary of the efforts of the faith- and

community-based liaisons designated under Section 550.0052 to comply with the duties imposed by and the purposes of Sections 550.0053 and 550.0055.

(b) The commission shall:

(1) post the annual report submitted under this section on the commission's Internet website; and

(2) provide copies of the report to the governor, the lieutenant governor, and the members of the legislature. (Gov. Code, Secs. 535.106(b), (c).)

Sec. 550.0110. CONSTRUCTION OF SUBCHAPTER. If the commission contracts with or awards a grant to the State Commission on National and Community Service under Section 550.0104, this subchapter may not be construed to:

(1) release that entity from any regulations or reporting or other requirements applicable to a commission contractor or grantee;

(2) impose regulations or reporting or other requirements on that entity that do not apply to other commission contractors or grantees solely because of the entity's status;

(3) alter the nonprofit status of that entity or the requirements for maintaining that status; or

(4) convert that entity into a governmental entity because of the receipt of account funds through the contract or grant. (Gov. Code, Sec. 535.104(f).)

SUBCHAPTER D. FAITH- AND COMMUNITY-BASED ORGANIZATION SUPPLEMENTAL ASSISTANCE PROGRAM FOR CERTAIN INDIVIDUALS RECEIVING PUBLIC ASSISTANCE

Sec. 550.0151. PROGRAM ESTABLISHMENT. (a) The commission shall:

(1) establish a program under which faith- and community-based organizations may, on an applicant's request, contact and offer supplemental assistance to the applicant for benefits under:

(A) the financial assistance program under Chapter 31, Human Resources Code;

(B) the medical assistance program under Chapter 32, Human Resources Code;

(C) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; or

(D) the child health plan program under Chapter 62, Health and Safety Code; and

(2) develop a procedure under which faith- and community-based organizations may apply to participate in the program.

(b) At the time an individual applies for benefits described by Subsection (a), the individual must be:

(1) informed about and given the opportunity to enroll in the program; and

(2) informed that enrolling in the program will not affect the individual's eligibility for benefits. (Gov. Code, Secs. 531.02482(b), (c), (d).)

Sec. 550.0152. RULES. The executive commissioner shall adopt rules to implement the program, including rules that:

(1) describe:

(A) the types of faith- and community-based organizations that may apply to participate in the program; and

(B) the qualifications and standards of service required of a participating organization;

(2) facilitate contact between an individual who enrolls in the program and a participating organization that provides supplemental services that may assist the individual;

(3) establish:

(A) processes for suspending, revoking, and periodically renewing an organization's participation in the program, as appropriate; and

(B) methods to ensure the confidentiality and appropriate use of applicant information shared with a participating organization; and

(4) permit an individual to terminate the individual's enrollment in the program. (Gov. Code, Sec. 531.02482(e).)

SUBCHAPTER D-1. PILOT PROGRAM FOR SELF-SUFFICIENCY OF CERTAIN INDIVIDUALS RECEIVING FINANCIAL ASSISTANCE OR SUPPLEMENTAL NUTRITION ASSISTANCE BENEFITS

Sec. 550.0201. DEFINITIONS. In this subchapter:

(1) "Financial assistance benefits" means money payments under:

(A) the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code;

or

(B) the state temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Pilot program" means the pilot program for self-sufficiency of certain individuals receiving financial assistance or supplemental nutrition assistance benefits developed and implemented under this subchapter.

(3) "Self-sufficiency" means:

(A) being employed in a position that pays a sufficient wage;

(B) having financial savings in an amount equal to at least $1,000 per member of a family's household; and

(C) maintaining a debt-to-income ratio that does not exceed 43 percent.

(4) "Slow reduction scale" means a graduated plan for reducing financial assistance or supplemental nutrition assistance benefits that correlates with a phase of the pilot program's progressive stages toward self-sufficiency.

(5) "Sufficient wage" means an amount of money sufficient to meet a family's minimum necessary spending on basic needs, including food, child care, health insurance, housing, and transportation, as determined by a market-based calculation that uses geographically specific expenditure data.

(6) "Supplemental nutrition assistance benefits" means money payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code. (Gov. Code, Sec. 531.02241(a); New.)

Sec. 550.0202. PILOT PROGRAM DEVELOPMENT AND IMPLEMENTATION. (a) The commission shall develop and implement a pilot program to assist not more than 500 eligible families in gaining permanent self-sufficiency and by eliminating the need for financial assistance, supplemental nutrition assistance, or other means-tested public benefits, notwithstanding the limitations and requirements of Section 31.043, Human Resources Code.

(b) If the commission determines the number of families participating in the pilot program during a year reaches capacity for that year, the number of families that may be served under the program in the following year may be increased by 20 percent.

(c) The commission shall develop and implement the pilot program with the assistance of:

(1) faith-based and other relevant public or private organizations;

(2) local workforce development boards;

(3) the Texas Workforce Commission; and

(4) any other person the commission determines appropriate.

(d) The pilot program must operate for at least 24 months. The program must also include 16 additional months for:

(1) planning and designing the program before the program begins operation;

(2) recruiting eligible families to participate in the program;

(3) randomly placing each participating family in one of at least three research groups, including:

(A) a control group;

(B) a group consisting of families for whom the application of income, asset, and time limits described by Section 550.0204 is waived; and

(C) a group consisting of families for whom the application of income, asset, and time limits described by Section 550.0204 is waived and who receive wraparound case management services under the program; and

(4) after the program begins operation, collecting and sharing data that allows for:

(A) obtaining participating families' eligibility and identification data before a family is randomly placed in a research group under Subdivision (3);

(B) conducting surveys or interviews of participating families to obtain information that is not contained in records related to a family's eligibility for financial assistance, supplemental nutrition assistance, or other means-tested public benefits;

(C) providing quarterly reports for not more than 60 months after a participating family's enrollment in the program regarding the program's effect on the family's labor market participation, income, and need for means-tested public benefits;

(D) assessing the interaction of the program's components with the desired outcomes of the program using data collected during the program and data obtained from state agencies concerning means-tested public benefits; and

(E) enlisting a third party to conduct a rigorous

experimental impact evaluation of the program.

(e) The pilot program must provide through a community-based provider to each participating family placed in the research group described by Subsection (d)(3)(C) holistic, wraparound case management services that meet all applicable program requirements under 7 C.F.R. Section 273.7(e) or 45 C.F.R. Section 261.10, as applicable. Case management services provided under this subsection must include the strategic use of financial assistance and supplemental nutrition assistance benefits to ensure that the goals included in the family's service plan are achieved. (Gov. Code, Secs. 531.02241(b), (i), (j), (k).)

Sec. 550.0203. PILOT PROGRAM DESIGN. (a) The commission shall design the pilot program to allow social services providers, public benefit offices, and other community partners to refer potential participating families to the program.

(b) The commission shall design the pilot program to assist eligible participating families in attaining self-sufficiency by:

(1) identifying eligibility requirements for the continuation of financial assistance or supplemental nutrition assistance benefits and time limits for the benefits, the application of which may be waived for a limited period and that, if applied, would impede self-sufficiency;

(2) implementing strategies, including waiving the application of the eligibility requirements and time limits identified in Subdivision (1), to remove barriers to self-sufficiency; and

(3) moving eligible participating families toward

self-sufficiency through progressive stages that include the following phases:

(A) an initial phase in which a family transitions out of an emergent crisis by securing housing, medical care, and financial assistance and supplemental nutrition assistance benefits, as necessary;

(B) a second phase in which:

(i) the family transitions toward stability by securing employment and any necessary child care and by participating in services that build the financial management skills necessary to meet financial goals; and

(ii) the family's financial assistance and supplemental nutrition assistance benefits are reduced according to the following scale:

(a) on reaching 25 percent of the family's sufficient wage, the amount of benefits is reduced by 10 percent;

(b) on reaching 50 percent of the family's sufficient wage, the amount of benefits is reduced by 25 percent; and

(c) on reaching 75 percent of the family's sufficient wage, the amount of benefits is reduced by 50 percent;

(C) a third phase in which the family:

(i) transitions to self-sufficiency by securing employment that pays a sufficient wage, reducing debt, and building savings; and

(ii) becomes ineligible for financial assistance and supplemental nutrition assistance benefits on reaching 100 percent of the family's sufficient wage; and

(D) a final phase in which the family attains self-sufficiency by retaining employment that pays a sufficient wage, amassing at least $1,000 per member of the family's household, and having manageable debt so that the family will no longer be dependent on financial assistance, supplemental nutrition assistance, or other means-tested public benefits for at least six months following the date the family stops participating in the program. (Gov. Code, Secs. 531.02241(d), (f).)

Sec. 550.0204. BENEFIT ELIGIBILITY FOR PILOT PROGRAM PARTICIPANTS. (a) To allow for continuation of financial assistance and supplemental nutrition assistance benefits and reduction of the benefits using a slow reduction scale, the pilot program will test extending the benefits for at least 24 months but not more than 60 months by waiving:

(1) the application of income and asset limit eligibility requirements for financial assistance and supplemental nutrition assistance benefits; and

(2) the time limits specified by Section 31.0065, Human Resources Code, for financial assistance benefits.

(b) The commission shall freeze a participating family's eligibility status for financial assistance and supplemental nutrition assistance benefits beginning on the date the participating family enters the pilot program and ending on the date the family ceases participating in the program.

(c) The waiver of the application of any asset limit requirement under this section must allow the participating family to have assets in an amount equal to at least $1,000 per member of the family's household. (Gov. Code, Sec. 531.02241(c).)

Sec. 550.0205. FAMILY ELIGIBILITY REQUIREMENTS. A family is eligible to participate in the pilot program if the family:

(1) includes one or more members who are recipients of financial assistance or supplemental nutrition assistance benefits, at least one of whom is:

(A) at least 18 years of age but not older than 62 years of age; and

(B) willing, physically able, and legally able to be employed; and

(2) has a total household income that is less than a sufficient wage based on the family's makeup and geographical area of residence. (Gov. Code, Sec. 531.02241(e).)

Sec. 550.0206. CASE MANAGEMENT REQUIREMENTS. (a) An individual from a family that wishes to participate in the pilot program must attend an in-person intake meeting with a program case manager. During the intake meeting the case manager shall:

(1) determine whether:

(A) the individual's family meets the eligibility requirements under Section 550.0205; and

(B) the application of income or asset limit eligibility requirements for continuation of financial assistance and supplemental nutrition assistance benefits and the time limits specified by Section 31.0065, Human Resources Code, for financial

assistance benefits may be waived under the program;

(2) review the family's demographic information and household financial budget;

(3) assess the family members' current financial and career situations;

(4) collaborate with the individual to develop and implement strategies for removing barriers to the family attaining self-sufficiency, including waiving the application of income and asset limit eligibility requirements and time limits described by Subdivision (1)(B) to allow for continuation of financial assistance and supplemental nutrition assistance benefits; and

(5) if the individual's family is determined eligible for and chooses to participate in the program, schedule a follow-up meeting to:

(A) further assess the family's crisis;

(B) review available referral services; and

(C) create a service plan.

(b) A participating family must be assigned a program case manager who shall:

(1) if the family is determined eligible, provide the family with a verification of the waived application of asset, income, and time limits described by Section 550.0204, allowing the family to continue receiving financial assistance and supplemental nutrition assistance benefits on a slow reduction scale;

(2) during the initial phase of the program, create medium- and long-term goals consistent with the strategies developed under Subsection (a)(4); and

(3) assess, at the follow-up meeting scheduled under Subsection (a)(5), the family's crisis, review available referral services, and create a service plan. (Gov. Code, Secs. 531.02241(g), (h).)

Sec. 550.0207. PILOT PROGRAM MONITORING AND EVALUATION. The commission shall monitor and evaluate the pilot program in a manner that allows for promoting research-informed results of the program. (Gov. Code, Sec. 531.02241(l).)

Sec. 550.0208. REPORTS. (a) On the conclusion of the pilot program but not later than 48 months following the date of the last participating family's enrollment in the program, the commission shall report to the legislature on the results of the program. The report must include:

(1) an evaluation of the program's effect on participating families in achieving self-sufficiency and eliminating the need for means-tested public benefits;

(2) the impact to this state on the costs of the financial assistance and supplemental nutrition assistance programs and of the child-care services program operated by the Texas Workforce Commission;

(3) a cost-benefit analysis of the program; and

(4) recommendations on the feasibility and continuation of the program.

(b) During the operation of the pilot program, the commission shall provide to the legislature additional reports concerning the program that the commission determines appropriate. (Gov. Code, Secs. 531.02241(m), (n).)

Sec. 550.0209. RULES. The executive commissioner and the Texas Workforce Commission may adopt rules to implement this subchapter. (Gov. Code, Sec. 531.02241(o).)

Sec. 550.0210. SUBCHAPTER EXPIRATION. This subchapter expires September 1, 2026. (Gov. Code, Sec. 531.02241(p).)

SUBCHAPTER E. COMMUNITY-BASED NAVIGATOR PROGRAM

Sec. 550.0251. DEFINITION. In this subchapter, "navigator" means an individual who is:

(1) a volunteer or other representative of a faith- or community-based organization; and

(2) certified by the commission to provide or facilitate the provision of information or assistance through the faith- or community-based organization to individuals applying or seeking to apply online for public assistance benefits administered by the commission through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system. (Gov. Code, Sec. 531.751(2).)

Sec. 550.0252. ESTABLISHMENT OF COMMUNITY-BASED NAVIGATOR PROGRAM. (a) The commission shall establish a statewide community-based navigator program if the executive commissioner determines the program can be established and operated using existing resources and without disrupting other commission functions.

(b) Under the statewide community-based navigator program, the commission will train and certify as navigators volunteers and other representatives of faith- and community-based organizations.

The navigators will assist individuals applying or seeking to apply online for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system.

(c) In establishing the navigator program, the commission:

(1) shall solicit the expertise and assistance of interested persons, including faith- and community-based organizations; and

(2) may establish a work group or other temporary, informal group of interested persons to provide input and assistance. (Gov. Code, Sec. 531.752.)

Sec. 550.0253. PROGRAM STANDARDS. The executive commissioner shall adopt standards to implement this subchapter, including standards:

(1) subject to Section 550.0254, regarding the qualifications and training required for navigator certification;

(2) regarding the suspension, revocation, and, if appropriate, periodic renewal of a navigator certificate;

(3) to protect the confidentiality of applicant information handled by navigators; and

(4) regarding any other issues the executive commissioner determines are appropriate. (Gov. Code, Sec. 531.753.)

Sec. 550.0254. NAVIGATOR TRAINING PROGRAM. The commission shall develop and administer a navigator training program that includes training on:

(1) the manner of completing an online application for

public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS);

(2) the importance of maintaining the confidentiality of information a navigator handles;

(3) the importance of obtaining and submitting complete and accurate information when completing an application for public assistance benefits online through the Texas Integrated Eligibility Redesign System (TIERS);

(4) the financial assistance program, the supplemental nutrition assistance program, Medicaid, the child health plan program, and any other public assistance benefits program for which an individual may complete an online application through the Texas Integrated Eligibility Redesign System (TIERS); and

(5) the method by which an individual may apply for other public assistance benefits for which the individual may not complete an online application through the Texas Integrated Eligibility Redesign System (TIERS). (Gov. Code, Sec. 531.754.)

Sec. 550.0255. CERTIFIED NAVIGATOR LIST. The commission shall publish and maintain on the commission's Internet website a list of certified navigators. (Gov. Code, Sec. 531.755.)

ARTICLE 2. CONFORMING AMENDMENTS

SECTION 2.01. Section 20.038, Business & Commerce Code, is amended to read as follows:

Sec. 20.038. EXEMPTION FROM SECURITY FREEZE. A security freeze does not apply to a consumer report provided to:

(1) a state or local governmental entity, including a

law enforcement agency or court or private collection agency, if the entity, agency, or court is acting under a court order, warrant, subpoena, or administrative subpoena;

(2) a child support agency as defined by Section 101.004, Family Code, acting to investigate or collect child support payments or acting under Title IV-D of the Social Security Act (42 U.S.C. Section 651 et seq.);

(3) the Health and Human Services Commission acting under the following provisions of the [~~Section 531.102,~~] Government Code:

(A) Section 544.0052;

(B) Section 544.0101;

(C) Section 544.0102;

(D) Section 544.0103;

(E) Section 544.0104;

(F) Section 544.0105;

(G) Section 544.0106;

(H) Section 544.0108;

(I) Sections 544.0109(b) and (d);

(J) Section 544.0110;

(K) Section 544.0113;

(L) Section 544.0114;

(M) Section 544.0251;

(N) Section 544.0252(b);

(O) Section 544.0254;

(P) Section 544.0255;

(Q) Section 544.0257;

(R) Section 544.0301;

(S) Section 544.0302;

(T) Section 544.0303; and

(U) Section 544.0304;

(4) the comptroller acting to investigate or collect delinquent sales or franchise taxes;

(5) a tax assessor-collector acting to investigate or collect delinquent ad valorem taxes;

(6) a person for the purposes of prescreening as provided by the Fair Credit Reporting Act (15 U.S.C. Section 1681 et seq.), as amended;

(7) a person with whom the consumer has an account or contract or to whom the consumer has issued a negotiable instrument, or the person's subsidiary, affiliate, agent, assignee, prospective assignee, or private collection agency, for purposes related to that account, contract, or instrument;

(8) a subsidiary, affiliate, agent, assignee, or prospective assignee of a person to whom access has been granted under Section 20.037(b);

(9) a person who administers a credit file monitoring subscription service to which the consumer has subscribed;

(10) a person for the purpose of providing a consumer with a copy of the consumer's report on the consumer's request;

(11) a check service or fraud prevention service company that issues consumer reports:

(A) to prevent or investigate fraud; or

(B) for purposes of approving or processing

negotiable instruments, electronic funds transfers, or similar methods of payment;

(12) a deposit account information service company that issues consumer reports related to account closures caused by fraud, substantial overdrafts, automated teller machine abuses, or similar negative information regarding a consumer to an inquiring financial institution for use by the financial institution only in reviewing a consumer request for a deposit account with that institution; or

(13) a consumer reporting agency that:

(A) acts only to resell credit information by assembling and merging information contained in a database of another consumer reporting agency or multiple consumer reporting agencies; and

(B) does not maintain a permanent database of credit information from which new consumer reports are produced.

SECTION 2.02. Section 140.002(f), Civil Practice and Remedies Code, is amended to read as follows:

(f) This chapter does not apply to:

(1) a workers' compensation insurance policy or any other source of medical benefits under Title 5, Labor Code;

(2) Medicare;

(3) the Medicaid program under Chapter 32, Human Resources Code;

(4) a Medicaid managed care program operated under Chapter 540 or Chapter 540A [~~533~~], Government Code, as applicable;

(5) the state child health plan or any other program

operated under Chapter 62 or 63, Health and Safety Code; or

(6) a self-funded plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

SECTION 2.03. Section 33.096(b), Education Code, is amended to read as follows:

(b) A student may request an electrocardiogram from any health care professional, including a health care professional provided through the student's patient-centered medical home, as defined by Section 540.0712 [~~533.0029~~], Government Code, a health care professional provided through a school district program, or another health care professional chosen by the parent or person standing in parental relation to the student, provided that the health care professional is:

(1) appropriately licensed in this state; and

(2) authorized to administer and interpret electrocardiograms under the health care professional's scope of practice, as established by the health care professional's Texas licensing act.

SECTION 2.04. Section 114.106(b), Estates Code, is amended to read as follows:

(b) Notwithstanding Subsection (a), real property transferred at the transferor's death by a transfer on death deed is not considered property of the probate estate for any purpose, including for purposes of Section 546.0403 [~~531.077~~], Government Code.

SECTION 2.05. Section 53.011(a), Family Code, is amended to

read as follows:

(a) In this section:

(1) "Community resource coordination group" has the meaning assigned by Section 547.0101 [~~531.421~~], Government Code.

(2) "Local-level interagency staffing group" means a group established under the memorandum of understanding described by Subchapter D, Chapter 522 [~~Section 531.055~~], Government Code.

SECTION 2.06. Section 58.0051(a)(2), Family Code, is amended to read as follows:

(2) "Juvenile service provider" means a governmental entity that provides juvenile justice or prevention, medical, educational, or other support services to a juvenile. The term includes:

(A) a state or local juvenile justice agency as defined by Section 58.101;

(B) health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, and the Health and Human Services Commission;

(C) the Department of Family and Protective Services;

(D) the Department of Public Safety;

(E) the Texas Education Agency;

(F) an independent school district;

(G) a juvenile justice alternative education program;

(H) a charter school;

(I) a local mental health or mental retardation

authority;

(J) a court with jurisdiction over juveniles;

(K) a district attorney's office;

(L) a county attorney's office; and

(M) a children's advocacy center established under Section 264.402.

SECTION 2.07. Section 261.401(b), Family Code, is amended to read as follows:

(b) Except as provided by Section 261.404 of this code and former Section 531.02013(1)(D), Government Code, a state agency that operates, licenses, certifies, registers, or lists a facility in which children are located or provides oversight of a program that serves children shall make a prompt, thorough investigation of a report that a child has been or may be abused, neglected, or exploited in the facility or program. The primary purpose of the investigation shall be the protection of the child.

SECTION 2.08. Sections 261.404(a-1) and (a-2), Family Code, are amended to read as follows:

(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 542.0001(11)(B) [~~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 542.0001(11)(B) [~~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.

SECTION 2.09. Section 264.019(b), Family Code, is amended to read as follows:

(b) Not later than November 1 of each year, the department shall:

(1) prepare for the preceding year a report containing:

(A) the information collected under Subsection (a); and

(B) the data collected under Section 532.0204 [~~531.02143~~], Government Code;

(2) post a copy of the report prepared under Subdivision (1) on the department's Internet website; and

(3) electronically submit to the legislature a copy of the report.

SECTION 2.10. Section 264.1212(a), Family Code, is amended to read as follows:

(a) In this section, "community resource coordination group" means a coordination group established under a memorandum of understanding under Subchapter D, Chapter 522 [~~Section 531.055~~],

Government Code.

SECTION 2.11. Section 264.757, Family Code, is amended to read as follows:

Sec. 264.757. COORDINATION WITH OTHER AGENCIES. The department shall coordinate with other health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, to provide assistance and services under this subchapter.

SECTION 2.12. Section 14.1025(a)(2), Finance Code, is amended to read as follows:

(2) "Health and human services agencies" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.13. Section 322.020(f), Government Code, is amended to read as follows:

(f) In this section, "state agency" has the meaning assigned by Section 2054.003, except that the term does not include a university system or institution of higher education, the Health and Human Services Commission, an agency identified in Section 521.0001(5) [~~531.001(4)~~], or the Texas Department of Transportation.

SECTION 2.14. Section 411.1143(a), Government Code, is amended to read as follows:

(a) The Health and Human Services Commission, an agency operating part of the medical assistance program under Chapter 32, Human Resources Code, or the office of inspector general established under Subchapter C, Chapter 544 [~~Chapter 531~~], Government Code, is entitled to obtain from the department the criminal history record information maintained by the department

that relates to a provider under the medical assistance program or a person applying to enroll as a provider under the medical assistance program.

SECTION 2.15. Section 418.043, Government Code, is amended to read as follows:

Sec. 418.043. OTHER POWERS AND DUTIES. The division shall:

(1) determine requirements of the state and its political subdivisions for food, clothing, and other necessities in event of a disaster;

(2) procure and position supplies, medicines, materials, and equipment;

(3) adopt standards and requirements for local and interjurisdictional emergency management plans;

(4) periodically review local and interjurisdictional emergency management plans;

(5) coordinate deployment of mobile support units;

(6) establish and operate training programs and programs of public information or assist political subdivisions and emergency management agencies to establish and operate the programs;

(7) make surveys of public and private industries, resources, and facilities in the state that are necessary to carry out the purposes of this chapter;

(8) plan and make arrangements for the availability and use of any private facilities, services, and property and provide for payment for use under terms and conditions agreed on if the facilities are used and payment is necessary;

(9) establish a register of persons with types of training and skills important in disaster mitigation, preparedness, response, and recovery;

(10) establish a register of mobile and construction equipment and temporary housing available for use in a disaster;

(11) assist political subdivisions in developing plans for the humane evacuation, transport, and temporary sheltering of service animals and household pets in a disaster;

(12) prepare, for issuance by the governor, executive orders and regulations necessary or appropriate in coping with disasters;

(13) cooperate with the federal government and any public or private agency or entity in achieving any purpose of this chapter and in implementing programs for disaster mitigation, preparation, response, and recovery;

(14) develop a plan to raise public awareness and expand the capability of the information and referral network under Section 526.0004 [~~531.0312~~];

(15) improve the integration of volunteer groups, including faith-based organizations, into emergency management plans;

(16) cooperate with the Federal Emergency Management Agency to create uniform guidelines for acceptable home repairs following disasters and promote public awareness of the guidelines;

(17) cooperate with state agencies to:

(A) encourage the public to participate in volunteer emergency response teams and organizations that respond

to disasters; and

(B) provide information on those programs in state disaster preparedness and educational materials and on Internet websites;

(18) establish a liability awareness program for volunteers, including medical professionals;

(19) define "individuals with special needs" in the context of a disaster;

(20) establish and operate, subject to the availability of funds, a search and rescue task force in each field response region established by the division to assist in search, rescue, and recovery efforts before, during, and after a natural or man-made disaster; and

(21) do other things necessary, incidental, or appropriate for the implementation of this chapter.

SECTION 2.16. Section 441.203(j), Government Code, is amended to read as follows:

(j) The council shall categorize state agency programs and telephone numbers by subject matter as well as by agency. The council shall cooperate with the Texas Information and Referral Network under Section 526.0004 [~~531.0312~~] to ensure that the council and the network use a single method of defining and organizing information about health and human services.

SECTION 2.17. Section 2001.223, Government Code, is amended to read as follows:

Sec. 2001.223. EXCEPTIONS FROM DECLARATORY JUDGMENT, COURT ENFORCEMENT, AND CONTESTED CASE PROVISIONS. Section 2001.038 and

Subchapters C through H do not apply to:

(1) except as provided by Subchapter D, Chapter 545 [~~Section 531.019~~], the granting, payment, denial, or withdrawal of financial or medical assistance or benefits under service programs that were operated by the former Texas Department of Human Services before September 1, 2003, and are operated on and after that date by the Health and Human Services Commission or a health and human services agency, as defined by Section 521.0001 [~~531.001~~];

(2) action by the Banking Commissioner or the Finance Commission of Texas regarding the issuance of a state bank or state trust company charter for a bank or trust company to assume the assets and liabilities of a financial institution that the commissioner considers to be in hazardous condition as defined by Section 31.002(a) or 181.002(a), Finance Code, as applicable;

(3) a hearing or interview conducted by the Board of Pardons and Paroles or the Texas Department of Criminal Justice relating to the grant, rescission, or revocation of parole or other form of administrative release; or

(4) the suspension, revocation, or termination of the certification of a breath analysis operator or technical supervisor under the rules of the Department of Public Safety.

SECTION 2.18. Section 2055.001(4), Government Code, is amended to read as follows:

(4) "State agency" has the meaning assigned by Section 2054.003, except that the term does not include a university system or institution of higher education or an agency identified in Section 521.0001(5) [~~531.001(4)~~].

SECTION 2.19. Section 2055.002(a), Government Code, is amended to read as follows:

(a) Except as provided by Subsection (b), the requirements of this chapter regarding electronic government projects do not apply to institutions of higher education or a health and human services agency identified in Section 521.0001(5) [~~531.001(4)~~], Government Code.

SECTION 2.20. Sections 2155.144(i), (j), (k), (m), and (p), Government Code, are amended to read as follows:

(i) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission shall develop a single statewide risk analysis procedure. Each health and human services agency shall comply with the procedure. The procedure must provide for:

(1) assessing the risk of fraud, abuse, or waste in health and human services agencies contractor selection processes, contract provisions, and payment and reimbursement rates and methods for the different types of goods and services for which health and human services agencies contract;

(2) identifying contracts that require enhanced contract monitoring; and

(3) coordinating contract monitoring efforts among health and human services agencies.

(j) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission shall publish a contract management handbook that establishes consistent contracting policies and practices to be followed by health and human services

agencies. The handbook may include standard contract provisions and formats for health and human services agencies to incorporate as applicable in their contracts.

(k) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission, in cooperation with the comptroller, shall establish a central contract management database that identifies each contract made with a health and human services agency. The comptroller may use the database to monitor health and human services agency contracts, and health and human services agencies may use the database in contracting. A state agency shall send to the comptroller in the manner prescribed by the comptroller the information the agency possesses that the comptroller requires for inclusion in the database.

(m) Subject to Section 524.0001(b) [~~531.0055(c)~~], the Health and Human Services Commission shall develop and implement a statewide plan to ensure that each entity that contracts with a health and human services agency and any subcontractor of the entity complies with the accessibility requirements of the Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.).

(p) In this section, "health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~].

SECTION 2.21. Section 2167.004(c), Government Code, is amended to read as follows:

(c) In this section, "health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~].

SECTION 2.22. Section 2306.252(g), Government Code, is

amended to read as follows:

(g) The center shall provide information regarding the department's housing and community affairs programs to the Texas Information and Referral Network for inclusion in the statewide information and referral network as required by Section 526.0004 [~~531.0312~~].

SECTION 2.23. Section 12.0001, Health and Safety Code, is amended to read as follows:

Sec. 12.0001. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this title or another law conflicts with any of the following provisions of the Government Code, the [~~Section 531.0055,~~] Government Code provision[~~, Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.24. Section 32.101, Health and Safety Code, is amended to read as follows:

Sec. 32.101. ENHANCED PRENATAL SERVICES FOR CERTAIN WOMEN. The commission, in collaboration with managed care organizations that contract with the commission to provide health care services to medical assistance recipients under Chapter 540 or 540A [~~533~~], Government Code, as applicable, shall develop and implement cost-effective, evidence-based, and enhanced prenatal services for high-risk pregnant women covered under the medical

assistance program.

SECTION 2.25. Section 32.151(3), Health and Safety Code, is amended to read as follows:

(3) "Medicaid managed care organization" means a managed care organization as defined by Section 540.0001 [~~533.001~~], Government Code, that contracts with the commission under Chapter 540 or 540A [~~533~~], Government Code, as applicable, to provide health care services to medical assistance program recipients.

SECTION 2.26. Section 32.155(e), Health and Safety Code, is amended to read as follows:

(e) The commission may submit the report required under Subsection (d) with the report required under Section 543A.0008 [~~536.008~~], Government Code.

SECTION 2.27. Section 33.018(a)(4), Health and Safety Code, is amended to read as follows:

(4) "Health agency" means the commission and the health and human services agencies listed in Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.28. Section 34.0159, Health and Safety Code, is amended to read as follows:

Sec. 34.0159. PROGRAM EVALUATIONS. The commission, in collaboration with the task force and other interested parties, shall:

(1) explore options for expanding the pilot program for pregnancy medical homes established under former Section 531.0996, Government Code;

(2) explore methods for increasing the benefits

provided under Medicaid, including specialty care and prescriptions, for women at greater risk of a high-risk pregnancy or premature delivery;

(3) evaluate the impact of supplemental payments made to obstetrics providers for pregnancy risk assessments on increasing access to maternal health services;

(4) evaluate a waiver to fund managed care organization payments for case management and care coordination services for women at high risk of severe maternal morbidity on conclusion of their eligibility for Medicaid;

(5) evaluate the average time required for pregnant women to complete the Medicaid enrollment process;

(6) evaluate the use of Medicare codes for Medicaid care coordination;

(7) study the impact of programs funded from the Teen Pregnancy Prevention Program federal grant and evaluate whether the state should continue funding the programs; and

(8) evaluate the use of telemedicine medical services for women during pregnancy and the postpartum period.

SECTION 2.29. Section 34.020(c), Health and Safety Code, is amended to read as follows:

(c) The commission shall develop criteria for selecting participants for the program by analyzing information in the reports prepared by the task force under this chapter and the outcomes of the study conducted under former Section 531.02163, Government Code.

SECTION 2.30. Section 35.0021(5), Health and Safety Code,

is amended to read as follows:

(5) "Family support services" means support, resources, or other assistance provided to the family of a child with special health care needs. The term may include services described by Part A of the Individuals with Disabilities Education Act (20 U.S.C. Section 1400 et seq.), as amended, and permanency planning, as that term is defined by Section 546.0201 [~~531.151~~], Government Code.

SECTION 2.31. Section 62.1571, Health and Safety Code, as amended by Chapters 624 (H.B. 4) and 811 (H.B. 2056), Acts of the 87th Legislature, Regular Session, 2021, is reenacted and amended to read as follows:

Sec. 62.1571. TELEMEDICINE MEDICAL SERVICES, [~~AND~~] TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES. (a) In providing covered benefits to a child, a health plan provider must permit benefits to be provided through telemedicine medical services, [~~and~~] teledentistry dental services, and telehealth services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services, [~~and~~] teledentistry dental services, and [~~or~~] telehealth services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services, [~~and~~] teledentistry dental services, and [~~or~~] telehealth services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a

single session of telemedicine medical services, teledentistry dental services, or both services, or of telehealth services, if the executive commissioner determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services, [~~or~~] teledentistry dental services, or telehealth services, including the costs of transportation and lodging and other direct costs.

(c) In this section, "teledentistry dental service," [~~and~~] "telehealth service," and "telemedicine medical service" have the meanings assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.32. Section 75.151, Health and Safety Code, is amended to read as follows:

Sec. 75.151. DEFINITION. In this subchapter, "health opportunity pool trust fund" means the trust fund established under Subchapter D [~~N~~], Chapter 526 [~~531~~], Government Code.

SECTION 2.33. Section 75.153, Health and Safety Code, is amended to read as follows:

Sec. 75.153. ELIGIBILITY FOR FUNDS; STATEWIDE ELIGIBILITY CRITERIA. To be eligible for funding from money in the health opportunity pool trust fund, a regional or local health care program must:

(1) comply with any requirement imposed under the waiver obtained under Section 526.0152 [~~531.502~~], Government Code, including, to the extent applicable, any requirement that health care benefits or services provided under the program be provided in accordance with statewide eligibility criteria; and

(2) provide health care benefits or services under the program to a person receiving premium payment assistance for health benefits coverage through a program established under Section 526.0157 [~~531.507~~], Government Code, regardless of whether the person is an employee, or dependent of an employee, of a small employer.

SECTION 2.34. Section 94.001(b), Health and Safety Code, is amended to read as follows:

(b) In developing the plan, the department shall seek the input of:

(1) the public, including members of the public that have hepatitis C;

(2) each state agency that provides services to persons with hepatitis C or the functions of which otherwise involve hepatitis C, including any appropriate health and human services agency described by Section 521.0001 [~~531.001~~], Government Code;

(3) any advisory body that addresses issues related to hepatitis C;

(4) public advocates concerned with issues related to hepatitis C; and

(5) providers of services to persons with hepatitis C.

SECTION 2.35. Section 94A.001(b), Health and Safety Code, is amended to read as follows:

(b) In developing the plan, the department shall seek the advice of:

(1) the public, including members of the public who

have been infected with Streptococcus pneumoniae;

(2) each state agency that provides services to persons infected with Streptococcus pneumoniae or that is assigned duties related to diseases caused by Streptococcus pneumoniae, including any appropriate health and human services agency described by Section 521.0001 [~~531.001~~], Government Code, the Employees Retirement System of Texas, and the Teacher Retirement System of Texas;

(3) any advisory body that addresses issues related to diseases caused by Streptococcus pneumoniae;

(4) public advocates concerned with issues related to diseases caused by Streptococcus pneumoniae;

(5) providers of services to persons with diseases caused by Streptococcus pneumoniae;

(6) a statewide professional association of physicians; and

(7) a statewide professional association of nurses.

SECTION 2.36. Section 98.110(a), Health and Safety Code, is amended to read as follows:

(a) Notwithstanding any other law, the department may disclose information reported by health care facilities under Section 98.103 or 98.1045 to other programs within the department, to the commission, to other health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, and to the federal Centers for Disease Control and Prevention, or any other agency of the United States Department of Health and Human Services, for public health research or analysis purposes only,

provided that the research or analysis relates to health care-associated infections or preventable adverse events. The privilege and confidentiality provisions contained in this chapter apply to such disclosures.

SECTION 2.37. Section 103.0131(a), Health and Safety Code, is amended to read as follows:

(a) In conjunction with developing each state plan described in Section 103.013, the council shall conduct a statewide assessment of existing programs for the prevention of diabetes and treatment of individuals with diabetes that are administered by the commission or a health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code. As part of the assessment, the council shall collect data regarding:

(1) the number of individuals served by the programs;

(2) the areas where services to prevent diabetes and treat individuals with diabetes are unavailable; and

(3) the number of health care providers treating individuals with diabetes under the programs.

SECTION 2.38. Section 108.0065(a), Health and Safety Code, is amended to read as follows:

(a) In this section, "Medicaid managed care organization" means a managed care organization, as defined by Section 540.0001 [~~533.001~~], Government Code, that is contracting with the commission to implement the Medicaid managed care program under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.39. Section 142.001(11-c), Health and Safety Code, is amended to read as follows:

(11-c) "Habilitation" means habilitation services, as defined by Section 542.0001 [~~534.001~~], Government Code, delivered by a licensed home and community support services agency.

SECTION 2.40. Section 142.003(a), Health and Safety Code, is amended to read as follows:

(a) The following persons need not be licensed under this chapter:

(1) a physician, dentist, registered nurse, occupational therapist, or physical therapist licensed under the laws of this state who provides home health services to a client only as a part of and incidental to that person's private office practice;

(2) a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech therapist, medical social worker, or any other health care professional as determined by the department who provides home health services as a sole practitioner;

(3) a registry that operates solely as a clearinghouse to put consumers in contact with persons who provide home health, hospice, habilitation, or personal assistance services and that does not maintain official client records, direct client services, or compensate the person who is providing the service;

(4) an individual whose permanent residence is in the client's residence;

(5) an employee of a person licensed under this chapter who provides home health, hospice, habilitation, or personal assistance services only as an employee of the license

holder and who receives no benefit for providing the services, other than wages from the license holder;

(6) a home, nursing home, convalescent home, assisted living facility, special care facility, or other institution for individuals who are elderly or who have disabilities that provides home health or personal assistance services only to residents of the home or institution;

(7) a person who provides one health service through a contract with a person licensed under this chapter;

(8) a durable medical equipment supply company;

(9) a pharmacy or wholesale medical supply company that does not furnish services, other than supplies, to a person at the person's house;

(10) a hospital or other licensed health care facility that provides home health or personal assistance services only to inpatient residents of the hospital or facility;

(11) a person providing home health or personal assistance services to an injured employee under Title 5, Labor Code;

(12) a visiting nurse service that:

(A) is conducted by and for the adherents of a well-recognized church or religious denomination; and

(B) provides nursing services by a person exempt from licensing by Section 301.004, Occupations Code, because the person furnishes nursing care in which treatment is only by prayer or spiritual means;

(13) an individual hired and paid directly by the

client or the client's family or legal guardian to provide home health or personal assistance services;

(14) a business, school, camp, or other organization that provides home health or personal assistance services, incidental to the organization's primary purpose, to individuals employed by or participating in programs offered by the business, school, or camp that enable the individual to participate fully in the business's, school's, or camp's programs;

(15) a person or organization providing sitter-companion services or chore or household services that do not involve personal care, health, or health-related services;

(16) a licensed health care facility that provides hospice services under a contract with a hospice;

(17) a person delivering residential acquired immune deficiency syndrome hospice care who is licensed and designated as a residential AIDS hospice under Chapter 248;

(18) the Texas Department of Criminal Justice;

(19) a person that provides home health, hospice, habilitation, or personal assistance services only to persons receiving benefits under:

(A) the home and community-based services (HCS) waiver program;

(B) the Texas home living (TxHmL) waiver program;

(C) the STAR + PLUS or other Medicaid managed care program under the program's HCS or TxHmL certification; or

(D) Section 542.0152 [~~534.152~~], Government Code;

(20) a person who provides intellectual and

developmental disabilities habilitative specialized services under Medicaid and is:

(A) a certified HCS or TxHmL provider; or

(B) a local intellectual and developmental disability authority contracted under Section 534.105; or

(21) an individual who provides home health or personal assistance services as the employee of a consumer or an entity or employee of an entity acting as a consumer's fiscal agent under Subchapter C, Chapter 546 [~~Section 531.051~~], Government Code.

SECTION 2.41. Section 161.0095(b), Health and Safety Code, is amended to read as follows:

(b) The department shall establish a work group to assist the department in developing the continuing education programs and educational information. The work group shall include physicians, nurses, department representatives, representatives of managed care organizations that provide health care services under Chapter 540 or 540A [~~533~~], Government Code, as applicable, representatives of health plan providers that provide health care services under Chapter 62, and members of the public.

SECTION 2.42. Section 191.0048(d), Health and Safety Code, is amended to read as follows:

(d) Notwithstanding Section 191.005, the local registrar or county clerk who collects the voluntary contribution under this section shall send the voluntary contribution to the comptroller, who shall deposit the voluntary contribution in the Texas Home Visiting Program trust fund under Section 523.0306 [~~531.287~~], Government Code.

SECTION 2.43. Section 242.0395(a), Health and Safety Code, is amended to read as follows:

(a) An institution licensed under this chapter shall register with the Texas Information and Referral Network under Section 526.0004 [~~531.0312~~], Government Code, to assist the state in identifying persons needing assistance if an area is evacuated because of a disaster or other emergency.

SECTION 2.44. Section 242.061(a-3), Health and Safety Code, is amended to read as follows:

(a-3) The executive commissioner may not revoke a license under Subsection (a-2) due to a violation described by Subsection (a-2)(1), if:

(1) the violation and the determination of immediate threat to health and safety are not included on the written list of violations left with the facility at the time of the initial exit conference under Section 242.0445(b) for a survey, inspection, or investigation;

(2) the violation is not included on the final statement of violations described by Section 242.0445; or

(3) the violation has been reviewed under the informal dispute resolution process established by Section 526.0202 [~~531.058~~], Government Code, and a determination was made that:

(A) the violation should be removed from the license holder's record; or

(B) the violation is reduced in severity so that the violation is no longer cited as an immediate threat to health and safety related to the abuse or neglect of a resident.

SECTION 2.45. Section 247.0275(a), Health and Safety Code, is amended to read as follows:

(a) An assisted living facility licensed under this chapter shall register with the Texas Information and Referral Network under Section 526.0004 [~~531.0312~~], Government Code, to assist the state in identifying persons needing assistance if an area is evacuated because of a disaster or other emergency.

SECTION 2.46. Section 247.043(b), Health and Safety Code, is amended to read as follows:

(b) If the thorough investigation reveals that abuse, exploitation, or neglect has occurred, the department shall:

(1) implement enforcement measures, including closing the facility, revoking the facility's license, relocating residents, and making referrals to law enforcement agencies;

(2) notify the Department of Family and Protective Services of the results of the investigation;

(3) notify a health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code, that contracts with the facility for the delivery of personal care services of the results of the investigation; and

(4) provide to a contracting health and human services agency access to the department's documents or records relating to the investigation.

SECTION 2.47. Sections 250.001(1-b) and (3-a), Health and Safety Code, are amended to read as follows:

(1-b) "Consumer-directed service option" has the meaning assigned by Section 546.0101 [~~531.051~~], Government Code.

(3-a) "Financial management services agency" means an entity that contracts with the commission [~~Department of Aging and Disability Services~~] to serve as a fiscal and employer agent for an individual employer in the consumer-directed service option described by Section 546.0101 [~~531.051~~], Government Code.

SECTION 2.48. Section 253.001(1-b), Health and Safety Code, is amended to read as follows:

(1-b) "Consumer-directed service option" has the meaning assigned by Section 546.0101 [~~531.051~~], Government Code.

SECTION 2.49. Section 322.001(2), Health and Safety Code, is amended to read as follows:

(2) "Health and human services agency" means an agency listed in Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.50. Section 461A.005, Health and Safety Code, is amended to read as follows:

Sec. 461A.005. CONFLICT WITH OTHER LAW. To the extent a power or duty given to the department or commissioner by this chapter conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.51. Section 461A.052(b), Health and Safety Code, is amended to read as follows:

(b) The department may establish regional alcohol advisory committees consistent with the regions established under Section 525.0151 [~~531.024~~], Government Code.

SECTION 2.52. Section 461A.056(a), Health and Safety Code, is amended to read as follows:

(a) The department shall develop and adopt a statewide service delivery plan. The department shall update the plan not later than February 1 of each even-numbered year. The plan must include:

(1) a statement of the department's mission, goals, and objectives regarding chemical dependency prevention, intervention, and treatment;

(2) a statement of how chemical dependency services and chemical dependency case management services should be organized, managed, and delivered;

(3) a comprehensive assessment of:

(A) chemical dependency services available in this state at the time the plan is prepared; and

(B) future chemical dependency services needs;

(4) a service funding process that ensures equity in the availability of chemical dependency services across this state and within each service region established under Section 525.0151 [~~531.024~~], Government Code;

(5) a provider selection and monitoring process that emphasizes quality in the provision of services;

(6) a description of minimum service levels for each region;

(7) a mechanism for the department to obtain and consider local public participation in identifying and assessing regional needs for chemical dependency services;

(8) a process for coordinating and assisting administration and delivery of services among federal, state, and local public and private chemical dependency programs that provide similar services; and

(9) a process for coordinating the department's activities with those of other state health and human services agencies and criminal justice agencies to avoid duplications and inconsistencies in the efforts of the agencies in chemical dependency prevention, intervention, treatment, rehabilitation, research, education, and training.

SECTION 2.53. Section 533.0002, Health and Safety Code, is amended to read as follows:

Sec. 533.0002. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this title or another law conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.54. Section 533.016(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human services agency," as that term is defined by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.55. Section 533.017(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human services agency," as that term is defined by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.56. Section 533.032(a), Health and Safety Code, is amended to read as follows:

(a) The department shall have a long-range plan relating to the provision of services under this title covering at least six years that includes at least the provisions required by Sections 525.0154, 525.0155, [~~531.022~~] and 525.0156 [~~531.023~~], Government Code, and Chapter 2056, Government Code. The plan must cover the provision of services in and policies for state-operated institutions and ensure that the medical needs of the most medically fragile persons with mental illness the department serves are met.

SECTION 2.57. Section 533A.002, Health and Safety Code, is amended to read as follows:

Sec. 533A.002. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this title or another law conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.58. Section 533A.016(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human services agency," as that term is defined by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.59. Section 533A.017(a), Health and Safety Code, is amended to read as follows:

(a) This section does not apply to a "health and human services agency," as that term is defined by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.60. Section 533A.032(a), Health and Safety Code, is amended to read as follows:

(a) The department shall have a long-range plan relating to the provision of services under this title covering at least six years that includes at least the provisions required by Sections 525.0154, 525.0155, [~~531.022~~] and 525.0156 [~~531.023~~], Government Code, and Chapter 2056, Government Code. The plan must cover the provision of services in and policies for state-operated institutions and ensure that the medical needs of the most medically fragile persons with an intellectual disability the department serves are met.

SECTION 2.61. Section 533A.0335(a), Health and Safety Code, is amended to read as follows:

(a) In this section:

(1) "Advisory committee" means the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052 [~~534.053~~], Government Code.

(2) "Functional need," "ICF-IID program," and "Medicaid waiver program" have the meanings assigned those terms by Section 542.0001 [~~534.001~~], Government Code.

SECTION 2.62. Section 533A.03551(b), Health and Safety Code, is amended to read as follows:

(b) The department, in cooperation with the Texas Department of Housing and Community Affairs, the Department of Agriculture, the Texas State Affordable Housing Corporation, and the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 542.0052 [~~534.053~~], Government Code, shall coordinate with federal, state, and local public housing entities as necessary to expand opportunities for accessible, affordable, and integrated housing to meet the complex needs of individuals with disabilities, including individuals with intellectual and developmental disabilities.

SECTION 2.63. Section 773.05711(a), Health and Safety Code, is amended to read as follows:

(a) In addition to the requirements for obtaining or renewing an emergency medical services provider license under this subchapter, a person who applies for a license or for a renewal of a license must:

(1) provide the department with a letter of credit issued by a federally insured bank or savings institution in the

amount of:

(A) $100,000 for the initial license and for renewal of the license on the second anniversary of the date the initial license is issued;

(B) $75,000 for renewal of the license on the fourth anniversary of the date the initial license is issued;

(C) $50,000 for renewal of the license on the sixth anniversary of the date the initial license is issued; and

(D) $25,000 for renewal of the license on the eighth anniversary of the date the initial license is issued;

(2) if the applicant participates in the medical assistance program operated under Chapter 32, Human Resources Code, the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code, or the child health plan program operated under Chapter 62 of this code, provide the Health and Human Services Commission with a surety bond in the amount of $50,000; and

(3) submit for approval by the department the name and contact information of the provider's administrator of record who satisfies the requirements under Section 773.05712.

SECTION 2.64. Section 773.06141(a), Health and Safety Code, is amended to read as follows:

(a) The department may suspend, revoke, or deny an emergency medical services provider license on the grounds that the provider's administrator of record, employee, or other representative:

(1) has been convicted of, or placed on deferred

adjudication community supervision or deferred disposition for, an offense that directly relates to the duties and responsibilities of the administrator, employee, or representative, other than an offense described by Section 542.304, Transportation Code;

(2) has been convicted of or placed on deferred adjudication community supervision or deferred disposition for an offense, including:

(A) an offense listed in Article 42A.054(a)(2), (3), (4), (7), (8), (9), (11), or (16), Code of Criminal Procedure; or

(B) an offense, other than an offense described by Subdivision (1), for which the person is subject to registration under Chapter 62, Code of Criminal Procedure; or

(3) has been convicted of Medicare or Medicaid fraud, has been excluded from participation in the state Medicaid program, or has a hold on payment for reimbursement under the state Medicaid program under Subchapter G [~~C~~], Chapter 544 [~~531~~], Government Code.

SECTION 2.65. Sections 1001.002(a) and (c), Health and Safety Code, are amended to read as follows:

(a) In this section, "function" includes a power, duty, program, or activity and an administrative support services function associated with the power, duty, program, or activity, unless consolidated under former Section 531.02012, Government Code.

(c) In accordance with former Subchapter A-1, Chapter 531, Government Code, and notwithstanding any other law, the department performs only functions related to public health, including health

care data collection and maintenance of the Texas Health Care Information Collection program.

SECTION 2.66. Section 1001.004, Health and Safety Code, is amended to read as follows:

Sec. 1001.004. REFERENCES IN LAW MEANING DEPARTMENT. In this code or any other law, a reference to the department in relation to a function described by Section 1001.002(c) means the department. A reference in law to the department in relation to any other function has the meaning assigned by Section 521.0002 [~~531.0011~~], Government Code.

SECTION 2.67. Section 1001.005, Health and Safety Code, is amended to read as follows:

Sec. 1001.005. REFERENCES IN LAW MEANING COMMISSIONER OR DESIGNEE. In this code or in any other law, a reference to the commissioner in relation to a function described by Section 1001.002(c) means the commissioner. A reference in law to the commissioner in relation to any other function has the meaning assigned by Section 521.0003 [~~531.0012~~], Government Code.

SECTION 2.68. Sections 1001.051(a-1), (c), and (d), Health and Safety Code, are amended to read as follows:

(a-1) The executive commissioner shall employ the commissioner in accordance with Subchapter B, Chapter 524, Government Code, and Section 524.0101(b) [~~531.0056~~], Government Code.

(c) Subject to the control of the executive commissioner, the commissioner shall:

(1) act as the department's chief administrative

officer;

(2) in accordance with the procedures prescribed by Section 524.0152 [~~531.00551~~], Government Code, assist the executive commissioner in the development and implementation of policies and guidelines needed for the administration of the department's functions;

(3) in accordance with the procedures adopted by the executive commissioner under Section 524.0152 [~~531.00551~~], Government Code, assist the executive commissioner in the development of rules relating to the matters within the department's jurisdiction, including the delivery of services to persons and the rights and duties of persons who are served or regulated by the department; and

(4) serve as a liaison between the department and commission.

(d) The commissioner shall administer this chapter under operational policies established by the executive commissioner and in accordance with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.69. Section 1001.075, Health and Safety Code, is amended to read as follows:

Sec. 1001.075. RULES. The executive commissioner may adopt rules reasonably necessary for the department to administer this chapter, consistent with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.70. Sections 1001.084(a) and (d), Health and Safety Code, as added by Chapter 1 (S.B. 219), Acts of the 84th Legislature, Regular Session, 2015, are amended to read as follows:

(a) The executive commissioner, as authorized by Section 524.0002 [~~531.0055~~], Government Code, may delegate to the department the executive commissioner's authority under that section for contracting and auditing relating to the department's powers, duties, functions, and activities.

(d) It is the legislature's intent that the executive commissioner retain the authority over and responsibility for contracting and auditing at each health and human services agency as provided by Section 524.0002 [~~531.0055~~], Government Code. A statute enacted on or after January 1, 2015, that references the contracting or auditing authority of the department does not give the department direct contracting or auditing authority unless the statute expressly provides that the contracting or auditing authority:

(1) is given directly to the department; and

(2) is an exception to the exclusive contracting and auditing authority given to the executive commissioner under Section 524.0002 [~~531.0055~~], Government Code.

SECTION 2.71. Section 1001.085, Health and Safety Code, is amended to read as follows:

Sec. 1001.085. MANAGEMENT AND DIRECTION BY EXECUTIVE COMMISSIONER. The department's powers and duties prescribed by this chapter and other law, including enforcement activities and functions, are subject to the executive commissioner's oversight

under the revised provisions derived from Chapter 531, Government Code, as that chapter existed on March 31, 2025, to manage and direct the operations of the department.

SECTION 2.72. Section 11.004, Human Resources Code, is amended to read as follows:

Sec. 11.004. POWERS AND FUNCTIONS NOT AFFECTED. The provisions of this title are not intended to interfere with the powers and functions of the commission, the health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, or county juvenile boards.

SECTION 2.73. Section 22.0001, Human Resources Code, is amended to read as follows:

Sec. 22.0001. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner of aging and disability services by this title or another law conflicts with any of the following provisions of the Government Code, the [~~Section 531.0055,~~] Government Code provision [~~, Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524, Government Code;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b), Government Code;

(4) Section 524.0202, Government Code; and

(5) Section 525.0254, Government Code.

SECTION 2.74. Section 31.0032(d), Human Resources Code, is amended to read as follows:

(d) This section does not prohibit the Texas Workforce Commission, the commission, or any health and human services

agency, as defined by Section 521.0001 [~~531.001~~], Government Code, from providing child care or any other related social or support services for an individual who is eligible for financial assistance but to whom that assistance is not paid because of the individual's failure to cooperate.

SECTION 2.75. Sections 31.0127(b) and (e), Human Resources Code, are amended to read as follows:

(b) The Health and Human Services Commission shall require the Texas Workforce Commission to comply with the revised provisions derived from Chapter 531, Government Code, as that chapter existed on March 31, 2025, solely for:

(1) the promulgation of rules relating to the programs described by Subsection (a);

(2) the expenditure of funds relating to the programs described by Subsection (a), within the limitations established by and subject to the General Appropriations Act and federal and other law applicable to the use of the funds;

(3) data collection and reporting relating to the programs described by Subsection (a); and

(4) evaluation of services relating to the programs described by Subsection (a).

(e) Subsection (b) does not authorize the Health and Human Services Commission to require a state agency, other than a health and human services agency, to comply with revised provisions derived from Chapter 531, Government Code, as that chapter existed on March 31, 2025, except as specifically provided by Subsection (b). The authority granted under Subsection (b) does not affect

Section 301.041, Labor Code.

SECTION 2.76. Section 32.003(1), Human Resources Code, is amended to read as follows:

(1) "Health and human services agencies" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.77. Section 32.021(d), Human Resources Code, is amended to read as follows:

(d) The commission shall include in its contracts for the delivery of medical assistance by nursing facilities provisions for monetary penalties to be assessed for violations as required by 42 U.S.C. Section 1396r, including without limitation the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, Nursing Home Reform Amendments of 1987, provided that the executive commissioner shall:

(1) provide for an informal dispute resolution process in the commission as provided by Section 526.0202 [~~531.058~~], Government Code; and

(2) develop rules to adjudicate claims in contested cases, including claims unresolved by the informal dispute resolution process of the commission.

SECTION 2.78. Section 32.0212, Human Resources Code, is amended to read as follows:

Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE. Notwithstanding any other law and subject to Sections 540.0502, 540.0701, and 540.0753 [~~Section 533.0025~~], Government Code, the commission shall provide medical assistance for acute care services through the Medicaid managed care system implemented under Chapters

540 and 540A [~~Chapter 533~~], Government Code, or another Medicaid capitated managed care program.

SECTION 2.79. Section 32.0214(b), Human Resources Code, is amended to read as follows:

(b) A recipient who receives medical assistance through a Medicaid managed care model or arrangement under Chapter 540 or 540A [~~533~~], Government Code, as applicable, that requires the designation of a primary care provider shall designate the recipient's primary care provider as required by that model or arrangement.

SECTION 2.80. Section 32.0246, Human Resources Code, is amended to read as follows:

Sec. 32.0246. MEDICAL ASSISTANCE REIMBURSEMENT FOR CERTAIN BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES. (a) In this section, "behavioral health services" has the meaning assigned by Section 540.0703(a) [~~533.00255(a)~~], Government Code, and includes targeted case management and psychiatric rehabilitation services.

(b) The commission shall provide to a public or private provider of behavioral health services medical assistance reimbursement through a fee-for-service delivery model for behavioral health or physical health services provided to a recipient before that recipient's enrollment with and receipt of medical assistance services through a managed care organization under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

(c) The commission shall ensure that a public or private provider of behavioral health services who is reimbursed under Subsection (b) through a fee-for-service delivery model is provided

medical assistance reimbursement through a managed care model for behavioral health or physical health services provided to a recipient after that recipient's enrollment with and receipt of medical assistance services through a managed care organization under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.81. Sections 32.0291(b) and (c), Human Resources Code, are amended to read as follows:

(b) Subject to Sections 544.0104 and 544.0105 and Subchapter G, Chapter 544 [~~Section 531.102~~], Government Code, and notwithstanding any other law, the commission may impose a payment hold on future claims submitted by a provider.

(c) A payment hold authorized by this section is governed by the requirements and procedures specified for a payment hold under Sections 544.0104 and 544.0105 and Subchapter G, Chapter 544 [~~Section 531.102~~], Government Code, including the notice requirements under Section 544.0302 [~~Subsection (g) of that section~~].

SECTION 2.82. Section 32.03115(b), Human Resources Code, as added by Chapters 640 (S.B. 1564) and 1167 (H.B. 3285), Acts of the 86th Legislature, Regular Session, 2019, is amended to read as follows:

(b) Notwithstanding Subchapters E [~~Sections 531.072~~] and F, Chapter 549 [~~531.073~~], Government Code, or any other law and subject to Subsections (c) and (d), the commission shall provide medical assistance reimbursement for medication-assisted opioid or substance use disorder treatment without requiring a recipient of medical assistance or health care provider to obtain prior

authorization or precertification for the treatment.

SECTION 2.83. Section 32.0322(a), Human Resources Code, is amended to read as follows:

(a) The commission or the office of inspector general established under Subchapter C, Chapter 544 [~~Chapter 531~~], Government Code, may obtain from any law enforcement or criminal justice agency the criminal history record information that relates to a provider under the medical assistance program or a person applying to enroll as a provider under the medical assistance program.

SECTION 2.84. Section 32.046(a), Human Resources Code, is amended to read as follows:

(a) The executive commissioner shall adopt rules governing sanctions and penalties that apply to a provider who participates in the vendor drug program or is enrolled as a network pharmacy provider of a managed care organization contracting with the commission under Chapter 540 [~~533~~], Government Code, or its subcontractor and who submits an improper claim for reimbursement under the program.

SECTION 2.85. Section 32.053(b), Human Resources Code, is amended to read as follows:

(b) The executive commissioner shall adopt rules as necessary to implement this section. In adopting rules, the executive commissioner shall:

(1) use the Bienvivir Senior Health Services of El Paso initiative as a model for the program;

(2) ensure that a person is not required to hold a

certificate of authority as a health maintenance organization under Chapter 843, Insurance Code, to provide services under the PACE program;

(3) ensure that participation in the PACE program is available as an alternative to enrollment in a Medicaid managed care plan under Chapter 540 [~~533~~], Government Code, for eligible recipients, including recipients eligible for assistance under both the medical assistance and Medicare programs;

(4) ensure that managed care organizations that contract under Chapter 540 [~~533~~], Government Code, consider the availability of the PACE program when considering whether to refer a recipient to a nursing facility or other long-term care facility; and

(5) establish protocols for the referral of eligible persons to the PACE program.

SECTION 2.86. Section 32.057(c-1), Human Resources Code, is amended to read as follows:

(c-1) A managed care health plan that develops and implements a disease management program under Section 540.0708 [~~533.009~~], Government Code, and a provider of a disease management program under this section shall coordinate during a transition period beneficiary care for patients that move from one disease management program to another program.

SECTION 2.87. Section 32.064(a), Human Resources Code, is amended to read as follows:

(a) To the extent permitted under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), as amended, and any other

applicable law or regulations, the executive commissioner shall adopt provisions requiring recipients of medical assistance to share the cost of medical assistance, including provisions requiring recipients to pay:

(1) an enrollment fee;

(2) a deductible; or

(3) coinsurance or a portion of the plan premium, if the recipients receive medical assistance under the Medicaid managed care program under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.88. Section 32.0705(a), Human Resources Code, is amended to read as follows:

(a) In this section, "Medicaid contractor" means an entity that:

(1) is not a health and human services agency as defined by Section 521.0001 [~~531.001~~], Government Code; and

(2) under a contract with the commission or otherwise on behalf of the commission, performs one or more administrative services in relation to the commission's operation of Medicaid, such as claims processing, utilization review, client enrollment, provider enrollment, quality monitoring, or payment of claims.

SECTION 2.89. Sections 32.101(3) and (4), Human Resources Code, are amended to read as follows:

(3) "Managed care organization" has the meaning assigned by Section 540.0001 [~~533.001~~], Government Code.

(4) "Managed care plan" has the meaning assigned by Section 540.0001 [~~533.001~~], Government Code.

SECTION 2.90. Section 36.005(a), Human Resources Code, is amended to read as follows:

(a) A health and human services agency, as defined by Section 521.0001 [~~531.001~~], Government Code:

(1) shall suspend or revoke:

(A) a provider agreement between the agency and a person, other than a person who operates a nursing facility or an ICF-IID, found liable under Section 36.052; and

(B) a permit, license, or certification granted by the agency to a person, other than a person who operates a nursing facility or an ICF-IID, found liable under Section 36.052; and

(2) may suspend or revoke:

(A) a provider agreement between the agency and a person who operates a nursing facility or an ICF-IID and who is found liable under Section 36.052; or

(B) a permit, license, or certification granted by the agency to a person who operates a nursing facility or an ICF-IID and who is found liable under Section 36.052.

SECTION 2.91. Section 40.0025, Human Resources Code, is amended to read as follows:

Sec. 40.0025. AGENCY FUNCTIONS. (a) In this section, "function" includes a power, duty, program, or activity and an administrative support services function associated with the power, duty, program, or activity, unless consolidated under former Section 531.02012, Government Code.

(b) In accordance with former Subchapter A-1, Chapter 531,

Government Code, and notwithstanding any other law, the department performs only functions, including the statewide intake of reports and other information, related to the following services:

(1) child protective services, including services that are required by federal law to be provided by this state's child welfare agency;

(2) adult protective services, other than investigations of the alleged abuse, neglect, or exploitation of an elderly person or person with a disability:

(A) in a facility operated, or in a facility or by a person licensed, certified, or registered, by a state agency; or

(B) by a provider that has contracted to provide home and community-based services; and

(3) prevention and early intervention services functions, including:

(A) prevention and early intervention services as defined under Section 265.001, Family Code; and

(B) programs that:

(i) provide parent education;

(ii) promote healthier parent-child relationships; or

(iii) prevent family violence.

SECTION 2.92. Section 40.021(c), Human Resources Code, is amended to read as follows:

(c) The council shall study and make recommendations to the commissioner regarding the management and operation of the department, including policies and rules governing the delivery of

services to persons who are served by the department, the rights and duties of persons who are served or regulated by the department, and the consolidation of the provision of administrative support services as provided by Subchapter E, Chapter 524 [~~Section 531.00553~~], Government Code. The council may not develop policies or rules relating to administrative support services provided by the commission for the department.

SECTION 2.93. Sections 40.0515(d) and (e), Human Resources Code, are amended to read as follows:

(d) A performance review conducted under Subsection (b)(3) is considered a performance evaluation for purposes of Section 40.032(c) of this code or Section 523.0055(b) [~~531.009(c)~~], Government Code, as applicable. The department shall ensure that disciplinary or other corrective action is taken against a supervisor or other managerial employee who is required to conduct a performance evaluation for adult protective services personnel under Section 40.032(c) of this code or Section 523.0055(b) [~~531.009(c)~~], Government Code, as applicable, or a performance review under Subsection (b)(3) and who fails to complete that evaluation or review in a timely manner.

(e) The annual performance evaluation required under Section 40.032(c) of this code or Section 523.0055(b) [~~531.009(c)~~], Government Code, as applicable, of the performance of a supervisor in the adult protective services division must:

(1) be performed by an appropriate program administrator; and

(2) include:

(A) an evaluation of the supervisor with respect to the job performance standards applicable to the supervisor's assigned duties; and

(B) an evaluation of the supervisor with respect to the compliance of employees supervised by the supervisor with the job performance standards applicable to those employees' assigned duties.

SECTION 2.94. Section 48.103(a), Human Resources Code, is amended to read as follows:

(a) Except as otherwise provided by Subsection (c), 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 521.0001 [~~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.

SECTION 2.95. Sections 48.251(a)(4), (8), and (9), Human Resources Code, are amended to read as follows:

(4) "Health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

(8) "Managed care organization" has the meaning assigned by Section 540.0001 [~~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 546.0101 [~~531.051~~], Government Code.

SECTION 2.96. Section 48.252(c), Human Resources Code, is amended to read as follows:

(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 542.0001(11)(B) [~~534.001(11)(B)~~], Government Code, regardless of whether the individual is receiving services under that waiver program from the provider.

SECTION 2.97. Section 48.256(c), Human Resources Code, is amended to read as follows:

(c) A provider of home and community-based services under the home and community-based services waiver program described by Section 542.0001(11)(B) [~~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.

SECTION 2.98. Section 48.401(3), Human Resources Code, is amended to read as follows:

(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 546.0101 [~~531.051~~], Government Code;

(B) provides personal care services, active treatment, or any other 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 546.0101 [~~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 546.0101 [~~531.051~~], Government Code.

SECTION 2.99. Section 73.0045, Human Resources Code, is amended to read as follows:

Sec. 73.0045. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner of assistive and rehabilitative services by this chapter or another law conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.100. Section 81.0055, Human Resources Code, is amended to read as follows:

Sec. 81.0055. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner of assistive and rehabilitative services by this chapter, or another law relating to services for persons who are deaf or hard of hearing, conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.101. Section 91.0205, Human Resources Code, is amended to read as follows:

Sec. 91.0205. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this chapter, or another law relating to services for the blind or persons with visual disabilities, conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.102. Section 101A.002, Human Resources Code, is amended to read as follows:

Sec. 101A.002. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this chapter or another law relating to state services for the aging conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.103. Section 111.0505, Human Resources Code, is amended to read as follows:

Sec. 111.0505. COMMISSIONER'S POWERS AND DUTIES; EFFECT OF CONFLICT WITH OTHER LAW. To the extent a power or duty given to the commissioner by this chapter, or another law relating to rehabilitation services for individuals with disabilities, conflicts with any of the following provisions of the [~~Section 531.0055,~~] Government Code, the Government Code provision [~~Section 531.0055~~] controls:

(1) Subchapter A, Chapter 524;

(2) Section 524.0101;

(3) Sections 524.0151(a)(2) and (b);

(4) Section 524.0202; and

(5) Section 525.0254.

SECTION 2.104. Section 117.003, Human Resources Code, is amended to read as follows:

Sec. 117.003. SUNSET PROVISION. Unless the commission is continued in existence as provided by Chapter 325, Government Code, after the review required by Section 523.0003 [~~531.004~~], Government Code, this chapter expires on the date the commission is abolished under that section.

SECTION 2.105. Section 117.073, Human Resources Code, is amended to read as follows:

Sec. 117.073. RULES. The executive commissioner may adopt rules reasonably necessary for the department to administer this chapter, consistent with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.106. Section 121.0014(b), Human Resources Code, is amended to read as follows:

(b) In this section, "health and human services agency" means an agency listed by Section 521.0001(5) [~~531.001(4)~~], Government Code.

SECTION 2.107. Section 122.0057(k), Human Resources Code, is amended to read as follows:

(k) The advisory committee shall provide input to the workforce commission in adopting rules applicable to the program administered under this chapter relating to the employment-first policies described by Sections 546.0003 [~~531.02447~~] and 546.0451 [~~531.02448~~], Government Code.

SECTION 2.108. Section 161.003, Human Resources Code, is amended to read as follows:

Sec. 161.003. SUNSET PROVISION. Unless the commission is continued in existence as provided by Chapter 325, Government Code, after the review required by Section 523.0003 [~~531.004~~], Government Code, this chapter expires on the date the commission is abolished under that section.

SECTION 2.109. Section 161.073, Human Resources Code, is amended to read as follows:

Sec. 161.073. RULES. The executive commissioner may adopt rules reasonably necessary for the department to administer this chapter, consistent with the memorandum of understanding under Section 524.0101(a) [~~531.0055(k)~~], Government Code, between the commissioner and the executive commissioner, as adopted by rule.

SECTION 2.110. Section 161.080(e), Human Resources Code, is amended to read as follows:

(e) Notwithstanding Subsection (c), a state supported living center, based on negotiations between the center and a managed care organization, as defined by Section 540.0001 [~~533.001~~], Government Code, may charge a fee for a service other than the fee provided by the schedule of fees created by the commission under this section.

SECTION 2.111. Sections 161.081(a), (c), and (d), Human Resources Code, are amended to read as follows:

(a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

(c) The department shall ensure that actions taken under Subsection (b) do not conflict with any requirements of the commission under Sections 546.0402(a), (b), and (c) [~~Section 531.0218~~], Government Code.

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

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

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

(3) integrate with other department and commission efforts to streamline and unify the administration and delivery of the program services, including those required by this section or Sections 546.0402(a), (b), and (c) [~~Section 531.0218~~], Government Code.

SECTION 2.112. Section 161.082(a), Human Resources Code, is amended to read as follows:

(a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.113. Sections 161.084(a) and (b), Human Resources Code, are amended to read as follows:

(a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

(b) The department, in cooperation with the commission,

shall educate the public on:

(1) the availability of home and community-based services under a Medicaid state plan program, including the primary home care and community attendant services programs, and under a Section 1915(c) waiver program; and

(2) the various service delivery options available under the Medicaid program, including the consumer direction models available to recipients under Subchapter C, Chapter 546 [~~Section 531.051~~], Government Code.

SECTION 2.114. Section 161.251(2), Human Resources Code, is amended to read as follows:

(2) "Health and human services agency" has the meaning assigned by Section 521.0001 [~~531.001~~], Government Code.

SECTION 2.115. Section 38.254(a), Insurance Code, is amended to read as follows:

(a) Upon request from the commissioner, the Texas Health and Human Services Commission shall provide to the commissioner data, including utilization and cost data, which is related to the mandate being assessed to the population covered by the Medicaid program, including a program administered under Chapter 32, Human Resources Code, and a program administered under Chapter 540 or 540A [~~533~~], Government Code, as applicable, even if the program is not necessarily subject to the mandate.

SECTION 2.116. Section 38.353(d), Insurance Code, is amended to read as follows:

(d) This subchapter does not apply to:

(1) standard health benefit plans provided under

Chapter 1507;

(2) children's health benefit plans provided under Chapter 1502;

(3) health care benefits provided under a workers' compensation insurance policy;

(4) Medicaid managed care programs operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(5) Medicaid programs operated under Chapter 32, Human Resources Code; or

(6) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

SECTION 2.117. Section 38.402(7), Insurance Code, is amended to read as follows:

(7) "Payor" means any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:

(A) an insurance company providing health or dental insurance;

(B) the sponsor or administrator of a health or dental plan;

(C) a health maintenance organization operating under Chapter 843;

(D) the state Medicaid program, including the Medicaid managed care program operating under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(E) a health benefit plan offered or administered

by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including:

(i) a basic coverage plan under Chapter 1551;

(ii) a basic plan under Chapter 1575; and

(iii) a primary care coverage plan under Chapter 1579; or

(F) any other entity providing a health insurance or health benefit plan subject to regulation by the department.

SECTION 2.118. Section 222.001(a), Insurance Code, is amended to read as follows:

(a) This chapter applies to any insurer, including a group hospital service corporation, any health maintenance organization, and any managed care organization that receives gross premiums or revenues subject to taxation under Section 222.002, including companies operating under Chapter 841, 842, 843, 861, 881, 882, 883, 884, 941, 942, 982, or 984, Insurance Code, Chapter 540 or 540A [~~533~~], Government Code, as applicable, or Title XIX of the federal Social Security Act.

SECTION 2.119. Section 843.010, Insurance Code, is amended to read as follows:

Sec. 843.010. APPLICABILITY OF CERTAIN PROVISIONS TO GOVERNMENTAL HEALTH BENEFIT PLANS. Sections 843.306(f) and 843.363(a)(4) do not apply to coverage under:

(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children

under Chapter 63, Health and Safety Code; or

(2) a Medicaid program, including a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.120. Section 1217.002(d), Insurance Code, is amended to read as follows:

(d) Notwithstanding any other law, this chapter applies to coverage under:

(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; and

(2) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.121. Section 1222.0002(b), Insurance Code, is amended to read as follows:

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

SECTION 2.122. Section 1301.0041(c), Insurance Code, is amended to read as follows:

(c) This chapter does not apply to:

(1) the child health plan program under Chapter 62, Health and Safety Code; or

(2) a Medicaid managed care program under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.123. Section 1356.002(i), Insurance Code, is amended to read as follows:

(i) To the extent allowed by federal law, this chapter applies to:

(1) the state Medicaid program operated under Chapter 32, Human Resources Code; and

(2) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.124. Section 1367.252, Insurance Code, is amended to read as follows:

Sec. 1367.252. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.251; or

(6) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter~~

~~533~~], Government Code.

SECTION 2.125. Section 1369.053, Insurance Code, is amended to read as follows:

Sec. 1369.053. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so

comprehensive that the policy is a health benefit plan as described by Section 1369.052;

(6) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(7) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.126. Section 1369.212(b), Insurance Code, is amended to read as follows:

(b) Notwithstanding any other law, this subchapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(12) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

SECTION 2.127. Section 1369.352, Insurance Code, is amended to read as follows:

Sec. 1369.352. CERTAIN BENEFITS EXCLUDED. This subchapter does not apply to maximum allowable costs for pharmacy benefits provided under:

(1) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the child health plan program under Chapter 62, Health and Safety Code;

(4) the health benefits plan for children under Chapter 63, Health and Safety Code;

(5) a health benefit plan issued under Chapter 1551, 1575, 1579, or 1601; or

(6) a workers' compensation insurance policy or other form of providing medical benefits under Title 5, Labor Code.

SECTION 2.128. Section 1369.452(f), Insurance Code, is

amended to read as follows:

(f) To the extent allowed by federal law, the child health plan program operated under Chapter 62, Health and Safety Code, and the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code, shall provide the coverage required under this subchapter to a recipient.

SECTION 2.129. Section 1369.552, Insurance Code, as added by Chapter 1012 (H.B. 1919), Acts of the 87th Legislature, Regular Session, 2021, is amended to read as follows:

Sec. 1369.552. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. Notwithstanding the definition of "health benefit plan" provided by Section 1369.551, this subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

(1) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code;

(2) the child health plan program under Chapter 62, Health and Safety Code;

(3) the TRICARE military health system;

(4) a basic coverage plan under Chapter 1551;

(5) a basic plan under Chapter 1575;

(6) a coverage plan under Chapter 1579;

(7) a plan providing basic coverage under Chapter 1601; or

(8) a workers' compensation insurance policy or other

form of providing medical benefits under Title 5, Labor Code.

SECTION 2.130. Section 1451.109(d), Insurance Code, is amended to read as follows:

(d) This section does not apply to:

(1) workers' compensation insurance coverage as defined by Section 401.011, Labor Code;

(2) a self-insured employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(4) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.131. Section 1451.1261(b), Insurance Code, is amended to read as follows:

(b) This section does not apply to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579;

(4) a plan providing basic coverage under Chapter 1601;

(5) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A [~~Chapter 533~~], Government Code; or

(6) the child health plan program under Chapter 62,

Health and Safety Code.

SECTION 2.132. Section 1451.451(a), Insurance Code, is amended to read as follows:

(a) An insurance company, health maintenance organization, or preferred provider organization that contracts with a health care provider to provide services in connection with Chapter 540 or 540A [~~533~~], Government Code, as applicable, or Chapter 62, Health and Safety Code, may not require the health care provider to provide access to or transfer the provider's name and contracted discounted fee for use with health benefit plans issued to individuals and groups under Chapter 1271 or 1301.

SECTION 2.133. Section 1451.503, Insurance Code, is amended to read as follows:

Sec. 1451.503. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1451.502;

(6) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(7) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.134. Section 1456.002(c), Insurance Code, is amended to read as follows:

(c) This chapter does not apply to:

(1) Medicaid managed care programs operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) Medicaid programs operated under Chapter 32, Human Resources Code; or

(3) the state child health plan operated under Chapter 62 or 63, Health and Safety Code.

SECTION 2.135. Section 1460.002, Insurance Code, is amended to read as follows:

Sec. 1460.002. EXEMPTION. This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(4) a Medicare supplement benefit plan, as defined by Chapter 1652.

SECTION 2.136. Section 1510.003(b), Insurance Code, is amended to read as follows:

(b) The pool may not be used to expand the Medicaid program, including the program administered under Chapter 32, Human Resources Code, and the program administered under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.137. Section 1660.003(b), Insurance Code, is amended to read as follows:

(b) This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the state child health plan or any similar plan operated under Chapter 62 or 63, Health and Safety Code; or

(4) a health benefit plan offered by an insurer or health maintenance organization that provides coverage only for dental services.

SECTION 2.138. Section 1661.003, Insurance Code, is amended to read as follows:

Sec. 1661.003. EXCEPTIONS. This chapter does not apply to:

(1) a health benefit plan that provides coverage only:

(A) for a specified disease or diseases or under a limited benefit policy;

(B) for accidental death or dismemberment;

(C) as a supplement to a liability insurance policy; or

(D) for dental or vision care;

(2) disability income insurance coverage;

(3) credit insurance coverage;

(4) a hospital confinement indemnity policy;

(5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(6) a workers' compensation insurance policy;

(7) medical payment insurance coverage provided under a motor vehicle insurance policy;

(8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan and should not be subject to the exemption provided under this section;

(9) the child health plan program under Chapter 62,

Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(10) a Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

SECTION 2.139. Section 4201.053(b), Insurance Code, is amended to read as follows:

(b) Sections 4201.303(c), 4201.304(b), 4201.357(a-1), and 4201.3601 do not apply to:

(1) the child health program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code;

(2) the Employees Retirement System of Texas or another entity issuing or administering a coverage plan under Chapter 1551;

(3) the Teacher Retirement System of Texas or another entity issuing or administering a plan under Chapter 1575 or 1579;

(4) The Texas A&M University System or The University of Texas System or another entity issuing or administering coverage under Chapter 1601; and

(5) a managed care organization providing a Medicaid managed care plan under Chapter 540 or 540A [~~533~~], Government Code, as applicable.

SECTION 2.140. Section 4201.652, Insurance Code, is amended to read as follows:

Sec. 4201.652. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a health benefit plan offered by a health maintenance organization operating under Chapter 843, except that this subchapter does not apply to:

(A) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(B) the state Medicaid program, including the Medicaid managed care program operated under Chapter 540 or 540A [~~533~~], Government Code, as applicable;

(2) a preferred provider benefit plan or exclusive provider benefit plan offered by an insurer under Chapter 1301; and

(3) a person who contracts with a health maintenance organization or insurer to issue preauthorization determinations or perform the functions described in this subchapter for a health benefit plan to which this subchapter applies.

SECTION 2.141. Section 310.005(b), Labor Code, is amended to read as follows:

(b) In addition to providing referrals to child-care and early childhood education services, the network, through its members, shall provide:

(1) referrals to available support services, including:

(A) parenting education classes; and

(B) services for parents or children offered by health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, or otherwise available in the community; and

(2) information for consumers of child-care and early childhood education services, including:

(A) information regarding early childhood development;

(B) criteria for identifying quality child-care and early childhood education services that support the healthy development of children; and

(C) other information that will assist consumers in making informed and effective choices regarding child-care and early childhood education services.

SECTION 2.142. Sections 352.105(b) and (c), Labor Code, are amended to read as follows:

(b) The training program must provide employees with information regarding:

(1) supports and services available from health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, for:

(A) youth with disabilities who are transitioning into post-schooling activities, services for adults, or community living; and

(B) adults with disabilities;

(2) community resources available to improve the quality of life for:

(A) youth with disabilities who are transitioning into post-schooling activities, services for adults, or community living; and

(B) adults with disabilities; and

(3) other available resources that may remove transitional barriers for youth with disabilities who are transitioning into post-schooling activities, services for adults, or community living.

(c) In developing the training program required by this section, the commission shall collaborate with health and human services agencies, as defined by Section 521.0001 [~~531.001~~], Government Code, as necessary.

SECTION 2.143. Section 118.022(d), Local Government Code, is amended to read as follows:

(d) The comptroller shall deposit the money received under Subsection (a)(3) in the Texas Home Visiting Program trust fund under Section 523.0306 [~~531.287~~], Government Code.

SECTION 2.144. Section 157.101(g), Occupations Code, is amended to read as follows:

(g) In this section, "federally qualified health center" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(B) [~~531.02192, Government Code~~].

ARTICLE 3. REPEALER

SECTION 3.01. The following laws are repealed:

(1) Sections 531.021 through 531.083 and Sections 531.0841 through 531.0999, Government Code;

(2) Subchapters A, C, D, D-1, E, F, G, G-1, H, I, J, J-1, L, M, M-1, N, O, S, U, V, W, and X, Chapter 531, Government Code; and

(3) Chapters 533, 534, 535, 536, 537, 538, 539, and 541, Government Code.

ARTICLE 4. GENERAL MATTERS

SECTION 4.01. This Act is enacted under Section 43, Article III, Texas Constitution. This Act is intended as a recodification only, and no substantive change in the law is intended by this Act.

SECTION 4.02. This Act takes effect April 1, 2025.

President of the Senate

Speaker of the House

I certify that H.B. No. 4611 was passed by the House on May 2, 2023, by the following vote: Yeas 137, Nays 7, 3 present, not voting; and that the House concurred in Senate amendments to H.B. No. 4611 on May 19, 2023, by the following vote: Yeas 139, Nays 0, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 4611 was passed by the Senate, with amendments, on May 17, 2023, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor