PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL
Government Code
Chapter 532
9/30/22

CHAPTER 532. MEDICAID ADMINISTRATION AND OPERATION IN GENERAL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 532.0001. DEFINITION. In this chapter, "recipient" means a Medicaid recipient. (New.)

Revisor's Note

The definition of "recipient" is added to the revised law for drafting convenience and to eliminate the frequent, unnecessary repetition of the substance of the definition.

SUBCHAPTER B. ADMINISTRATION

Revised Law

Sec. 532.0051. COMMISSION ADMINISTRATION OF MEDICAID. (a) The commission is the state agency designated to administer federal Medicaid money.

(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).)

Source Law

Sec. 531.021. ADMINISTRATION OF MEDICAID. (a) The commission is the state agency designated to administer federal Medicaid funds.

(b) The commission shall:

(1) plan and direct Medicaid in each agency that operates a portion of Medicaid, including the management of the Medicaid managed care system and the development, procurement, management, and monitoring of contracts necessary to implement the Medicaid managed care 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.

Revisor's Note

Section 531.021(a), Government Code, refers to federal Medicaid "funds." Throughout this chapter, the revised law substitutes "money" for "funds" because, in context, the meaning is the same and "money" is the more commonly used term.

Revised Law

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.)

Source Law

> Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in Medicaid and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of Medicaid by any method the commission determines is cost-effective, including:
>
> (1) expanding the utilization of the electronic claims payment system;
>
> (2) developing an Internet portal system for prior authorization requests;

(3) encouraging Medicaid providers to submit their program participation applications electronically;

(4) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently apply to the program;

(5) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in Medicaid; and

(6) encouraging the increased use of medical technology by providers, including increasing their use of:

(A) electronic communications between patients and their physicians or other health care providers;

(B) electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health care practitioner writes a prescription and that support the electronic transmission of a prescription;

(C) ambulatory computerized order entry systems that facilitate physician and other health care practitioner orders at the point of care for medications and laboratory and radiological tests;

(D) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting;

(E) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and

(F) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely.

Revisor's Note

Sections 531.02411(6)(B) and (C), Government Code, refer to a health care "practitioner," while other provisions of Section 531.02411 refer to a health care "provider." The revised law substitutes "provider" for "practitioner" for consistency of terminology and because the terms are synonymous and the former is more commonly used in Subtitle I, Title 4, Government Code, which includes this chapter.

Revised Law

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.)

Source Law

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) The commission shall 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.

(b) The commission shall standardize Medicaid grievance data reporting and tracking among divisions within the commission.

(c) The commission shall implement a no-wrong-door system for Medicaid grievances reported to the commission.

(d) 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.

(e) The commission shall verify grievance data reported by a Medicaid managed care organization.

(f) The commission shall:

(1) aggregate Medicaid recipient and 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.

Revised Law

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.)

Source Law

Sec. 531.020. 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 the delivery of Medicaid services; and

(2) sharing with Medicaid providers, including hospitals, any best practices, resources, or other information regarding improvements to the health care system.

Revised Law

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.)

Source Law

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. (a) 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 those elements of the program that are determined to present the greatest risks;

(2) ensure that sufficient oversight is in place for the Medicaid medical transportation program;

(3) ensure that a quality review assessment of the Medicaid medical transportation program occurs; and

(4) 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.

Revised Law

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 money from the disproportionate share hospitals and upper payment limit supplemental payment programs and other federal Medicaid money, to ensure the most effective and efficient use of those funding streams;

(7) allow flexibility in the use of state money used to obtain federal matching money, including allowing the use of intergovernmental transfers, certified public expenditures, costs not otherwise matchable, or other money and funding mechanisms to obtain federal matching money;

(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.)

Source Law

Sec. 537.002. FEDERAL AUTHORIZATION FOR MEDICAID REFORM. (a) The executive commissioner shall seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan.

(b) The waiver under this section must be 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 people 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.

Revisor's Note

Section 537.002(b)(4), Government Code, refers to "people" who have access to private employer-based health benefits. Throughout this chapter, the revised law substitutes "individuals" or "individual" for "people" or "person," respectively, for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), applicable to this code.

Revised Law

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 money; 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 533]]], 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).)

Source Law

(b-1) The executive commissioner shall adopt reasonable rules and standards governing the determination of fees, charges, and rates for Medicaid payments.

(c) The executive commissioner in the adoption of reasonable rules and standards under Subsection (b-1) 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 the state and federal requirements of Medicaid.

(d) In adopting rules and standards required by Subsection (b-1), the executive commissioner may provide for payment of fees, charges, and rates in accordance with:

(1) formulas, procedures, or methodologies prescribed by the commission's rules;

(2) applicable state or federal law, policies, rules, regulations, or guidelines;

(3) economic conditions that substantially and materially affect provider participation in Medicaid, as determined by the executive commissioner; or

(4) available levels of appropriated state and federal funds.

(e) Notwithstanding any other provision of Chapter 32, Human Resources Code, Chapter 533, or this chapter, 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 (d).

(f) In adopting rates for Medicaid payments under Subsection (b-1), 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.

(g) In adopting rates for Medicaid payments under Subsection (b-1), the executive commissioner may adopt cost-effective reimbursement rates for group appointments with Medicaid providers for certain diseases and medical conditions specified by rules of the executive commissioner.

Revisor's Note

Section 531.021(g), Government Code, refers to "rules of the executive commissioner." The revised law

substitutes "commission rules" for the quoted language for clarity and consistency in the terminology used within Subtitle I, Title 4, Government Code, which includes this chapter, and because under Section 531.033, Government Code, revised as Section _____, the executive commissioner of the Health and Human Services Commission adopts rules for the commission.

Revised Law

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 money 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).)

Source Law

Sec. 531.02413. BILLING COORDINATION SYSTEM. (a) [If cost-effective and feasible, the commission shall, on or before March 1, 2008, contract through an existing procurement process for the implementation of] an acute care Medicaid billing coordination system for the fee-for-service and primary care case management delivery models that will, upon entry in the claims system, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the entity the system determines is the primary payor. The system may not increase Medicaid claims payment error rates.

(a-1) If cost-effective and feasible, the commission shall contract to expand the Medicaid billing coordination system described by Subsection (a) to process claims for all other health care services provided through Medicaid in the manner claims for acute care services are processed by the system under Subsection (a). This subsection does not apply to claims for health care services provided through Medicaid if, before September 1, 2009, those claims were being processed by an alternative billing coordination system.

(b) If cost-effective, the executive commissioner shall adopt rules for the purpose of enabling the system described by Subsection (a) to identify an entity with primary responsibility for paying a claim that is processed by the system under Subsection (a) and establish reporting requirements for any 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 under Subsection (a).

(c) An entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state 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 adopted under this section, and is subject to an administrative penalty or other sanction as provided by the law applicable to the permit, license, or certificate of authority for a violation by the entity of a rule adopted under this section.

(d) After September 1, 2008, no public funds shall be expended on entities not in compliance with this section unless a memorandum of understanding is entered into between the entity and the executive commissioner.

(e) 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.

Revisor's Note

(1) Section 531.02413(a), Government Code, requires the Health and Human Services Commission to contract for the implementation of an acute care Medicaid billing coordination system on or before March 1, 2008, if cost-effective and feasible. Because the commission has implemented the described system, the revised law omits this provision as executed. The omitted law reads:

> (a) If cost-effective and feasible, the commission shall, on or before March 1, 2008, contract through an existing procurement process for the implementation of [an acute care Medicaid billing coordination system] . . . .

(2) Section 531.02413(d), Government Code, restricts certain spending of public money "[a]fter September 1, 2008." The revised law omits the quoted language as unnecessary because the specified date has

passed, and any future expenditure of public money would necessarily occur after that date.

Revised Law

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.)

Source Law

> Sec. 531.0392. RECOVERY OF CERTAIN THIRD-PARTY REIMBURSEMENTS UNDER MEDICAID. (a) In this section, "dually eligible individual" means an individual who is eligible to receive health care benefits under both Medicaid and the Medicare program.
>
> (b) 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 rendered to a dually eligible individual.

Revised Law

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.)

Source Law

> Sec. 531.02114. DENTAL DIRECTOR. The executive commissioner shall appoint for Medicaid a dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and rules adopted under that subtitle by the State Board of Dental Examiners.

Revised Law

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.)

Source Law

> Sec. 531.099. ALIGNMENT OF MEDICAID DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES WITH MEDICARE DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES. (a) The commission shall review forms and requirements under Medicaid regarding written orders for diabetic equipment and supplies to identify variations between permissible ordering procedures under that program and ordering procedures available to providers under the Medicare program.
>
> (b) To the extent practicable, and in conformity with Chapter 157, Occupations Code, and Chapter 483, Health and Safety Code, after conducting a review under Subsection (a) the commission or executive commissioner, as appropriate, shall modify only forms, rules, and procedures applicable to orders for diabetic equipment and supplies under Medicaid to provide for an ordering system that is comparable to the ordering system for diabetic equipment and supplies under the Medicare program. The ordering system must permit a diabetic equipment or supplies supplier to complete the forms by hand or to enter by electronic format medical information or supply orders into any form as necessary to provide the information required to dispense diabetic equipment or supplies.
>
> (c) A provider of diabetic equipment and

supplies 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 that is signed by a medical practitioner licensed in this state to treat diabetic patients. Additional documentation may not be required.

Revisor's Note

Section 531.099(c), Government Code, refers to a "medical practitioner." The revised law substitutes "provider" for "practitioner" for the reason stated in the revisor's note to Section 532.0052 of this chapter.

SUBCHAPTER C. FINANCING

Revised Law

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 money;

(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.)

Source Law

Sec. 531.02113. OPTIMIZATION OF MEDICAID FINANCING. The commission shall ensure that the Medicaid finance system is optimized to:
(1) maximize the 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 the improvement of the quality of care.

Revised Law

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.)

Source Law

> Sec. 531.021135. COMMISSION'S AUTHORITY TO RETAIN CERTAIN MONEY TO ADMINISTER CERTAIN MEDICAID PROGRAMS; 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 federal Social Security Act (42 U.S.C. Section 1315) or a directed payment program or successor program as determined by the commission.
>
> (c) Subject to Subsection (e), 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 money is received, but not to exceed $8 million for a state fiscal year.
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> (d) The commission shall spend money retained under this section to assist in paying the costs necessary to administer the program for which the money is received, 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.
>
> (e) 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 approval of the governor and the Legislative Budget Board, but not to exceed a total retained amount equal to 0.25 percent of the total amount estimated to be received for the program.
>
> (f) The commission shall submit an annual report to the governor and the Legislative Budget Board that:
>
> (1) details the amount of money retained and spent by the commission under this section during the preceding state fiscal year, including a separate detail of any increase in the amount of money retained for a program under Subsection (e);
>
> (2) contains a transparent description of how the commission used the money described by Subdivision (1); and
>
> (3) assesses the extent to which the money retained by the commission under this section 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.

Revised Law

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 money related to Medicaid the agency received and disbursed during the period the report covers, including:

(i) the amount of any federal Medicaid money allocated to the agency for the support of each of the Medicaid components the agency operates;

(ii) the amount of any money 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 money 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.)

Source Law

Sec. 531.02111. BIENNIAL MEDICAID FINANCIAL REPORT. (a) The commission shall prepare a biennial Medicaid financial report covering each state agency that operates any part of Medicaid and each component of Medicaid operated by those agencies.

(b) The report must include:

(1) for each state agency described by Subsection (a):

(A) a description of each of the components of Medicaid operated by the agency; and

(B) an accounting of all funds related to Medicaid received and disbursed by the agency during the period covered by the report, including:

(i) the amount of any federal Medicaid funds allocated to the agency for the support of each of the Medicaid components operated by the agency;

(ii) the amount of any funds appropriated by the legislature 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.

SUBCHAPTER D. PROVIDERS

Revised Law

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.)

Source Law

Sec. 531.02118. STREAMLINING MEDICAID PROVIDER ENROLLMENT AND CREDENTIALING PROCESSES. (a) The commission shall streamline provider enrollment and credentialing processes under Medicaid.

(b) In streamlining the Medicaid provider enrollment process, the commission shall establish a centralized Internet portal through which providers may enroll in Medicaid. The commission may use the Internet portal created under this subsection to create a single, consolidated Medicaid provider enrollment and credentialing process.

(c) In streamlining the Medicaid provider credentialing process under this section, the commission may designate a centralized credentialing entity and may:

(1) share information in the database established under Subchapter C, Chapter 32, Human Resources Code, with the centralized credentialing entity; and

(2) require all managed care organizations contracting with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization to use the centralized credentialing entity as a hub for the collection and sharing of information.

(d) If cost-effective, the commission may contract with a third party to develop the single, consolidated Medicaid provider enrollment and credentialing process authorized under Subsection (b).

Revisor's Note

Section 531.02118(c)(2), Government Code, refers to "managed care organizations contracting with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization." Section 531.001(4-c), Government Code, which is revised in this subtitle as Section ____, defines "Medicaid managed care organization" as "a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients." That definition applies throughout the subtitle and is synonymous with the quoted phrase. The revised law therefore substitutes the defined term "Medicaid managed care organization" for the quoted phrase from Section 531.02118(c)(2). Furthermore, for consistency of terminology throughout this chapter, the revised law substitutes "Medicaid managed care organization" for substantively synonymous source law references to "managed care organization that contracts with the commission under Chapter 533," "managed care organization participating in Medicaid," "managed care organization under Chapter 533," "managed care

organization that contracts with the commission to provide health care services to Medicaid recipients," and other similar references to managed care organizations.

Revised Law

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.)

Source Law

Sec. 531.021182. 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), 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.

Revised Law

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 _____ [[[Chapter 533]]]; 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 Medicaid managed care

organization to provide health care services to recipients under Chapter _____ [[[Chapter 533]]];

(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.)

Source Law

Sec. 531.021191. MEDICAID 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 managed care organization to provide health care services to recipients under Chapter 533; 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 provider under Medicaid;

(3) if applicable, complies with the requirements of the contract between the provider or the provider's group and the applicable managed care organization; 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 533;

(2) applies to be an enrolled provider under Medicaid;

(3) complies with the requirements of the contract between the provider and the applicable managed care organization; and

(4) complies with all other applicable requirements related to being a Medicaid provider.

Revisor's Note

Section 531.021191(b)(1), Government Code, refers to a health care provider or provider group that has a contract with a "managed care organization" to provide health care services to Medicaid recipients, and Section 531.021191(c)(1), Government Code, refers to an institution of higher education having a contract with a "managed care organization" to provide health care services to those recipients. As explained in the revisor's note to Section 532.0151 of this chapter, a Medicaid managed care organization is a managed care organization that contracts with the Health and Human Services Commission to provide health care services to Medicaid recipients, and the term is defined by Section 531.001(4-c), Government Code, which is revised as Section _____ and applies to Subtitle I, Title 4, Government Code, which includes this chapter. For clarity, the revised law substitutes "Medicaid managed care organization" for the references to "managed care organization" because the only type of managed care organization that would contract with a health care provider, provider group, or institution of higher education for the provision of health care services to Medicaid recipients is a Medicaid managed care organization.

Revised Law

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.)

Source Law

> Sec. 531.02193. CERTAIN CONDITIONS ON MEDICAID REIMBURSEMENT OF RURAL HEALTH CLINICS PROHIBITED. The commission may not impose any condition on the reimbursement of a rural health clinic under the Medicaid program if the condition is more stringent than the conditions imposed by the Rural Health Clinic Services Act of 1977 (Pub. L. No. 95-210) or the laws of this state regulating the practice of medicine, pharmacy, or professional nursing.

Revisor's Note

Section 531.02193, Government Code, refers to "the Medicaid program." Section 531.001, Government Code, revised as Section ____, defines "Medicaid" as the medical assistance program, which is synonymous with the Medicaid program. That definition applies to Subtitle I, Title 4, Government Code, which includes this chapter. For that reason, the revised law substitutes "Medicaid" for "the Medicaid program."

Revised Law

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.)

Source Law

Sec. 531.02194. REIMBURSEMENT METHODOLOGY FOR RURAL HOSPITALS. (a) In this section, "rural hospital" has the meaning assigned by commission rules for purposes of the reimbursement of hospitals for providing inpatient or outpatient services under Medicaid.

(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 Medicaid 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 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 managed care organization to share in the total amount of reimbursement paid to rural hospitals; and

(2) require that the amount of reimbursement paid to a rural hospital is subject to any applicable adjustments made by the commission 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 federal 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

Medicaid 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 Medicaid recipients during the previous state fiscal year.

(f) Notwithstanding Subsection (e), if federal law does not permit the use of a true cost-based reimbursement methodology described by that subsection, the commission shall continue to use the prospective cost-based reimbursement methodology adopted under Subsection (b) for the payment of rural hospitals for providing inpatient and general outpatient services to Medicaid recipients.

Revisor's Note

Sections 531.02194(c)(1)(A) and (B), Government Code, refer to reimbursement to rural hospitals by a "managed care organization" for services delivered through the Medicaid managed care program. The only type of managed care organization that would provide reimbursement under the Medicaid managed care program is a Medicaid managed care organization. For the reasons stated in the revisor's note to Section 532.0153 of this chapter, the revised law substitutes "Medicaid managed care organization" for the references to "managed care organization."

Revised Law

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).)

Source Law

(g) The executive commissioner by rule may develop and the commission may implement a system to reimburse providers of health care services under the state Medicaid program for review and transmission of electronic health information if feasible and cost-effective.

(h) In this section, . . . "provider of health care services" include a physician.

Revisor's Note

(1) Section 531.0162(g), Government Code, refers to "the state Medicaid program." Section 531.001, Government Code, revised as Section ____, defines "Medicaid" as the medical assistance program, which is synonymous with the state Medicaid program. That definition applies to Subtitle I, Title 4, Government Code, which includes this chapter. For that reason, the revised law substitutes "Medicaid" for "the state Medicaid program."

(2) Sections 531.0162(g) and (h), Government Code, refer to "providers of health care services" and a "provider of health care services," respectively. The revised law substitutes "health care provider" for "provider of health care services" because the terms are synonymous and the former is more commonly used in Subtitle I, Title 4, Government Code, which includes this chapter.

SUBCHAPTER E. DATA AND TECHNOLOGY

Revised Law

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 money 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.)

Source Law

Sec. 531.0214. MEDICAID 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 perpetrated by a program provider or client.

(b) To minimize cost and duplication of activities, the commission shall assist and coordinate:

(1) the efforts of the agencies that are participating in the development of the system required by Subsection (a); 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 request of the executive commissioner, a state agency that administers any part of Medicaid shall assist the commission in developing the system required by this section.

(d) The commission shall develop the database system in a manner that will enable a complete analysis

of the use of prescription medications, including information relating to:

(1) Medicaid clients 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 Medicaid clients.

(e) The commission shall ensure that the database system is used each month to match vital statistics unit death records with a list of persons eligible for Medicaid, and that each person who is deceased is promptly removed from the list of persons eligible for Medicaid.

Revisor's Note

Section 531.0214(a), Government Code, refers to a Medicaid program "client" and Section 531.0214(d), Government Code, refers to "Medicaid clients." A "Medicaid client" is an individual who receives health care services through Medicaid. The term is synonymous with "Medicaid recipient." The revised law in Section 532.0001 of this chapter adds a definition of "recipient" for purposes of the chapter and provides that the term means "a Medicaid recipient." For consistency of terminology, the revised law throughout this chapter substitutes "recipient" for "client," "Medicaid client," and other similar references to individuals receiving health care services under Medicaid.

Revised Law

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.)

Source Law

Sec. 531.02141. MEDICAID INFORMATION COLLECTION AND ANALYSIS. (a) The commission shall make every effort to improve data analysis and integrate available information associated with Medicaid. The commission shall use the decision support system in the commission's center for strategic decision support for this purpose and shall modify or redesign the system to allow for the data collected by Medicaid to be used more systematically and effectively for Medicaid evaluation and policy development. The commission shall develop or redesign the system as necessary to ensure that the system:

(1) incorporates program enrollment, utilization, and provider data that are currently collected;

(2) allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within the program;

(3) is able to obtain consistent and accurate answers to questions;

(4) allows for analysis of multiple issues within the program to determine whether any

programmatic or policy issues overlap or are in conflict;

(5) includes predefined data reports on utilization of high-cost services that allow program management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate;

(6) includes any encounter data with respect to recipients that a managed care organization that contracts with the commission under Chapter 533 receives from a health care provider under the organization's provider network; and

(7) links Medicaid and non-Medicaid data sets, including data sets related to Medicaid, the Temporary Assistance for Needy Families program, the Special Supplemental Nutrition Program for Women, Infants, and Children, vital statistics, and other public health programs.

(b) The commission shall ensure that all Medicaid data sets created or identified by the decision support system 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 through that means either by removing information by which particular individuals may be identified or by aggregating the data in a manner so that individual records cannot be associated with particular individuals.

(c) The commission shall regularly evaluate data submitted by managed care organizations that contract with the commission under Chapter 533 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 received by Medicaid recipients.

(e) The commission shall develop a dashboard for agency leadership that is designed to assist leadership with overseeing Medicaid and comparing the performance of managed care organizations participating in Medicaid. The dashboard must identify a concise number of important Medicaid indicators, including key data, performance measures, trends, and problems.

Revisor's Note

(1) Section 531.02141(a), Government Code, refers to the "center for strategic decision support" within the Health and Human Services Commission. According to the commission, the current name of the center is the "center for analytics and decision support." The revised law is drafted accordingly.

(2) Section 531.02141(a)(7), Government Code, refers to the "Temporary Assistance for Needy Families

program," meaning the financial assistance program under Chapter 31, Human Resources Code. For clarity, the revised law substitutes "financial assistance program under Chapter 31, Human Resources Code" for "Temporary Assistance for Needy Families program."

(3) Section 531.02141(a)(7), Government Code, refers to the "Special Supplemental Nutrition Program for Women, Infants, and Children," meaning the federal program authorized by 42 U.S.C. Section 1786. For clarity, the revised law adds a reference to the federal statute.

Revised Law

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.)

Source Law

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) To the extent permitted by federal law, the commission in consultation and 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 received by Medicaid recipients and the health outcomes of those recipients. Data made available to the public under this section must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing its 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.

Revisor's Note

Section 531.02142(a), Government Code, provides that the Health and Human Services Commission shall take certain action in "consultation and collaboration" with certain advisory committees. The revised law omits "consultation" in this context as redundant because "consultation" is included within the meaning of "collaboration."

Revised Law

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.)

Source Law

Sec. 531.02143. DATA REGARDING POSTNATAL ALCOHOL AND CONTROLLED SUBSTANCE TREATMENT. (a) The commission shall collect hospital discharge data for Medicaid recipients regarding treatment of a newborn child for prenatal exposure to alcohol or a controlled substance.

(b) The commission shall provide the data collected under Subsection (a) to the Department of Family and Protective Services.

Revised Law

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.)

Source Law

Sec. 531.0081. MEDICAL TECHNOLOGY. (b) The commission shall explore and evaluate new developments in medical technology and propose implementing the technology in Medicaid, if appropriate and

cost-effective.

(c) Commission staff implementing this section must have skills and experience in research regarding health care technology.

Revised Law

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.)

Source Law

Sec. 531.062. PILOT PROJECTS RELATING TO TECHNOLOGY APPLICATIONS. (a) Notwithstanding any other law, the commission may establish one or more pilot projects through which reimbursement under Medicaid is made to demonstrate the applications of technology in providing services under that program.

(b) A pilot project established under this section may relate to providing rehabilitation services, services for the aging or persons with disabilities, or long-term care services, including community care services and support.

(c) Notwithstanding an eligibility requirement prescribed by any other law or rule, the commission may establish requirements for a person to receive services provided through a pilot project under this section.

(d) Receipt of services provided through a pilot project under this section does not entitle the recipient to other services under a government-funded health program.

(e) The commission may set a maximum enrollment limit for a pilot project established under this section.

SUBCHAPTER F. ELECTRONIC VISIT VERIFICATION SYSTEM

Revised Law

Sec. 532.0251. DEFINITION. In this subchapter, "electronic visit verification system" means the electronic visit verification system implemented under Section 532.0253. (New.)

Revisor's Note

The definition of "electronic visit verification system" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

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).)

Source Law

> (a) . . . Notwithstanding any other provision of this section, the commission is required to implement a change in law made to this section by 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 review. . . .

Revisor's Note

Section 531.024172(a), Government Code, requires the Health and Human Services Commission to conduct a review of the electronic visit verification system not later than March 31, 2018, and states that the commission may combine the review with any similar review. The revised law omits these provisions as executed. The omitted law reads:

> Sec. 531.024172. ELECTRONIC VISIT

VERIFICATION SYSTEM. (a) Not later than March 31, 2018, the commission shall conduct a review of the electronic visit verification system in use under this section on August 31, 2017. . . . The commission may combine the review required by this subsection with any similar review required to be conducted by the commission.

Revised Law

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).)

Source Law

(b) Subject to Subsection (g), the commission shall, in accordance with federal law, implement an electronic visit verification system to electronically verify through a telephone, global positioning, or computer-based system that personal care services, attendant care services, or other services identified by the commission that are provided to recipients under Medicaid, 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 federal 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. . . .

Revised Law

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).)

Source Law

> (b) . . . The electronic visit verification system implemented under this subsection 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 is 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.

Revised Law

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).)

Source Law

(d) In implementing the electronic visit verification system:

(1) subject to Subsection (e), 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 managed care organizations that contract with the commission to provide health care services to Medicaid recipients and across commission programs;

(B) processes required by managed care organizations to retrospectively correct data are standardized and publicly accessible to health care providers;

(C) standardized processes are established for addressing the failure of a 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 electronic visit verification system.

(e) In establishing compliance standards for health care providers under Subsection (d), 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.

Revised Law

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).)

Source Law

(c) The commission shall inform each Medicaid recipient who receives personal care services, attendant care services, or other services identified by the commission that the health care provider providing the services and the recipient are each required to comply with the electronic visit verification system. A managed care organization that contracts with the commission to provide health care services to Medicaid recipients described by this subsection shall also inform recipients enrolled in a managed care plan offered by the organization of those requirements.

Revised Law

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).)

Source Law

(f) A health care provider that provides personal care services, attendant care services, or other services identified by the commission to Medicaid recipients shall:

(1) use an electronic visit verification system to document the provision of those services;

(2) comply with all documentation requirements established by the commission;

(3) comply with applicable federal and state laws regarding confidentiality of recipients' information;

(4) ensure that the commission or the 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 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.

Revisor's Note

Section 531.024172(f)(1), Government Code, requires certain health care providers to use "an electronic visit verification system." Section 531.024172(g), Government Code, revised as Section 532.0258(a) of this chapter, authorizes a health care provider to use a proprietary electronic visit verification system if allowed by the Health and Human Services Commission. It is clear that "an electronic visit verification system" referenced in Section 531.024172(f)(1) could mean either the system

implemented under Section 531.024172, which is revised in relevant part as Section 532.0253 of this chapter, or the proprietary system authorized by Section 531.024172(g). For clarity, the revised law refers to "the electronic visit verification system," which is defined by Section 532.0251 of this chapter to mean the system implemented under Section 532.0253 of this chapter, and to "a proprietary system the commission allows as provided by Section 532.0258."

Revised Law

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).)

Source Law

> (g) 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 section and allow the health care provider to use that system for a period determined by the commission if the commission determines that the system:
>
> (1) complies with all necessary data submission, exchange, and reporting requirements established under this section; and
>
> (2) meets all other standards and requirements established under this section.
>
> (g-1) If feasible, the executive commissioner shall ensure a health care provider that uses the provider's proprietary electronic visit verification system recognized under Subsection (g) is reimbursed for the use of that system.
>
> (g-2) For purposes of facilitating the use of proprietary electronic visit verification systems by health care providers under Subsection (g) and in consultation with industry stakeholders and the work group established under Subsection (h), the commission or the executive commissioner, as appropriate, shall:
>
> (1) develop an open model system that mitigates the administrative burdens identified by providers required to use electronic visit verification;
>
> (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.

Revised Law

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).)

Source Law

(h) The commission shall create a stakeholder work group comprised of representatives of affected health care providers, managed care organizations, and Medicaid recipients and periodically solicit from that work group input regarding the ongoing operation of the electronic visit verification system under this section.

Revisor's Note

Section 531.024172(h), Government Code, refers to "affected . . . managed care organizations," meaning managed care organizations affected by the electronic visit verification system described in Section 531.024172, which is revised as this subchapter. The only type of managed care organization that would be affected by the electronic visit verification system is a Medicaid managed care organization. For the reasons stated in the revisor's note to Section 532.0153 of this chapter, the revised law substitutes "Medicaid managed care organizations" for the reference to "managed care organizations."

Revised Law

Sec. 532.0260. RULES. The executive commissioner may adopt rules necessary to implement this subchapter. (Gov. Code, Sec. 531.024172(i).)

Source Law

(i) The executive commissioner may adopt rules necessary to implement this section.

SUBCHAPTER G. APPLICANTS AND RECIPIENTS

Revised Law

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 benefits 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.)

Source Law

Sec. 531.0212. MEDICAID 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 person enrolled in Medicaid.

(b) The bill of rights must address a client's right to:

(1) respect, dignity, privacy, confidentiality, and nondiscrimination;

(2) a reasonable opportunity to choose a health care 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 client'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 client's responsibility to:

(1) learn and understand each right the client has under Medicaid;

(2) abide by the health plan and Medicaid policies and procedures;

(3) share information relating to the client'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 client's health.

Revisor's Note

Section 531.0212(b)(2), Government Code, refers to a Medicaid recipient's opportunity to choose a "health care plan," and Section 531.0212(c)(2), Government Code, refers to that recipient's responsibility to follow the "health plan" policies and procedures. The revised law substitutes "health benefits plan" for the quoted phrases because that is the term more commonly used to reference that type of plan offered by a managed care organization.

Revised Law

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).)

Source Law

> Sec. 531.024. PLANNING AND DELIVERY OF HEALTH SERVICES; DATA SHARING. (a) The executive commissioner shall:
>
> . . .
>
> (7) promulgate uniform fair hearing rules for all Medicaid-funded services.
>
> (b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services and to a Medicaid recipient who seeks a Medicaid service, including a service that requires prior authorization. The rules must provide the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:
>
> (1) the written notice to an individual of the individual's right to a hearing must:
>
> (A) contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and

(B) 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

(2) if a hearing is requested before the date a Medicaid 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:

(A) it is determined at the hearing that the sole issue is one of federal or state law or policy; and

(B) the agency promptly informs the recipient in writing that services are to be terminated, suspended, or reduced pending the hearing decision.

(c) The commission shall develop a process to address a situation in which:

(1) an individual does not receive adequate notice as required by Subsection (b)(1); or

(2) the notice required by Subsection (b)(1) is delivered without a postmark.

Revised Law

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 Section ___ [[[Section 533.00253]]]; 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.)

Source Law

Sec. 531.0213. SUPPORT SERVICES FOR MEDICAID RECIPIENTS. (a) The commission shall provide support and information services to a person enrolled in or applying for Medicaid coverage who experiences barriers to receiving health care services.

(b) The commission shall give emphasis to assisting a person with an urgent or immediate medical or support need.

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

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

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

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

(4) area agencies on aging;

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

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

(c) The commission may provide support and information services by contracting with 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 required by this section, the commission shall:

(1) operate a statewide toll-free assistance telephone number that includes relay services for persons with speech or hearing disabilities and assistance for persons who speak Spanish;

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

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

(4) educate persons so that they:

(A) understand the concept of managed care;

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

(C) are able to advocate for themselves;

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

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

(B) identify trends in delivery and access problems;

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

(D) indicate other problems identified with Medicaid managed care;

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

(7) meet the needs of all current and future Medicaid managed care recipients, including children receiving dental benefits and other recipients receiving benefits, under the:

(A) STAR Medicaid managed care program;

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

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

(D) STAR Health program;

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

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

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

Revisor's Note

Section 531.0213(d)(2), Government Code, requires the Health and Human Services Commission, as part of the information and services required to be provided to a Medicaid applicant or recipient under Section 531.0213, to intervene with "managed care organizations and providers" on behalf of an individual with urgent medical needs, and Section 531.0213(d)(6), Government Code, requires the

commission to assist "managed care organizations and providers" in identifying and correcting problems as part of the information and services. The revised law substitutes "Medicaid managed care organizations and providers" for the quoted phrases because it is clear from the context that the provisions apply only to managed care organizations and providers participating in Medicaid.

Revised Law

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.)

Source Law

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

(b) If cost-effective, the commission shall develop an objective assessment process for use in

assessing a Medicaid recipient's needs for acute nursing services. If the commission develops an objective assessment process under this section, the commission shall require that:

(1) the assessment be conducted:

(A) by a state employee or contractor who is a registered nurse who is licensed to practice in this state and who is not the person who will deliver any necessary services to the recipient and is not affiliated with the person who will deliver those services; and

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

(2) the process include:

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

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

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

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

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

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

(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 shall be waived if the recipient's need for therapy services has been established by a recommendation from a therapist providing care prior to discharge of the recipient from a licensed hospital or nursing home. The assessment may not be waived if the recommendation is made by a therapist who will deliver any services to the recipient or is affiliated with a person who will deliver those services when the recipient is discharged from the licensed hospital or nursing home.

(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.

Revisor's Note

Section 531.02417(d), Government Code, refers to a "nursing home." The revised law substitutes "nursing facility" for "nursing home" because the terms are synonymous and for consistency of

terminology throughout Subtitle I, Title 4, Government Code, which includes this chapter.

Revised Law

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.)

Source Law

Sec. 531.024171. 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 531.02417, the commission shall consider whether implementing age- and diagnosis-appropriate objective assessment processes for assessing the needs of a Medicaid recipient 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 provider of therapy services to request and obtain a review of the results of an assessment conducted as provided by this section that is comparable to the process implemented under rules adopted under Section 531.02417(e).

Revised Law

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.)

Source Law

Sec. 531.0981. WELLNESS SCREENING PROGRAM. If cost-effective, the commission may implement a wellness screening program for Medicaid recipients designed to evaluate a recipient's risk for having certain diseases and medical conditions for purposes of establishing a health baseline for each recipient that may be used to tailor the recipient's treatment plan or for establishing the recipient's health goals.

Revised Law

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).)

Source Law

Sec. 531.02192. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES. (a) In this section:

. . .

(2) "Federally qualified health center services" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(A).

(3) . . . "rural health clinic services" have the meanings 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 Medicaid 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).

Revisor's Note

(1) Section 531.02192(a), Government Code, defines "federally qualified health center," "federally qualified health center services," "rural health clinic," and "rural health clinic services" for purposes of Section 531.02192, Government Code. However, "federally qualified health center" is not used in the section independently from "federally qualified health center services," and "rural health clinic" is not used in the section independently from "rural health clinic services," and the revised law omits the definitions of those terms as unnecessary. The omitted law reads:

[(a) In this section:]

(1) "Federally qualified health center" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(B).

. . .

(3) "Rural health clinic" and . . . [have the meanings assigned by 42 U.S.C. Section 1396d(l)(1).]

(2) Section 531.02192(b), Government Code, refers to "any provision of this chapter," meaning Chapter 531, Government Code, "or any other law." Chapter 531 is revised throughout Subtitle I, Title 4, Government Code, including in this chapter. The revised law substitutes a reference to "any provision of this chapter . . . or any other law" for the quoted phrases because the provisions of Chapter 531 that are not revised in this chapter are included within the meaning of "any other law."

SUBCHAPTER H. PROGRAMS AND SERVICES FOR CERTAIN CATEGORIES OF MEDICAID POPULATION

Revised Law

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.)

Source Law

Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a) The executive commissioner may seek a waiver under Section 1115 of the federal 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 for those recipients;

(3) improve those recipients' access to services;

(4) achieve cost containment and efficiency; and

(5) 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 Medicaid 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 Medicaid recipients.

(c) If the commission develops tailored benefit packages under Subsection (b)(2), the commission shall submit a report to the standing committees of the senate and house of representatives having primary jurisdiction over Medicaid that specifies, in detail, the categories of Medicaid 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 under this section and determine the respective categories of Medicaid recipients to which the packages apply in a manner that preserves recipients' access to necessary services and is consistent with federal requirements.

(e) Each tailored benefit package developed under this section must include:

(1) a basic set of benefits that are provided under all tailored benefit packages; and

(2) to the extent applicable to the category of Medicaid 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.

(f) In addition to the benefits required by Subsection (e), a tailored benefit package developed under this section that applies to Medicaid recipients who are children must provide at least the services required by federal law under the early and periodic screening, diagnosis, and treatment program.

(g) A tailored benefit package developed under this section may include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventive health or wellness service.

(g-1) A tailored benefit package developed under this section must increase the 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 Medicaid recipient population.

(h) In developing the tailored benefit packages, the commission shall consider similar benefit packages established in other states as a guide.

(i) 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) persons with disabilities or special health needs;

(2) elderly persons;

(3) children without special health care needs; and

(4) working-age parents and caretaker relatives.

Revised Law

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 money to maximize the receipt of federal Medicaid matching money 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 money. (Gov. Code, Sec. 531.0226.)

Source Law

Sec. 531.0226. CHRONIC HEALTH CONDITIONS SERVICES MEDICAID WAIVER PROGRAM. (a) If feasible and cost-effective, the commission may apply for a waiver from the federal Centers for Medicare and Medicaid Services or another appropriate federal agency to more efficiently leverage the use of state and local funds in order to maximize the receipt of federal Medicaid matching funds by providing benefits under Medicaid 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 under this section, the commission shall:

(1) ensure that the 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 received by an individual 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.

Revised Law

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.)

Source Law

Sec. 531.02444. MEDICAID BUY-IN PROGRAMS FOR CERTAIN PERSONS WITH DISABILITIES. (a) The executive commissioner shall develop and implement:

(1) a Medicaid buy-in program for persons 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) as authorized by the Deficit Reduction Act of 2005 (Pub. L. No. 109-171), a Medicaid buy-in program for children with disabilities that is described by 42 U.S.C. Section 1396a(cc)(1) whose family incomes do not exceed 300 percent of the applicable federal poverty level.

(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 participants in the program to pay premiums or cost-sharing payments, subject to Subsection (c).

(c) Rules adopted by the executive commissioner 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).

Revisor's Note

Section 531.02444(a)(2), Government Code, refers to the Medicaid buy-in program for children with disabilities "that is described by 42 U.S.C. Section 1396a(cc)(1)." 42 U.S.C. Section 1396a(cc)(1) describes the children with disabilities who are eligible for the Medicaid buy-in program, not the program itself. The revised law is drafted accordingly.

SUBCHAPTER I. UTILIZATION REVIEW, PRIOR AUTHORIZATION, AND COVERAGE PROCESSES AND DETERMINATIONS

Revised Law

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.)

Source Law

> Sec. 531.076. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. (a) The commission shall periodically review in accordance with an established schedule the prior authorization and utilization review processes within the Medicaid fee-for-service delivery model to determine if those processes need modification to reduce authorizations of unnecessary services and inappropriate use of services. The commission shall also monitor the processes described in this subsection for anomalies and, on identification of an anomaly in a process, shall review the process for modification earlier than scheduled.
>
> (b) The commission shall 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.

Revised Law

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 _____ [[[Section 533.00283]]], 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.)

Source Law

> Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING MEDICAID 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 Medicaid 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 up-to-date catalogue 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 the prior authorization requirement conducted under Section 533.00283, 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 Medicaid 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.

Revised Law

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 _____ [[[Section 533.00284]]], 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.)

Source Law

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (a) The commission shall ensure

that notice sent by the commission or a Medicaid managed care organization to a Medicaid recipient or 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 applicable 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 sent to the provider; and

(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and 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 Medicaid recipient on whose behalf the request was submitted. The notice issued under this subsection 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 533.00284, 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 531.024163; 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.

Revised Law

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.)

Source Law

Sec. 531.024164. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" and "reviewer" mean 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 applicable 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 Medicaid 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) a denial by the commission of eligibility for a Medicaid program in which eligibility is based on a Medicaid 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 a common procedure for reviews. To the greatest extent possible, the procedure must reduce administrative burdens on providers and the submission of duplicative information or documents. Medical necessity under the procedure must be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The reviewer shall conduct the review within a period specified by the commission. The commission shall also establish a procedure and time frame for expedited reviews that allows the reviewer to:

(1) identify an appeal that requires an expedited resolution; and

(2) resolve the review of the appeal within a specified period.

(f) A Medicaid recipient or 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) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing and is granted when a Medicaid 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.

(g) The external medical reviewer's determination of medical necessity establishes the minimum level of services a Medicaid recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

(h) 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.

(i) To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations reviewed by the external medical reviewer, including the rate of prior authorization denials overturned by the external medical reviewer and additional information the commission and the external medical reviewer determine appropriate.

SUBCHAPTER J. COST-SAVING INITIATIVES

Revised Law

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.)

Source Law

Sec. 531.085. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES. (a) The commission shall develop and implement a comprehensive plan to reduce the use of hospital emergency room services by recipients under Medicaid. The plan may include:

(1) a pilot program designed to facilitate program participants in accessing an appropriate level of health care, which may include as components:

(A) providing program participants access to bilingual health services providers; and

(B) giving program participants information on how to access primary care physicians, advanced practice registered nurses, and local health clinics;

(2) a pilot program under which health care providers, other than hospitals, are given financial incentives for treating recipients outside of normal business hours to divert those recipients from hospital emergency rooms;

(3) payment of a nominal referral fee to hospital emergency rooms that perform an initial medical evaluation of a recipient and subsequently refer 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 managed care organization that enters into a contract with the commission under Chapter 533 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 hospital emergency rooms;

(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 under Medicaid 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 the health care needs of their children 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

hospital emergency rooms.

(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 federal 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 Medicaid 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.

Revised Law

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.)

Source Law

Sec. 531.0861. 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 the use of hospital emergency room services for non-emergent conditions by recipients under Medicaid.

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

(c) If the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, the executive commissioner shall implement controls to ensure that the after-hours services billed are actually being provided outside of normal business hours.

Revisor's Note

Section 531.0861(b), Government Code, refers to a study conducted under "former Section 531.086," Government Code. Section 531.086 required the Health and Human Services Commission to conduct a study to evaluate physician incentive programs that attempt to reduce Medicaid recipients' hospital emergency room use for non-emergent conditions. Section 531.086(d) provided that the section expired September 1, 2014. The revised law includes a reference to the expiration date for the convenience of the reader.

Revised Law

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.)

Source Law

Sec. 531.0862. CONTINUED IMPLEMENTATION OF

CERTAIN INTERVENTIONS AND BEST PRACTICES BY PROVIDERS; BIANNUAL REPORT. (a) The commission shall encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid 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 federal 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 biannually prepare and submit a report to the legislature that contains a summary of the commission's efforts under this section and Section 531.085(b).

Revised Law

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 money remaining in the recipient's health savings account. (Gov. Code, Sec. 531.0941.)

Source Law

> Sec. 531.0941. MEDICAID 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 health care cost awareness and sensitivity by adult recipients; and
>
> (2) promote appropriate utilization of Medicaid services by adult recipients.
>
> (b) If the commission implements the pilot program, the commission may only include adult recipients as participants in the program.
>
> (c) If the commission implements the pilot program, the commission shall ensure that:
>
> (1) participation in the pilot program is voluntary; and
>
> (2) a recipient who participates in the pilot program may, at the recipient's option and subject to Subsection (d), discontinue participation in the program and resume receiving benefits and services under the traditional Medicaid delivery model.
>
> (d) A recipient who chooses to discontinue participation 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.

Revised Law

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).)

Source Law

Sec. 531.0843. DURABLE MEDICAL EQUIPMENT REUSE PROGRAM. (a) In this section:

(1) "Complex rehabilitation technology equipment" means equipment that is classified as durable medical equipment under the Medicare program on January 1, 2013, 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 medically necessary to prevent the individual's hospitalization or institutionalization. The term 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 a person 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 under the Medicaid program.

(c) The program must include provisions for ensuring that:

(1) reused equipment meets applicable standards of functionality and sanitation; and

(2) a Medicaid recipient's participation in the reuse program is voluntary.

(d) The program does not:

(1) waive any immunity from liability of the commission or an employee of the commission; or

(2) create a cause of action against the commission or an employee of the commission arising from the provision of reused durable medical equipment under the program.

Revisor's Note

Section 531.0843(e), Government Code, requires the executive commissioner of the Health and Human Services Commission to provide notice of each proposed rule, adopted rule, and hearing in accordance with Chapter 551 or 2001, Government Code, as applicable. Chapter 551, Government Code, requires a governmental body to give notice of each meeting held by the governmental body. See Section 551.041, Government Code. Section 551.001 of that chapter defines "governmental body" for purposes of the chapter in a manner that includes the Health and Human Services Commission. Chapter 2001, Government Code, requires a state agency to give notice of proposed rules and to file adopted rules with the office of the secretary of

state for publication in the Texas Register. See Sections 2001.023 and 2001.036(c), Government Code. Section 2001.003 of that chapter defines "state agency" for purposes of the chapter in a manner that includes the Health and Human Services Commission. The notice requirements of Chapters 551 and 2001 apply by their own terms. Therefore, the revised law omits the requirements of Section 531.0843(e) as unnecessary. The omitted law reads:

> (e) In accordance with Chapter 551 or 2001, as applicable, the executive commissioner shall provide notice of each proposed rule, adopted rule, and hearing that relates to establishing the program under this section.