BILL ANALYSIS

C.S.S.B. 10
By: Nelson
Appropriations
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The federal Deficit Reduction Act of 2005 included provisions that give states additional flexibility in the way Medicaid is administered. The Senate Committee on Health and Human Services was charged during the interim with monitoring state and federal Medicaid reform proposals, including their impact on the Medicaid program in Texas, as well as cost-containment measures in other states. The committee made recommendations in its interim report based on those reform measures that were considered most applicable to the Texas Medicaid program.

C.S.S.B. 10 enacts the recommendations of the Senate Committee on Health and Human Services with the goal of improving the Texas Medicaid program by focusing on prevention, individual choice, better planning, modernizing services, reducing Texas' rate of uninsured, and helping Texans to live longer, healthier lives.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 1, 2, 3, 5, 6, and 13 of the bill.

It is the committee's opinion that rulemaking authority granted to the commissioner of insurance relating to continuing education credits for participation in a training program is referenced in SECTION 11 of the bill.

It is the committee's opinion that rulemaking authority previously granted to the former Texas Department of Health is statutorily updated, due to the organizational changes implemented by HB 2292, 78th Legislature, Regular Session, 2003, to reflect that the executive commissioner of the Health and Human Services Commission exercises that authority, in SECTION 11 of the bill.

ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02114 and 531.02192 to read, as follows:

> Sec. 531.02114. PILOT PROJECT TO SIMPLIFY, STREAMLINE, AND REDUCE COSTS ASSOCIATED WITH MEDICAID COST REPORTING AND AUDITING PROCESS FOR CERTAIN PROVIDERS. (a) The bill defines the terms "Pilot project" and "Provider."
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> (b) Requires the Health and Human Services Commission (commission) to develop and implement a pilot project to simplify, streamline, and reduce costs associated with the Medicaid cost reporting and auditing process for private ICF-MR facilities and home and community-based services waiver program providers.
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> (c) Requires the executive commissioner of the Health and Human Services Commission (executive commissioner) by rule, with the assistance of the work group established under Subsection (d), to adopt cost reporting and auditing processes and guidelines similar to standard business financial reporting processes and guidelines. The rules must:

(1) require that cost report forms: not exceed 20 letter-size pages in length, including any appendices; and be distributed to providers at least one month before the beginning of the applicable reporting period;

(2) require that a provider summarize information regarding program revenue, administrative costs, central office costs, facility costs, and direct-care costs, including the hourly wage detail of direct-care staff;

(3) allow a provider to electronically submit cost reports;

(4) require the filing of cost reports in alternating years as follows: in even-numbered years, private ICF-MR facility providers; and in odd-numbered years, home and community-based services waiver program providers;

(5) allow a provider to request and receive from the commission information, including reports, relating to the services provided by the provider that is maintained by the commission in a database or under another program or system to facilitate the cost reporting process; and

(6) require that each provider receive a full audit by the commission's office of inspector general at least once during the period the pilot project is in operation.

(d) Requires the commission, in developing the pilot project, to establish a work group that reports to the executive commissioner and is responsible for:

(1) developing and proposing cost report forms and processes, audit processes, and rules necessary to implement the pilot project;

(2) developing: a plan for monitoring the pilot project's implementation; and recommendations for improving and expanding the pilot project to other Medicaid programs;

(3) establishing an implementation date for the pilot project that allows the commission to have sufficient information related to the pilot project for purposes of preparing the commission's legislative appropriations request for the state fiscal biennium beginning September 1, 2009;

(4) monitoring wage levels of the direct-care staff of providers to assess the value and need for minimum spending levels; and

(5) submitting a quarterly report to the lieutenant governor, the speaker of the house of representatives, the senate finance committee, and the house appropriations committee regarding the status of the pilot project.

(e) Requires the executive commissioner to determine the number of members of the work group described by Subsection (d). Requires the executive commissioner to ensure that the work group includes members who represent:

(1) public and private providers of ICF-MR services and home and community-based waiver program services;

(2) experienced cost report preparers who have received cost report training from the commission;

(3) accounting firms licensed under Chapter 901, Occupations Code, that are familiar with the provision of program services described by Subdivision (1);

(4) commission staff; and

(5) other interested stakeholders, as determined by the executive commissioner.

(f) Requires the commission, not later than September 1, 2012, to submit a report to the legislature that evaluates the operation of the pilot project, and makes recommendations regarding the continuation or expansion of the pilot project.

(g) Provides that this section expires September 1, 2013.

Sec. 531.02192. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES. (a) Defines "Federally qualified health center," "Federally qualified health center services," "Rural health clinic," and "rural health clinic services."

(b) Requires the commission, notwithstanding any provision of this chapter, Chapter 32, Human Resources Code, or any other law, to promote Medicaid recipient access to federally qualified health center services or rural health clinic services and to 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).

SECTION 2. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02413 and 531.02414, as follows:

Sec. 531.02413. BILLING COORDINATION SYSTEM. (a) If cost-effective and feasible, the commission is required, on or before September 1, 2008, to contract for the implementation of an acute care billing coordination system (system) that will, on submission at the point of service of a claim for a service provided to a Medicaid recipient by a Medicaid provider, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the issuer the system determines is the primary payor.

(b) Requires the executive commissioner to adopt rules for the purpose of enabling the system to identify an entity with primary responsibility for paying a claim and to establish reporting requirements for any entity that may have a contractual responsibility to pay for the types of acute care services provided under the Medicaid program.

(c) Provides that an entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state must allow the contractor under Subsection (a) 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 subchapter, and the entity 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 of a rule adopted under this subchapter.

(d) Requires that after March 1, 2009, no public funds 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) Provides that information obtained under this section is confidential, and authorizes the contractor to use the information only for purposes authorized under this section. Provides that a person commits an offense if the person knowingly uses information obtained under this section for any purpose not authorized under this section, and that an offense under this subsection is a Class B misdemeanor.

(f) In addition to the criminal penalty under Subsection (e), a person who violates that subsection is subject to any applicable administrative or civil penalty imposed under state or federal law.

(g) Establishes that providing a person access to or transmitting or otherwise using information obtained under this section must be done in a manner that is consistent with all applicable state and federal law, including rules.

Sec. 531.02414. ADMINISTRATION AND OPERATION OF MEDICAL TRANSPORTATION PROGRAM. (a) The bill defines the term "medical transportation program."

(b) Requires the commission, notwithstanding any other law, to directly supervise the administration and operation of the medical transportation program.

(c) Prohibits the commission, notwithstanding any other law, from delegating its duty to supervise the medical transportation program to any other person,

including through a contract with the Texas Department of Transportation (TxDOT) for it to assume any of the commission's responsibilities relating to the provision of services through that program.

(d) Authorizes the commission to contract with a public transportation provider, as defined by Section 461.002, Transportation Code, a private transportation provider, or a regional transportation broker for the provision of public transportation services, as defined by Section 461.002, Transportation Code, under the medical transportation program.

(b) Amends Section 531.02412(b), Government Code, as follows:

(b) Makes a conforming change to reflect the newly added prohibition in Section 531.02414(c) against delegation by the commission of its duty to supervise the medical transportation program.

(c) Amends Section 455.0015, Transportation Code, by amending Subsection (c) and adding Subsection (c-1), as follows:

(c) Makes a conforming change to reflect the newly added prohibition in Section (c-1) against the commission contracting with TxDOT to provide transportation services under the medical transportation program. Deletes text referring to the Texas Department of Health.

(c-1) Prohibits the commission from contracting with TxDOT to assume any responsibilities of the commission relating to the provision of transportation services under the medical transportation program, as defined by Section 531.02414, Government Code.

(d) Requires the commission to take any action allowed under state law that is necessary to terminate or modify a contract prohibited by Section 455.0015(c-1), Transportation Code, as added by this section, and to ensure compliance with Section 531.02414, Government Code, as added by this section, as soon as possible after the effective date of this section. On the date a contract termination or modification as described by this subsection takes effect all powers, duties, functions, activities, property, and records related to the medical transportation program, as defined by Section 531.02414, Government Code, as added by this section, are transferred to the commission, and a reference in law to the Texas Department of Transportation with respect to that program means the commission.

SECTION 3. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.094, 531.0941, 531.097, and 531.0971, as follows:

Sec. 531.094. PILOT PROGRAM AND OTHER PROGRAMS TO PROMOTE HEALTHY LIFESTYLES. (a) Requires the commission to develop and implement a pilot program in one region of this state under which Medicaid recipients are provided positive incentives to lead healthy lifestyles, including through participating in certain health-related programs or engaging in certain health-conscious behaviors, thereby resulting in better health outcomes for those recipients.

(b) Authorizes the commission, except as provided by Subsection (c), in implementing the pilot program, to provide:

(1) expanded health care benefits or value-added services for Medicaid recipients who participate in certain programs, such as specified weight loss or smoking cessation programs;

(2) individual health rewards accounts that allow Medicaid recipients who follow certain disease management protocols to receive credits in the accounts that may be exchanged for health-related items specified by the commission that are not covered by Medicaid; and

(3) any other positive incentive the commission determines would promote healthy lifestyles and improve health outcomes for Medicaid recipients.

(c) Requires the commission to consider similar incentive programs implemented in other states to determine the most cost-effective measures to implement in the pilot program under this section.

(d) Requires the commission, not later than December 1, 2010, to submit a report to the legislature that describes the operation of the pilot program; analyzes the effect of the incentives provided under the pilot program on the health of program participants; and makes recommendations regarding the continuation or expansion of the pilot program.

(e) Authorizes the commission, in addition to developing and implementing the pilot program under this section, if feasible and cost-effective, to develop and implement an additional incentive program to encourage Medicaid recipients who are younger than 21 years of age to make timely health care visits under the early and periodic screening, diagnosis, and treatment program. The commission shall provide incentives under the program for managed care organizations contracting with the commission under Chapter 533 and Medicaid providers to encourage those organizations and providers to support the delivery and documentation of timely and complete health care screenings under the early and periodic screening, diagnosis, and treatment program.

(f) Provides that this section expires September 1, 2011.

Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a) Requires the commission, if it determines that it is cost-effective and feasible, to develop and implement a Medicaid health savings account pilot program that is consistent with federal law to encourage health care cost awareness and sensitivity by adult recipients, and promote appropriate utilization of Medicaid services by adult recipients.

(b) Provides that if the commission implements the pilot program, the commission may only include adult recipients as participants in the program.

(c) Requires the commission, if it implements the pilot program, to ensure that participation is voluntary and that 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) Establishes that 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.

Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a) Authorizes the executive commissioner to 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), to 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) Provides that 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) Requires the commission, if it develops tailored benefit packages under Subsection (b)(2), to submit a report to the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program that specifies, in detail, the categories of Medicaid recipients to which each of those packages will apply and the services available under each package. Prohibits the commission from implementing a package developed under Subsection (b)(2) before September 1, 2009.

(d) Provides that 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) Provides that each tailored benefit package developed under this section must include: a basic set of benefits that are provided under all tailored benefit packages; and to the extent applicable to the category of Medicaid recipients to which the package applies: a set of benefits customized to meet the health care needs of recipients in that category; and services to integrate the management of a recipient's acute and long-term care needs, to the extent feasible.

(f) Provides that, 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) Authorizes a tailored benefit package developed under this section to include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventive health or wellness service.

(g-1) Provides that 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) Requires the commission, in developing the tailored benefit packages, to consider similar benefit packages established in other states as a guide.

(i) Requires the executive commissioner, by rule, to 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.

(j) Provides that this section does not apply to a tailored benefit package or similar package of benefits if, before September 1, 2007:

(1) a federal waiver was requested to implement the package of benefits;

(2) the package of benefits is being developed, as directed by the legislature; or

(3) the package of benefits has been implemented.

Sec. 531.0971. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) Requires the commission to identify state or federal non-Medicaid programs that provide health care services to persons whose health care needs could be met by providing customized benefits through a system of care that is used under a Medicaid tailored benefit package implemented under Section 531.097.

(b) Requires the commission, if it determines that it is feasible and to the extent permitted by federal and state law to:

(1) provide the health care services for persons identified under Subsection (a) through the applicable Medicaid tailored benefit package; and

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

(b) Requires the commission, not later than September 1, 2008, to implement the pilot program under Section 531.094, Government Code, as added by this section.

SECTION 4. (a) Amends Subchapter C, Chapter 531, Government Code, by adding Section 531.1112, as follows:

Sec. 531.1112. STUDY CONCERNING INCREASED USE OF TECHNOLOGY TO STRENGTHEN FRAUD DETECTION AND DETERRENCE; IMPLEMENTATION. (a) Requires the commission and the commission's office of inspector general (inspector general) to jointly study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in the state Medicaid program. Provides that the study must include the determination of the feasibility of using technology to verify a person's citizenship and eligibility for coverage.

(b) Requires the commission to implement any methods it and the inspector general determine are effective at strengthening fraud detection and deterrence.

(b) Requires the commission, not later than December 1, 2008, to submit to the legislature a report detailing the findings of the study required by Section 531.1112, Government Code, as added by this section. Provides that the report must include a description of any method described by Subsection (b), Section 531.1112, Government Code, as added by this section, that the commission has implemented or intends to implement.

SECTION 5. (a) Chapter 531, Government Code, is amended by adding Subchapter N to read as follows:

SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND

Sec. 531.501. DEFINITION. The bill defines the term "fund."

Sec. 531.502. DIRECTION TO OBTAIN FEDERAL WAIVER. (a) Authorizes the executive commissioner to seek a waiver under Section 1115 of the federal Social Security Act to the state Medicaid plan to allow the commission to more efficiently and effectively use federal money paid to this state under various programs to defray costs associated with providing uncompensated health care in this state by using that federal money, appropriated state money to the extent necessary, and any other money described by this section for purposes consistent with this subchapter.

(b) Authorizes the executive commissioner to include the following federal money in the waiver:

(1) all money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs;

(2) money provided by the federal government in lieu of some or all of the payments under those programs;

(3) any combination of funds authorized to be pooled by Subdivisions (1) and (2); and

(4) any other money available for that purpose, including federal money and money identified under Subsection (c).

(c) Requires the commission to seek to optimize federal funding by:

(1) identifying health care related state and local funds and program expenditures that, before September 1, 2007, are not being matched with federal money, and

(2) exploring the feasibility of:

(A) certifying or otherwise using those funds and expenditures as state expenditures for which this state may receive federal matching money; and

(B) depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 531.504, or substituting that federal matching money for federal money that otherwise would be received under the disproportionate share hospitals and upper payment limit supplemental payment programs as a match for local funds received by this state through intergovernmental transfers.

(d) Provides that the terms of a waiver approved under this section must:

(1) include safeguards to ensure that the total amount of federal money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs that is deposited as provided by Section 531.504 is, for a particular state fiscal year, at least equal to the greater of the annualized amount provided to this state under those supplemental payment programs during state fiscal year 2007, excluding amounts provided during that state fiscal year that are retroactive payments, or the state fiscal years during which the waiver is in effect; and

(2) allow for the development by this state of a methodology for allocating money in the fund to:

(A) offset, in part, the uncompensated health care costs incurred by hospitals;

(B) reduce the number of persons in this state who do not have health benefits coverage; and

(C) maintain and enhance the community public health infrastructure provided by hospitals.

(e) Requires the executive commissioner, in a waiver under this section, to seek to:

(1) obtain maximum flexibility with respect to using the money in the fund for purposes consistent with this subchapter;

(2) include an annual adjustment to the aggregate caps under the upper payment limit supplemental payment program to account for inflation, population growth, and other appropriate demographic factors that affect the ability of residents of this state to obtain health benefits coverage;

(3) ensure, for the term of the waiver, that the aggregate caps under the upper payment limit supplemental payment program for each of the three classes of hospitals are not less than the aggregate caps that applied during state fiscal year 2007; and

(4) to the extent allowed by federal law, including federal regulations, and federal waiver authority, preserve the federal supplemental payment program payments made to hospitals, the state match with respect to which is funded by intergovernmental transfers or certified public expenditures that are used to optimize Medicaid payments to safety net providers for uncompensated care, and preserve allocation methods for those payments, unless the need for the payments is revised through measures that reduce the Medicaid shortfall or uncompensated care costs.

(f) Requires the executive commissioner to seek broad-based stakeholder input in the development of the waiver under this section and to provide information to

stakeholders regarding the terms and components of the waiver for which the executive commissioner seeks federal approval.

(g) Requires the executive commissioner to seek the advice of the Legislative Budget Board before finalizing the terms and conditions of the negotiated waiver.

Sec. 531.503. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL TRUST FUND. Provides that subject to approval of the waiver authorized by Section 531.502, the Texas health opportunity pool trust fund (fund) is created as a trust fund outside the state treasury to be held by the comptroller and administered by the commission as trustee on behalf of residents of this state who do not have private health benefits coverage and health care providers providing uncompensated care to those persons. Authorizes the commission to make expenditures of money in the fund only for purposes consistent with this subchapter and the terms of the waiver authorized by Section 531.502.

Sec. 531.504. DEPOSITS TO FUND. (a) Requires the comptroller to deposit in the fund all federal money provided to this state under the disproportionate share hospitals and upper payment limit supplemental payment programs, and all other non-supplemental payment program federal money provided to this state that is included in the waiver authorized by Section 531.502, other than money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs to state-owned and operated hospitals and state money appropriated to the fund.

(b) Authorizes the commission and comptroller of public accounts (comptroller) to accept gifts, grants, and donations from any source for purposes consistent with this subchapter and the terms of the waiver. Requires the comptroller to deposit a gift, grant, or donation made for those purposes in the fund.

Sec. 531.505. USE OF FUND IN GENERAL; RULES FOR ALLOCATION. (a) Provides that except as otherwise provided by the terms of a waiver authorized by Section 531.502, money in the fund may be used:

(1) subject to Section 531.506, to provide reimbursements to health care providers that are based on the providers' costs related to providing uncompensated care; and compensate the providers for at least a portion of those costs;
(2) to reduce the number of persons in this state who do not have health benefits coverage;
(3) to reduce the need for uncompensated health care provided by hospitals in this state; and
(4) for any other purpose specified by this subchapter or the waiver.

(b) Requires the executive commissioner, on approval of the waiver, to seek input from a broad base of stakeholder representatives on the development of rules with respect to, and the administration of, the fund, and by rule, to develop a methodology for allocating money in the fund that is consistent with the terms of the waiver.

Sec. 531.506. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Authorizes money in the fund to be allocated to hospitals in this state and political subdivisions of this state to defray the costs of providing uncompensated health care in this state, except as otherwise provided by the terms of a waiver authorized by Section 531.502 and subject to Subsections (b) and (c).

(b) Provides that to be eligible for money from the fund under this section, a hospital or political subdivision must use a portion of the money to implement strategies that will reduce the need for uncompensated inpatient and outpatient care, including care provided in a hospital emergency room. Strategies that may be implemented by a hospital or political subdivision, as applicable, include:

(1) fostering improved access for patients to primary care systems or other programs that offer those patients medical homes, including the following programs:

(A) three share or multiple share programs;

(B) programs to provide premium subsidies for health benefits coverage; and

(C) other programs to increase access to health benefits coverage; and

(2) creating health care systems efficiencies, such as using electronic medical records systems.

(c) Provides that the allocation methodology adopted by the executive commissioner under Section 531.505(b) must specify the percentage of the money from the fund allocated to a hospital or political subdivision that the hospital or political subdivision must use for strategies described by Subsection (b).

Sec. 531.507. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Provides that except as otherwise provided by the terms of a waiver authorized by Section 531.502, money in the fund that is available to reduce the number of persons in this state who do not have health benefits coverage or to reduce the need for uncompensated health care provided by hospitals in this state may be used for purposes relating to increasing access to health benefits coverage for low-income persons, including:

(1) providing premium payment assistance to those persons through a premium payment assistance program developed under this section;

(2) making contributions to health savings accounts for those persons; and

(3) providing other financial assistance to those persons through alternate mechanisms established by hospitals in this state or political subdivisions of this state that meet certain criteria, as specified by the commission.

(b) Requires the commission and the Texas Department of Insurance (TDI) to jointly develop a premium payment assistance program designed to assist persons described by Subsection (a) in obtaining and maintaining health benefits coverage. The program may provide assistance in the form of payments for all or part of the premiums for that coverage. In developing the program, the executive commissioner shall adopt rules establishing:

(1) eligibility criteria for the program;

(2) the amount of premium payment assistance that will be provided under the program;

(3) the process by which that assistance will be paid; and

(4) the mechanism for measuring and reporting the number of persons who obtained health insurance or other health benefits coverage as a result of the program.

(c) Requires the commission to implement the premium payment assistance program developed under Subsection (b), subject to availability of money in the fund for that purpose.

Sec. 531.508. INFRASTRUCTURE IMPROVEMENTS. (a) Authorizes money in the fund to be used for purposes related to developing and implementing initiatives to improve the infrastructure of local provider networks that provide services to Medicaid recipients and low-income uninsured persons in this state, except as otherwise provided by the terms of a waiver authorized by Section 531.502 and subject to Subsection (c),

(b) Authorizes infrastructure improvements under this section to include developing and implementing a system for maintaining medical records in an electronic format.

(c) Provides that not more than 10 percent of the total amount of money in the fund used in a state fiscal year for purposes other than providing reimbursements

to hospitals for uncompensated health care may be used for infrastructure improvements described by Subsection (b).

(b) Provides that if the executive commissioner obtains federal approval for a waiver under Section 531.502, Government Code, as added by this section, the executive commissioner shall submit a report to the Legislative Budget Board that outlines the components and terms of that waiver as soon as possible after federal approval is granted.

SECTION 6. (a) Amends Chapter 531, Government Code, by adding Subchapter O as follows:

SUBCHAPTER O. UNCOMPENSATED HOSPITAL CARE

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS. (a) Requires the executive commissioner to adopt rules providing for:

(1) a standard definition of "uncompensated hospital care";

(2) a methodology to be used by hospitals in this state to compute the cost of that care that incorporates the standard set of adjustments described by Section 531.552(g)(4); and

(3) procedures to be used by those hospitals to report the cost of that care to the commission and to analyze that cost.

(b) Authorizes the rules adopted by the executive commission under Subsection (a)(3) to provide for procedures by which the commission is authorized to periodically verify the completeness and accuracy of the information reported by hospitals.

(c) Requires the commission to notify the attorney general of a hospital's failure to report the cost of uncompensated care on or before the date the report was due in accordance with rules adopted under Subsection (a)(3). Requires the attorney general, on receipt of the notice, to impose an administrative penalty on the hospital in the amount of $1,000 for each day after the date the report was due that the hospital has not submitted the report, not to exceed $10,000.

(d) Requires the commission, if it determines through the procedures adopted under Subsection (b) that a hospital submitted a report with incomplete or inaccurate information, to notify the hospital of the specific information the hospital must submit and prescribe a date by which the hospital must provide that information. Requires the commission, if the hospital fails to submit the specified information on or before the date prescribed by the commission, to notify the attorney general of that failure. Requires the attorney general, on receipt of the notice, to impose an administrative penalty on the hospital in an amount not to exceed $10,000. Requires the attorney general, in determining the amount of the penalty to be imposed, to consider the seriousness of the violation, whether the hospital had previously committed a violation, and the amount necessary to deter the hospital from committing future violations.

(e) Provides that a report by the commission to the attorney general under Subsection (c) or (d) must state the facts on which the commission based its determination that the hospital failed to submit a report or failed to completely and accurately report information, as applicable.

(f) Requires the attorney general to give written notice of the commission's report to the hospital alleged to have failed to comply with a requirement. The notice must include a brief summary of the alleged violation, a statement of the amount of the administrative penalty to be imposed, and a statement of the hospital's right to a hearing on the alleged violation, the amount of the penalty, or both.

(g) Provides that not later than the 20th day after the date the notice is sent under Subsection (f), the hospital must make a written request for a hearing or remit the amount of the administrative penalty to the attorney general. Failure to timely request a hearing or remit the amount of the administrative penalty results in a

waiver of the right to a hearing under this section. Requires the attorney general, if the hospital timely requests a hearing, to conduct the hearing in accordance with Chapter 2001, Government Code. Requires that attorney general, if the hearing results in a finding that a violation has occurred, to provide to the hospital written notice of the findings established at the hearing and the amount of the penalty, and enter an order requiring the hospital to pay the amount of the penalty.

(h) Requires the hospital, not later than the 30th day after the date the hospital receives the order entered by the attorney general under Subsection (g), to:

(1) pay the amount of the administrative penalty;

(2) remit the amount of the penalty to the attorney general for deposit in an escrow account and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both; or

(3) without paying the amount of the penalty, file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both and file with the court a sworn affidavit stating that the hospital is financially unable to pay the amount of the penalty.

(i) Establishes that the attorney general's order is subject to judicial review as a contested case under Chapter 2001, Government Code.

(j) Requires the attorney general, if the hospital paid the penalty and on review the court does not sustain the occurrence of the violation or finds that the amount of the administrative penalty should be reduced, to remit the appropriate amount to the hospital not later than the 30th day after the date the court's judgment becomes final.

(k) Provides that if the court sustains the occurrence of the violation:

(1) the court shall order the hospital to pay the amount of the administrative penalty; and may award to the attorney general the attorney's fees and court costs incurred by the attorney general in defending the action; and

(2) the attorney general shall remit the amount of the penalty to the comptroller for deposit in the general revenue fund.

(l) Authorizes the attorney general to enforce the penalty as provided by law for legal judgments, if the hospital does not pay the amount of the administrative penalty after the attorney general 's order becomes final for all purposes.

Sec. 531.552. WORK GROUP ON UNCOMPENSATED HOSPITAL CARE. (a) Defines "work group."

(b) Requires the executive commissioner to establish the work group on uncompensated hospital care (work group) to assist the executive commissioner in developing rules required by Section 531.551 by performing the functions described by Subsection (g).

(c) Requires the executive commissioner to determine the number of members of the work group, and to ensure that the work group includes representatives from the office of the attorney general and the hospital industry. Establishes that a member of the work group serves at the will of the executive commissioner.

(d) Requires the executive commissioner to designate a member of the work group to serve as presiding officer. Requires the members of the work group to elect any other necessary officers.

(e) Requires the work group to meet at the call of the executive commissioner.

(f) Provides that a member of the work group may not receive compensation for serving on the work group, but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the work group as provided by the General Appropriations Act.

(g) Requires the work group to study and advise the executive commissioner in:

(1) identifying the number of different reports required to be submitted to the state that address uncompensated hospital care, care for low-income uninsured persons in this state, or both;

(2) standardizing the definitions used to determine uncompensated hospital care for purposes of those reports;

(3) improving the tracking of hospital charges, costs, and adjustments as those charges, costs, and adjustments relate to identifying uncompensated hospital care and maintaining a hospital's tax-exempt status;

(4) developing and applying a standard set of adjustments to a hospital's initial computation of the cost of uncompensated hospital care that account for all funding streams that are not patient-specific and are used to offset the hospital's initially computed amount of uncompensated care;

(5) developing a standard and comprehensive center for data analysis and reporting with respect to uncompensated hospital care; and

(6) analyzing the effect of the standardization of the definition of uncompensated hospital care and the computation of its cost, as determined in accordance with the rules adopted by the executive commissioner, on the laws of this state, and analyzing potential legislation to incorporate the changes made by the standardization.

(b) Requires the executive commissioner to establish the work group on uncompensated hospital care required by Section 531.552, Government Code, as added by this section, not later than October 1, 2007; and adopt the rules required by Section 531.551, Government Code, as added by this section, not later than January 1, 2009.

(c) Requires the executive commissioner to review the methodology used under the Medicaid disproportionate share hospitals supplemental payment program to compute low-income utilization costs to ensure that the Medicaid disproportionate share methodology is consistent with the standardized adjustments to uncompensated care costs described by Section 531.552(g)(4), Government Code, as added by this section, and adopted by the executive commissioner.

SECTION 7. Amends Chapter 531, Government Code, by adding Subchapter P, as follows:

SUBCHAPTER P. PHYSICIAN-CENTERED NURSING FACILITY MODEL DEMONSTRATION PROJECT

Sec. 531.601. DEFINITIONS. The bill defines the terms "Nursing facility" and "Project."

Sec. 531.602. PHYSICIAN-CENTERED NURSING FACILITY MODEL DEMONSTRATION PROJECT. (a) Authorizes the commission to develop and implement a demonstration project to determine whether paying an enhanced Medicaid reimbursement rate to a nursing facility that provides continuous, on-site oversight of residents by physicians specializing in geriatric medicine results in improved overall health of residents of that facility, and cost savings resulting from a reduction of acute care hospitalization and pharmaceutical costs.

(b) Authorizes the commission, in developing the project, to consider similar physician-centered nursing facility models implemented in other states to determine the most cost-effective measures to implement in the project under this subchapter.

(c) Authorizes the commission to consider whether the project could involve the Medicare program, subject to federal law and approval.

Sec. 531.603. REPORT. (a) Requires the commission, if it develops and implements the project, not later than December 1, 2008, to submit a preliminary status report to the governor,

the lieutenant governor, the speaker of the house of representatives, and the chairs of the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program. The report must describe the project, including the implementation and performance of the project during the preceding year; and evaluate the operation of the project.

(b) Requires the commission, if it develops and implements the project, to submit a subsequent report to the persons listed in Subsection (a) preceding the regular session of the 82nd Legislature. The report must make recommendations regarding the continuation or expansion of the project, to be determined based on the cost-effectiveness of the project, and if the commission recommends expanding the project, any necessary statutory or budgetary changes.

Sec. 531.604. EXPIRATION. This subchapter expires September 1, 2011.

SECTION 8. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0051 as follows:

Sec. 533.0051. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS. (a) Requires the commission to establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization (HMO) and the commission for the provision of health care services to recipients that is procured and managed under a value-based purchasing model (value-based contracts). Provides that the performance measures and incentives must be designed to facilitate and increase recipients' access to appropriate health care services.

(b) Requires the commission, subject to Subsection (c), to include the performance measures and incentives established under Subsection (a) in each contract described by that subsection in addition to all other contract provisions required by this chapter.

(c) Authorizes the commission to use a graduated approach to including the performance measures and incentives established under Subsection (a) in contracts described by that subsection to ensure incremental and continued improvements over time.

(d) Requires the commission to assess the feasibility and cost-effectiveness of including provisions in the contract described by Subsection (a) that require the HMO to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in the care of Medicaid recipients. Provides that if the commission determines that the provisions are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission will include the provisions in contracts with health maintenance organizations offering managed care plans in the region.

SECTION 9. (a) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.019 as follows:

Sec. 533.019. VALUE-ADDED SERVICES. Requires the commission to actively encourage managed care organizations that contract with the commission to offer benefits, including health care services or benefits or other types of services, that are in addition to the services ordinarily covered by the managed care plan offered by the managed care organization, and have the potential to improve the health status of enrollees in the plan.

(b) Provides that the changes in law made by Section 533.019, Government Code, as added by this section, apply to a contract between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this section. Requires the commission to seek to amend contracts entered into with managed care organizations under that chapter before the effective date of this

section to authorize those managed care organizations to offer value-added services to enrollees in accordance with Section 533.019, Government Code, as added by this section.

SECTION 10. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0214, as follows:

Sec. 32.0214. DESIGNATIONS OF PRIMARY CARE PROVIDER BY CERTAIN RECIPIENTS. (a) Requires the commission or an agency operating part of the medical assistance program, as appropriate (department), if the department determines that it is cost-effective and feasible and subject to Subsection (b), to require each recipient of medical assistance to designate a primary care provider with whom the recipient will have a continuous, ongoing professional relationship and who will provide and coordinate the recipient's initial and primary care, maintain the continuity of care provided to the recipient, and initiate any referrals to other health care providers.

(b) Requires a recipient who receives medical assistance through a Medicaid managed care model or arrangement under Chapter 533, Government Code, that requires the designation of a primary care provider to designate the recipient's primary care provider as required by that model or arrangement.

SECTION 11. Amends Section 32.0422, Human Resources Code, as follows:

Sec. 32.0422. HEALTH INSURANCE PREMIUM PAYMENT REIMBURSEMENT PROGRAM FOR MEDICAL ASSISTANCE RECIPIENTS. (a) Deletes the definition of "Department" and defines the terms "Commission," "Executive commissioner," and "Group health benefit plan." The bill makes conforming changes by replacing the term "department" with the term "commission" throughout SECTION 11.

(b) Makes conforming changes.

(b-1) Provides that to assist the commission in identifying individuals described by Subsection (b):

(1) Requires the commission to include on an application for medical assistance and on a form for recertification of a recipient's eligibility for medical assistance:

(A) an inquiry regarding whether the applicant or recipient, as applicable, is eligible to enroll in a group health benefit plan; and

(B) a statement informing the applicant or recipient, as applicable, that reimbursements for required premiums and cost-sharing obligations under the group health benefit plan may be available to the applicant or recipient; and

(2) Requires the office of the attorney general, not later than the 15th day of each month, to provide to the commission the name, address, and social security number of each newly hired employee reported to the state directory of new hires operated under Chapter 234, Family Code, during the previous calendar month.

(c) Requires the commission, to require an individual requesting medical assistance or a recipient, during the recipient's eligibility recertification review, to provide information as necessary relating to any group health benefit plan that is available to the individual or recipient through an employer of the individual or recipient or an employer of the individual's or recipient's spouse or parent to assist the commission in making the determination required by Subsection (d). Makes conforming changes.

(d) Makes conforming changes.

(e) Makes conforming changes.

(e-1) Provides that this subsection applies only to an individual who is identified under Subsection (b) as being eligible to enroll in a group health benefit plan offered by an employer. If the commission determines under Subsection (d) that enrolling the individual in the group health benefit plan is not cost-effective, but the individual prefers to enroll in that plan instead of receiving benefits and services under the medical

assistance program, the commission, if authorized by a waiver obtained under federal law, shall:

(1) allow the individual to voluntarily opt out of receiving services through the medical assistance program and enroll in the group health benefit plan;

(2) consider that individual to be a recipient of medical assistance; and

(3) provide written notice to the issuer of the group health benefit plan in accordance with Chapter 1207, Insurance Code.

(f) Requires the commission, except as provided by Subsection (f-1), to provide for payment of the employee's share of required premiums for coverage of an individual enrolled in the group health benefit plan, and any deductible, copayment, coinsurance, or other cost-sharing obligation imposed on the enrolled individual for an item or service otherwise covered under the medical assistance program. Makes conforming changes.

(f-1) Requires the commission, for an individual described by Subsection (e-1) who enrolls in a group health benefit plan, to provide for payment of the employee's share of the required premiums, except that if the employee's share of the required premiums exceeds the total estimated Medicaid costs for the individual, as determined by the executive commissioner, the individual is required to pay the difference between the required premiums and those estimated costs. Requires the individual to also pay all deductibles, copayments, coinsurance, and other cost-sharing obligations imposed on the individual under the group health benefit plan.

(g) Provides that a payment made by the commission under Subsection (f) or (f-1) is considered to be a payment for medical assistance. Makes conforming changes.

(h) Provides that a premium payment for an individual who is a member of the family of an individual enrolled in a group health benefit plan under Subsection (e), and who is not eligible for medical assistance, is considered to be a payment for medical assistance for an eligible individual if enrollment of the family members who are eligible for medical assistance is not possible under the plan without also enrolling members who are not eligible and the commission determines it to be cost-effective. Makes conforming changes

(i) Makes no changes to this subsection.

(i-1) Requires the commission to make every effort to expedite payments made under this section, including by ensuring that those payments are made through electronic transfers of money to the recipient's account at a financial institution, if possible. Authorizes the commission, if feasible, in lieu of reimbursing the individual enrolled in the group health benefit plan for required premium or cost-sharing payments made by the individual, to make payments under this section for required premiums directly to the employer providing the group health benefit plan in which an individual is enrolled, or make payments under this section for required premiums and cost-sharing obligations directly to the group health benefit plan issuer.

(j) Requires the commission to treat coverage under the group health benefit plan as a third party liability to the program. Provides that subject to Subsection (j-1), enrollment of an individual in a group health benefit plan under this section does not affect the individual's eligibility for medical assistance benefits, except that the state is entitled to payment under Sections 32.033 and 32.038. Makes conforming changes.

(j-1) Establishes that an individual described by Subsection (e-1) who enrolls in a group health benefit plan is not ineligible for community-based services provided under a Section 1915(c) waiver program or another federal waiver program solely based on the individual's enrollment in the group health benefit plan, and authorizes the individual to receive those services if the individual is otherwise eligible for the program. Provides that the individual is otherwise limited to the health benefits coverage provided under the health benefit plan in which the individual is enrolled, and that the individual may not receive any benefits or services under the medical assistance program other than the

premium payment as provided by Subsection (f-1) and, if applicable, waiver program services described by this subsection.

(k) Makes conforming changes.

(l) Requires the commission, in consultation with the Texas Department of Insurance (TDI), to provide training to agents who hold a general life, accident, and health license under Chapter 4054, Insurance Code, regarding the health insurance premium payment reimbursement program and the eligibility requirements for participation in the program. Establishes that participation in a training program established under this subsection is voluntary, and a general life, accident, and health agent who successfully completes the training is entitled to receive continuing education credit under Subchapter B, Chapter 4004, Insurance Code, in accordance with rules adopted by the commissioner of insurance.

(m) Authorizes the commission to pay a referral fee, in an amount determined by the commission, to each general life, accident, and health agent who, after completion of the training program established under Subsection (l), successfully refers an eligible individual to the commission for enrollment in a group health benefit plan under this section. Deletes language requiring the Texas Department of Human Services to provide information and otherwise cooperate with the department as necessary to ensure the enrollment of eligible individuals in the group health benefit plan under this section.

(n) Requires the commission to develop procedures by which an individual described by Subsection (e-1) who enrolls in a group health benefit plan may, at the individual's option, resume receiving benefits and services under the medical assistance program instead of the group health benefit plan.

(o) Requires the commission to develop procedures which ensure that, prior to allowing an individual described by Subsection (e-1) to enroll in a group health benefit plan or allowing the parent or caretaker of an individual described by Subsection (e-1) under the age of 21 to enroll that child in a group health benefit plan:

(1) the individual must receive counseling informing them that for the period in which the individual is enrolled in the group health benefit plan:

(A) the individual shall be limited to the health benefits coverage provided under the health benefit plan in which the individual is enrolled;

(B) the individual may not receive any benefits or services under the medical assistance program other than the premium payment as provided by Subsection (f-1);

(C) the individual shall pay the difference between the required premiums and the premium payment as provided by Subsection (f-1) and shall also pay all deductibles, copayments, coinsurance, and other cost-sharing obligations imposed on the individual under the group health benefit plan; and

(D) the individual may, at the individual's option through procedures developed by the commission, resume receiving benefits and services under the medical assistance program instead of the group health benefit plan; and

(2) the individual must sign and the commission shall retain a copy of a waiver indicating the individual has provided informed consent.

(p) Requires the executive commissioner, rather than department, to adopt rules as necessary to implement this section.

SECTION 12. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0641, as follows:

Sec. 32.0641. COST SHARING FOR CERTAIN HIGH-COST MEDICAL SERVICES. (a) Provides that if the department determines that it is feasible and cost-effective, and to the extent permitted under Title XIX, Social Security Act (42 U.S.C. Section 1396 et

seq.) and any other applicable law or regulation or under a federal waiver or other authorization, the executive commissioner shall adopt cost-sharing provisions that require a recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical service if:

(1) the hospital from which the recipient seeks service:

(A) performs an appropriate medical screening and determines that the recipient does not have a condition requiring emergency medical services;

(B) informs the recipient:

(i) that the recipient does not have a condition requiring emergency medical services;

(ii) that, if the hospital provides the nonemergency service, the hospital may require payment of a copayment, premium payment, or other cost-sharing payment by the recipient in advance; and

(iii) of the name and address of a nonemergency Medicaid provider who can provide the appropriate medical service without imposing a cost-sharing payment; and

(C) offers to provide the recipient with a referral to the nonemergency provider to facilitate scheduling of the service; and

(2) after receiving the information and assistance described by Subdivision (1) from the hospital, the recipient chooses to obtain emergency medical services despite having access to medically acceptable, lower-cost medical services.

(b) Prohibits the department from seeking a federal waiver or other authorization under Subsection (a) that would prevent a Medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room, or waive any provision under Section 1867, Social Security Act (42 U.S.C. Section 1395dd).

SECTION 13. Amends Chapter 32, Human Resources Code, by adding Subchapter C, as follows:

SUBCHAPTER C. ELECTRONIC COMMUNICATIONS

Sec. 32.101. DEFINITIONS. The bill defines the terms: "Electronic health record," "Executive commissioner," "Health care provider," "Health information technology" "Operating agency," "Participating provider," "Physician," and "Recipient."

Sec. 32.102. ELECTRONIC COMMUNICATIONS. (a) Authorizes the executive commissioner, to the extent allowed by federal law, to adopt rules allowing the Health and Human Services Commission to permit, facilitate, and implement the use of health information technology for the medical assistance program to allow for electronic communication among the commission, the operating agencies, and participating providers for:

(1) eligibility, enrollment, verification procedures, and prior authorization for health care services or procedures covered by the medical assistance program, as determined by the executive commissioner, including diagnostic imaging;

(2) the update of practice information by participating providers;

(3) the exchange of recipient health care information, including electronic prescribing and electronic health records;

(4) any document or information requested or required under the medical assistance program by the Health and Human Services Commission, the operating agencies, or participating providers; and

(5) the enhancement of clinical and drug information available through the vendor drug program to ensure a comprehensive electronic health record for recipients.

(b) Provides that if the executive commissioner determines that a need exists for the use of health information technology in the medical assistance program and that the

technology is cost-effective, the Health and Human Services Commission may, for the purposes prescribed by Subsection (a):

(1) acquire and implement the technology; or

(2) evaluate the feasibility of developing and, if feasible, develop, the technology through the use or expansion of other systems or technologies the commission uses for other purposes, including the technologies used in the pilot program implemented under Section 531.1063, Government Code; and the health passport developed under Section 266.006, Family Code.

(c) Provides that the commission:

(1) must ensure that health information technology used under this section complies with the applicable requirements of the Health Insurance Portability and Accountability Act;

(2) may require the health information technology used under this section to include technology to extract and process claims and other information collected, stored, or accessed by the medical assistance program, program contractors, participating providers, and state agencies operating any part of the medical assistance program for the purpose of providing patient information at the location where the patient is receiving care;

(3) must ensure that a paper record or document is not required to be filed if the record or document is permitted or required to be filed or transmitted electronically by rule of the executive commissioner;

(4) may provide for incentives to participating providers to encourage their use of health information technology under this subchapter;

(5) may provide recipients with a method to access their own health information; and

(6) may present recipients with an option to decline having their health information maintained in an electronic format under this subchapter.

(d) Requires the executive commissioner to consult with participating providers and other interested stakeholders in developing any proposed rules under this section, and to request advice and information from those stakeholders concerning the proposed rules, including advice regarding the impact of and need for a proposed rule.

SECTION 14. (a) Amends Chapter 32, Human Resources Code, by adding Subchapter D, as follows:

SUBCHAPTER D. ELECTRONIC HEALTH INFORMATION PILOT PROGRAM

Sec. 32.151. DEFINITIONS. The bill defines the terms "Electronic health record," "Executive commissioner," "Health information technology," "Physician," and "Recipient."

Sec. 32.152. ELECTRONIC HEALTH INFORMATION PILOT PROGRAM. Requires the executive commissioner, from money appropriated for this purpose, to develop and implement a pilot program for providing health information technology, including electronic health records, for use by primary care physicians who provide medical assistance to recipients.

Sec. 32.153. PROVIDER PARTICIPATION. Requires the department, for participation in the pilot program, to select physicians who: volunteer to participate in the program; are providers of medical assistance, including physicians who contract or otherwise agree with a managed care organization to provide medical assistance under this chapter; and demonstrate that at least 40 percent of the physicians' practice involves the provision of primary care services to recipients in the medical assistance program.

Sec. 32.154. SECURITY OF PERSONALLY IDENTIFIABLE HEALTH INFORMATION. (a) Provides that personally identifiable health information of recipients enrolled in the pilot program must be maintained in an electronic format or technology that meets interoperability standards that are recognized by the Certification

Commission for Healthcare Information Technology or other federally approved certification standards.

(b) Provides that the system used to access a recipient's electronic health record must be secure and maintain the confidentiality of the recipient's personally identifiable health information in accordance with applicable state and federal law.

Sec. 32.155. GIFTS, GRANTS, AND DONATIONS. Authorizes the department to request and accept gifts, grants, and donations from public or private entities for the implementation of the pilot program.

Sec. 32.156. PROTECTED HEALTH INFORMATION. Provides that to the extent that this subchapter authorizes the use or disclosure of protected health information by a covered entity, as those terms are defined by the privacy rule of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) contained in 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E, the covered entity shall ensure that the use or disclosure complies with all applicable requirements, standards, or implementation specifications of the privacy rule.

Sec. 32.157. EXPIRATION OF SUBCHAPTER. This subchapter expires September 1, 2011.

(b) Requires the executive commissioner, not later than December 31, 2008, to submit to the governor, lieutenant governor, speaker of the house of representatives, presiding officer of the House Committee on Public Health, and presiding officer of the Senate Committee on Health and Human Services a report regarding the preliminary results of the pilot program established under Subchapter D, Chapter 32, Human Resources Code, as added by this section, and any recommendations regarding expansion of the pilot program, including any recommendations for legislation and requests for appropriation necessary for the expansion of the pilot program.

SECTION 15. (a) The bill defines the term "committee."

(b) Establishes the committee on health and long-term care insurance incentives (committee) to study and develop recommendations regarding methods by which this state may reduce the need for residents of this state to rely on the Medicaid program by providing incentives for employers to provide health insurance, long-term care insurance, or both, to their employees.

(c) Provides that the committee on health and long-term care insurance incentives is composed of:

(1) the presiding officers of: the Senate Committee on Health and Human Services; the House Committee on Public Health; the Senate Committee on State Affairs; and the House Committee on Insurance;

(2) three public members, appointed by the governor, who collectively represent the diversity of businesses in this state, including diversity with respect to: the geographic regions in which those businesses are located; the types of industries in which those businesses are engaged; and the sizes of those businesses, as determined by number of employees; and

(3) the following ex officio members: the comptroller of public accounts; the commissioner of insurance; and the executive commissioner of the Health and Human Services Commission.

(d) Requires the committee to elect a presiding officer from the committee members and to meet at the call of the presiding officer.

(e) Requires the committee to study and develop recommendations regarding incentives this state may provide to employers to encourage those employers to provide health insurance, long-term care insurance, or both, to employees who would otherwise rely on

the Medicaid program to meet their health and long-term care needs. Requires the committee, in conducting the study, to:

(1) examine the feasibility and determine the cost of providing incentives through:

(A) the franchise tax under Chapter 171, Tax Code, including allowing exclusions from an employer's total revenue of insurance premiums paid for employees, regardless of whether the employer chooses under Section 171.101(a)(1)(B)(ii), Tax Code, as effective January 1, 2008, to subtract cost of goods sold or compensation for purposes of determining the employer's taxable margin;

(B) deductions from or refunds of other taxes imposed on the employer; and

(C) any other means, as determined by the committee; and

(2) for each incentive the committee examines under Subdivision (1) of this subsection, determine the impact that implementing the incentive would have on reducing the number of individuals in this state who do not have private health or long-term care insurance coverage, including individuals who are Medicaid recipients.

(f) Requires the committee, not later than September 1, 2008, to submit to the Senate Committee on Health and Human Services, the House Committee on Public Health, the Senate Committee on State Affairs, and the House Committee on Insurance a report regarding the results of the study required by this section. Provides that the report must include a detailed description of each incentive the committee examined and determined is feasible and, for each of those incentives, specify:

(1) the anticipated cost associated with providing that incentive;

(2) any statutory changes needed to implement the incentive; and

(3) the impact that implementing the incentive would have on reducing: the number of individuals in this state who do not have private health or long-term care insurance coverage; and the number of individuals in this state who are Medicaid recipients.

SECTION 16. (a) Requires the commission to conduct a study regarding the feasibility and cost-effectiveness of developing and implementing an integrated Medicaid managed care model designed to improve the management of care provided to Medicaid recipients who are aging, blind, or disabled or have chronic health care needs and are not enrolled in a managed care plan offered under a capitated Medicaid managed care model, including recipients who reside in rural areas of this state, or urban or surrounding areas in which the Medicaid Star + Plus program or another capitated Medicaid managed care model is not available.

(b) Requires the commission, not later than September 1, 2008, to submit a report regarding the results of the study to the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program.

SECTION 17. (a) The bill defines the terms "Child health plan program" and "Medicaid."

(b) Requires the commission to conduct a study of the feasibility of providing a health passport for children under 19 years of age who are receiving Medicaid and are not provided a health passport under another law of this state, and children enrolled in the child health plan program.

(c) Provides that the feasibility study must:

(1) examine the cost-effectiveness of the use of a health passport in conjunction with the coordination of health care services under each program;

(2) identify any barriers to the implementation of the health passport developed for each program and recommend strategies for the removal of those barriers;

(3) examine whether the use of a health passport will improve the quality of care for children described in Subsection (b) of this section; and

(4) determine the fiscal impact to this state of the proposed initiative.

(d) Requires the commission, not later than January 1, 2009, to submit to the governor, lieutenant governor, speaker of the house of representatives, and presiding officers of each standing committee of the legislature with jurisdiction over the commission a written report containing the findings of the study and the commission's recommendations.

(e) Provides that this section expires September 1, 2009.

SECTION 18. (a) Creates the Medicaid Reform Legislative Oversight Committee to facilitate the reform efforts in Medicaid, the process of addressing the issues of uncompensated hospital care, and the establishment of programs addressing the uninsured.

(b) Establishes that the Medicaid Reform Legislative Oversight Committee is composed of six members, as follows: three members of the senate, appointed by the lieutenant governor not later than October 1, 2007; and three members of the house of representatives, appointed by the speaker of the house of representatives not later than October 1, 2007.

(c) Provides that a member of the Medicaid Reform Legislative Oversight Committee serves at the pleasure of the appointing official.

(d) Requires the lieutenant governor to designate a member of the Medicaid Reform Legislative Oversight Committee as the presiding officer.

(e) Provides that a member of the Medicaid Reform Legislative Oversight Committee may not receive compensation for serving on the committee but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the committee as provided by the General Appropriations Act.

(f) Requires the Medicaid Reform Legislative Oversight Committee to:

(1) facilitate the design and development of any Medicaid waivers needed to affect reform as directed by this Act;

(2) facilitate a smooth transition from existing Medicaid payment systems and benefit designs to the new model of Medicaid enabled by waiver or policy change by the Health and Human Services Commission;

(3) meet at the call of the presiding officer; and

(4) research, take public testimony, and issue reports requested by the lieutenant governor or speaker of the house of representatives.

(g) Authorizes the Medicaid Reform Legislative Oversight Committee to request reports and other information from the commission and review the findings of the work group on uncompensated hospital care established under Section 531.552, Government Code, as added by this Act.

(h) Requires the Medicaid Reform Legislative Oversight Committee to use existing staff of the senate, the house of representatives, and the Texas Legislative Council to assist the committee in performing its duties under this section.

(i) Provides that Chapter 551, Government Code, applies to the Medicaid Reform Legislative Oversight Committee.

(j) Requires the committee to report to the lieutenant governor and speaker of the house of representatives not later than November 15, 2008. The report must include:

(1) identification of significant issues that impede the transition to a more effective Medicaid program;

(2) the measures of effectiveness associated with changes to the Medicaid program;

(3) the impact of Medicaid changes on safety net hospitals and other significant traditional providers; and

(4) the impact on the uninsured in Texas.

(k) Provides that this section expires September 1, 2009, and the Medicaid Reform Legislative Oversight Committee is abolished on that date.

(l) This section takes effect immediately if this Act receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for this section to have immediate effect, this section takes effect September 1, 2007.

SECTION 19. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 20. Except as otherwise provided by this Act, this Act takes effect September 1, 2007.

EFFECTIVE DATE

SECTION 18 takes effect upon passage, or, if the Act does not receive the necessary vote, SECTION 18 takes effect September 1, 2007. The remaining SECTIONS of the Act take effect September 1, 2007.

COMPARISON OF ORIGINAL TO SUBSTITUTE

The committee substitute differs from the original as follows:

The portion of SECTION 1 of the committee substitute that adds Section 531.02114, Government Code (PILOT PROJECT TO SIMPLIFY, STREAMLINE, AND REDUCE COSTS ASSOCIATED WITH MEDICAID COST REPORTING AND AUDITING PROCESS FOR CERTAIN PROVIDERS) is not contained in the original bill.

The portion of SECTION 1 of the committee substitute that adds Section 531.02192, Government Code (FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC SERVICES) differs from the original by requiring the commission to promote Medicaid recipient access to federally qualified health center (FQHC) services or rural health clinic services and ensure that payment for FQHC services or rural health clinic services is in accordance with 42 U.S.C. Section 1396a(bb). The original bill prohibited the commission from providing Medicaid services to a recipient through a delivery model or by enrolling the recipient in a program, including a delivery model or program implemented under a Section 1115 waiver unless, under the delivery model or program, the recipient has access to FQHC services or rural health clinic services and payment for FQHC services or rural health clinic services is in accordance with 42 U.S.C. Section 1396a(bb).

In SECTION 2, CSSB 10 modifies the provision contained in the original relating to BILLING COORDINATION SYSTEM by changing the section number from 531.02414 to 531.02413, Government Code, and making changes to the following subsections:

(a) CSSB 10 requires the commission, if cost-effective and feasible, on or before September 1, 2008, to contract for the implementation of an acute care billing coordination system that will, on submission at the point of service of a claim for a service provided to a Medicaid recipient by a Medicaid provider, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the issuer the system determines is the primary payor. The original bill requires the commission, on or before March 1, 2008, to contract for the implementation of a billing coordination system 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 issuer the system determines is the primary payor.

(b) CSSB 10 modifies the original by adding "acute care."

(c) CSSB 10 modifies the original by changing "purposes of this subchapter" to "purposes of this section" and clarifying that the entity is subject to the administrative penalty.

(d) CSSB 10 modifies the original by changing the date from after June 1, 2008, to after March 1, 2009, and changing "subchapter" to "section."

(e) CSSB 10 modifies the original by authorizing the contractor, rather than the agent, to use the information, and changing "subchapter" to "section."

(f) This subsection was not contained in the original bill.

(g) This subsection was not contained in the original bill.

The language in SECTION 2 of the committee substitute relating to the medical transportation program (Section 531.02414, Government Code, and Subsections (b), (c), and (d) of SECTION 2) was not contained in the original bill.

In SECTION 3, CSSB 10 modifies the provision contained in the original adding Sec. 531.0941, Government Code, relating to MEDICAID HEALTH SAVINGS ACCOUNT PILOT PROGRAM by making changes to the following subsections:

(b) CSSB 10 deletes the words "under this section" from the original bill.

(c) CSSB 10 modifies the original by changing "a Medicaid health savings account pilot program" to "the pilot program" and adding "subject to Subsection (d)."

(d) This subsection was not contained in the original bill.

In SECTION 3, CSSB 10 modifies the provision contained in the original adding Sec. 531.097, Government Code, relating to TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION, by making changes to the following subsections:

(g-1) CSSB 10 provides that a tailored benefit package "must increase the state's flexibility with respect to the use of Medicaid funding and may not reduce the benefits available under the Medicaid state plan to any Medicaid recipient population," whereas the original bill provided that a tailored benefit package "may not reduce the scope of benefits that were available under the Medicaid state plan immediately before September 1, 2007, to the category of Medicaid recipients to which the package applies."

(j) The original bill provided that the section did not apply to a tailored benefit package or similar package implemented before September 1, 2007, whereas the committee substitute provides that the section does not apply to a tailored benefits package or similar package if, before September 1, 2007, a federal waiver was requested to implement the package of benefits, the package of benefits is being developed, as directed by the legislature, or the package of benefits has been implemented.

In SECTION 5(a), CSSB 10 changes the provisions contained in the original relating to Subchapter N, Chapter 531, Government Code by changing the title from "TEXAS HEALTH OPPORTUNITY POOL" to "TEXAS HEALTH OPPORTUNITY POOL TRUST FUND." CSSB 10 adds a new Section 531.501, Government Code, not contained in the original, to provide a definition of "fund." CSSB 10 renumbers the remaining sections accordingly, changes section references, and makes the following other changes:

CSSB 10 modifies the original by changing "Sec. 531.501 DIRECTION TO OBTAIN FEDERAL WAIVER FOR POOLED FUNDS" to "Sec. 531.502 DIRECTION TO OBTAIN FEDERAL WAIVER" and making changes to the following subsections:

(a) With regard to use of federal money under the waiver authorized in this subsection, CSSB 10 modifies the original by changing "(1) depositing that federal money and, to the extent necessary, state money, into a pooled fund established in the state treasury outside the general revenue fund; and (2) using the money for purposes consistent with this subchapter" to read "using that federal money, appropriated state money to the extent necessary, and any other money described by this section for purposes consistent with this subchapter."

(b) CSSB 10 modifies the original by changing "The federal money the executive commissioner may seek approval to pool includes: (1) money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs, other than money provided under the disproportionate share hospitals supplemental payment program to state-owned and operated hospitals" to read "The executive commissioner may include the following federal money in the waiver: (1) all money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs;"

(c)(2)(B) CSSB 10 modifies the original by changing "pooling federal matching money received as provided by Paragraph (A) with other federal money pooled under Subsection (b), …" to read "depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 531.504 …"

(d)(1) CSSB 10 modifies the original by changing "include safeguards to ensure that the total amount of federal money in the pooled fund and any federal money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs that is not included in the pooled fund is ..." to read "include safeguards to ensure that the total amount of federal money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs that is deposited as provided by Section 531.504 is …"

(e) (1) CSSB 10 modifies the original by deleting "pooled."

(e)(4) CSSB 10 modifies the original by changing "to the extent allowed by federal rule, federal regulations, and federal waiver authority, preserve existing resources funded by intergovernmental transfer or certified public expenditure that are used to optimize Medicaid payments to safety net hospitals for uncompensated care, unless the need for the resources is revised through measures that reduce the Medicaid shortfall or uncompensated care costs" to read "to the extent allowed by federal law, including federal regulations, and federal waiver authority, preserve the federal supplemental payment program payments made to hospitals, the state match with respect to which is funded by intergovernmental transfers or certified public expenditures that are used to optimize Medicaid payments to safety net providers for uncompensated care, and preserve allocation methods for those payments, unless the need for the payments is revised through measures that reduce the Medicaid shortfall or uncompensated care costs."

CSSB 10 modifies the original by changing "Sec. 531.502. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL" to "Sec. 531.503. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL TRUST FUND" and making changes to the following subsections:

(a) CSSB 10 modifies the original by changing "the Texas health opportunity pool is established in accordance with the terms of that waiver as an account in the state treasury outside the general revenue fund. Money in the pool may be used only for purposes consistent with this subchapter and the terms of the waiver" to read "the Texas health opportunity pool trust fund is created as a trust fund outside the state treasury to be held by the comptroller and administered by the commission as trustee on behalf of residents of this state who do not have private health benefits coverage and health care providers providing uncompensated care to those persons. The commission may make expenditures of money in the fund only for purposes consistent with this subchapter and the terms of the waiver authorized by Section 531.502."

CSSB 10 adds Sec. 531.504. DEPOSITS TO FUND, a section that was not contained in the original bill.

CSSB 10 modifies the original by changing "Sec. 531.503. USE OF TEXAS HEALTH OPPORTUNITY POOL IN GENERAL; RULES FOR ALLOCATION" to read "Sec. 531.505. USE OF FUND IN GENERAL; RULES FOR ALLOCATION" and making changes to the following subsections:

(a) CSSB 10 modifies the original by changing "Texas health opportunity pool" to read "fund."

(b) (1) CSSB 10 modifies the original by changing "the implementation of, the pool" to read "the administration of, the fund."

(b)(2) CSSB 10 modifies the original by changing "pool" to "fund."

In the provisions of SECTION 5(a) of CSSB 10 relating to REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE, INCREASING ACCESS TO HEALTH BENEFITS

COVERAGE, and INFRASTRUCTURE IMPROVEMENTS, CSSB 10 modifies the original by changing the section numbers accordingly and changing "Texas health opportunity pool" and "pool" to "fund."

In the provisions of SECTION 5(a) of CSSB 10 relating to INCREASING ACCESS TO HEALTH BENEFITS COVERAGE (Sec. 531.507(c) of committee substitute; Sec. 531.505(c) of original), CSSB 10 modifies the original by changing "subject to appropriations for that purpose" to read "subject to availability of money in the fund for that purpose."

In SECTION 5(b) of CSSB 10, relating to submission of a report to the LBB by the executive commissioner, CSSB 10 modifies the original by changing "Act" to "section."

In SECTION 6(b) of CSSB 10, relating to the adoption of the rules required by Section 531.551, Government Code, CSSB 10 requires the rules to be adopted not later than January 1, 2009, whereas the original required the rules to be adopted not later than March 1, 2008.

In SECTION 6(c) of CSSB 10, relating to the review of the methodology by the executive commissioner, CSSB 10 modifies the original by changing "Act" to "section."

SECTION 7 of CSSB 10, which adds Subchapter P, Chapter 531, Government Code relating to PHYSICIAN-CENTERED NURSING FACILITY MODEL DEMONSTRATION PROJECT, was not contained in the original bill.

SECTION 8 of CSSB 10, which adds Sec. 533.0051, Government Code, relating to PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS, was not contained in the original bill.

In SECTION 9(b) of CSSB 10 (which corresponds to SECTION 7(b) of the original), CSSB 10 modifies the original by changing "Act" to "section."

In SECTION 10 of CSSB 10 (which corresponds to SECTION 8 of the original), CSSB 10 modifies the original by changing the title of Sec. 32.0214 from "DESIGNATIONS OF PRIMARY CARE PHYSICIAN BY CERTAIN RECIPIENTS" to "DESIGNATIONS OF PRIMARY CARE PROVIDER BY CERTAIN RECIPIENTS" and making changes to the following subsections:

(a) CSSB 10 modifies the original by changing "primary care physician" to read "primary care provider" and changing "manage and coordinate all aspects of the recipient's health care" to read "provide and coordinate the recipient's initial and primary care, maintain the continuity of care provided to the recipient, and initiate any referrals to other health care providers."

(b) CSSB 10 modifies the original by changing "primary care physician" to read "primary care provider."

In SECTION 11 of CSSB 10 (which corresponds to SECTION 9 of the original), CSSB 10 modifies the original by changing Section 32.0422(o)(1)(D), Human Resources Code, from "the individual may, at the individual's option, resume receiving benefits and services under the medical assistance program instead of the group health benefit plan;" to "the individual may, at the individual's option through procedures developed by the commission, resume receiving benefits and services under the medical assistance program instead of the group health benefit plan;"

In SECTION 12 of CSSB 10 (which corresponds to SECTION 10 of the original), CSSB 10 modifies the original by adding Subsection (b) of Section 32.0641, Human Resources Code, which provides that the department may not seek a federal waiver or other authorization under Subsection (a) that would: (1) prevent a Medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room; or (2) waive any provision under Section 1867, Social Security Act (42 U.S.C. Section 1395dd).

SECTION 11 of the original, relating to PROGRAMS PROVIDING HEALTH CARE BENEFITS AND SERVICES, is not contained in CSSB 10.

SECTION 13 of CSSB 10, which adds Subchapter C, Chapter 32, Human Resources Code, relating to ELECTRONIC COMMUNICATIONS, was not contained in the original bill.

SECTION 14 of CSSB 10, which adds Subchapter D, Chapter 32, Human Resources Code, relating to ELECTRONIC HEALTH INFORMATION PILOT PROGRAM, and provides for the submission of a report regarding the pilot program, was not contained in the original bill.

In SECTION 15 of the original (which corresponds to SECTION 18 of the committee substitute), the original bill creates the Health and Human Services Transition Legislative Oversight Committee, whereas CSSB 10 creates the Medicaid Reform Legislative Oversight Committee to facilitate the reform efforts in Medicaid, the process of addressing the issues of uncompensated hospital care, and the establishment of programs addressing the uninsured. CSSB10 deletes the provision contained in the original that the executive commissioner of the Health and Human Services Commission serves as an ex officio member of the committee. The original bill provided that the lieutenant governor and the speaker of the house of representatives shall alternate designating a presiding officer from among their respective appointments, with the lieutenant governor making the first appointment after the effective date of this Act, whereas CSSB 10 provides that lieutenant governor shall designate a member of the committee as the presiding officer. CSSB 10 deletes the requirement in the original bill that the committee facilitate the establishment of common definitions for uncompensated hospital care and any application of those definitions in the determination of policy that affects reimbursement for that care. The original bill required the committee to "issue reports on other appropriate issues or specific issues requested by the lieutenant governor or speaker of the house of representatives," whereas CSSB 10 requires the committee to "issue reports requested by the lieutenant governor or speaker of the house of representatives." CSSB 10 adds a provision not contained in the original bill that authorizes the committee to review the findings of the work group on uncompensated hospital care established under Section 531.552, Government Code, as added by this Act. The original bill requires the committee to report to the lieutenant governor and speaker of the house of representatives not later than November 15 of each even-numbered year, whereas CSSB 10 requires the committee to report to the lieutenant governor and speaker of the house of representatives not later than November 15, 2008. CSSB 10 adds provisions not contained in the original bill that provide for this section to expire on September 1, 2009, for the committee to be abolished on that date, and for the section to take immediate effect if it receives the required number of votes.

CSSB 10 also makes conforming and non-substantive changes to the substitute bill.