REVIEW OF ARTICLE I OF HB 2292

Article 1 of HB 2292 provides for the eventual consolidation of all health and human services (HHS) agencies into five agencies, replaces agency boards with advisory councils, consolidates all policy development and rulemaking authority for HHS programs and services with the commissioner of the Health and Human Services Commission (HHSC), and creates a Transition Legislative Oversight Committee to facilitate the consolidation.

An analysis of the major provisions in Article 1 follows, with our major concerns noted.

Reorganization of agencies and functions

At present, 12 separate agencies provide an array of health and human services to Texans. The new law consolidates the functions of these 12 agencies into five agencies by grouping similar programs and services. Administrative support services for all five agencies are centralized at the Health and Human Services Commission. The new agencies are organized as follows:

Health and Human Services Commission (Section 1.03)

- Policy development and rulemaking for all HHS agencies.
- Manages and directs the general operations of each agency.
- Administrative functions for all HHS agencies, including information technology, human resources, planning and evaluation, contract management, financial management, budget, audit, legal, purchasing, rate setting
- Eligibility determination for Food Stamps, Medicaid, CHIP, TANF, SSI (to the extent permitted by federal law), long-term care services, and community-based support services (eligibility for these programs is now determined by the Department of Human Services, DHS).
- Domestic violence programs and coordination of early childhood services are transferred to the commission.

Divisions/Offices within HHSC (Section 1.05)

- *Eligibility Services Division*: The core programs that serve low-income Texans—CHIP, Medicaid, TANF, and Food Stamps—are all transferred to the Commission and placed under this division, along with long-term care services, community-based support services, and other HHS services as appropriate.
- *Office of the Inspector General*: Will perform fraud and abuse investigation and enforcement (gubernatorial appointee). These functions are now performed by DHS.
- *Purchasing Division*
- *Office of the Ombudsman*
- *Internal Audit Division*

Department of State Health Services (Section 1.09)

- Health and mental health care programs and services.
- State health and mental health facilities and hospitals.
- Community health and mental services.
- Substance abuse programs and facilities.
- Licensing, inspecting, and enforcing regulations at health and mental health facilities, other than long-term care facilities.

Department of Family and Protective Services (Section 1.10-1.12)

- Adult and child protective services (including family support and prevention services and early intervention and prevention programs).
- Investigating abuse and neglect in MH/MR facilities.
- Licensing and regulating child care facilities.

Department of Assistive and Rehabilitative Services (Section 1.13)

- Rehabilitation services for persons with disabilities.
- Services for the blind, deaf, and visually impaired.
- Early childhood intervention services.

Department of Aging and Disability Services (Section 1.13A)

- Community-based care and support services to promote independent living.
- Institutional care services through convalescent and nursing homes.
- Mental retardation programs and services.
- Services for persons with disabilities.
- State facilities for persons with disabilities and sate schools for persons with mental retardation.
- Licensing and enforcement activities related to long-term care facilities, convalescent and nursing homes, assisted living facilities, intermediate care facilities for persons with mental retardation, home and community acre services agencies
- Services for the aging.

Abolition of Agencies (Section 1.26)

The following agencies are abolished on the date specified in the transition plan: the Interagency Council on Early Childhood Intervention; the Texas Commission for the Blind; the Texas Commission for the Deaf and Hard of Hearing; the Texas Commission on Alcohol and Drug Abuse; the Texas Department of Health; the Texas Department of Human Services; the Texas Department of Mental Health and Mental Retardation; the Texas Department on Aging; the Texas Health Care Information Council; the Texas Rehabilitation Commission.

Consolidation of Power with HHSC commissioner (Section 1.03)

The consolidation of agencies in Article 1 is accompanied by a massive centralization of power at HHSC, whose commissioner is given total authority over the rulemaking and policy direction of HHS agencies, while individual agency directors and boards are largely stripped of these responsibilities. In an improvement added by the Senate, individual agency directors are permitted to assist in the development of rules and policies at the request of the HHSC commissioner (Section 1.04). While final authority to adopt rules rests with the HHSC commissioner, delegating some rulemaking authority to agency directors will ensure that the HHSC commissioner does end up spending all of his/her time promulgating rules.

The consolidation of power with the commissioner raises the concern that HHS policy decisions will become less open to the public—in particular, the advocates who look out for the interests of the people these programs serve—more subject to the priorities of the governor, over those of the legislature, and more susceptible to political considerations.

Agency Councils and Public Input (Sections 1.08 1.09, 1.12, 1.13A, 1.13)

The law replaces agency boards, which have rulemaking authority, with advisory councils that do not. An advisory council is created for each of the five agencies (an improvement over the original bill, which did not include an HHSC council), composed of nine members of the public appointed by the governor. The councils are intended to assist the commissioner in developing rules and polices for the department.

The center unsuccessfully urged the legislature to vest these advisory councils with the same rulemaking authority as their predecessor boards. In removing this authority from these boards (and consolidating it with one person—the HHSC commissioner), we are concerned that these gubernatorial appointees will become less responsive and accountable to the public.

The law does provide for public hearings before substantive rule changes are made (according to current public hearing laws) and requires agency directors to consider all oral and written public input. The final version of the bill also requires council appointments to reflect the ethnic diversity of the state.

Appointment of Agency Directors (Section 1.04)

In another Senate improvement, the HHSC commissioner is given the authority to appoint agency directors, who serve at the pleasure of the commissioner. The original bill gave this authority to the governor and set one-year terms for agency directors. This is a good change that will prevent the politicization of day-to-day agency operations and avoid embroiling the governor in what are operational rather than policy issues.

Transition Plan and Legislative Oversight Committee (Sections 1.22, 1.23, 1.25)

The law directs the HHSC commissioner to develop a transition plan that includes a schedule for the consolidation of agencies. A public hearing is required before November 1, 2003, on the plan, which must be presented to the governor no later than December 1, 2003. While the consolidation of administrative support services has already begun, the consolidation of agencies is not expected to be complete for 4-6 years. The law creates a HHS Transition Legislative Oversight Committee to facilitate a smooth transition, hold public hearings on the transition process, and oversee the development of workplans by each agency to guide them through the transition process. The committee is composed of two members of the senate, appointed by the lieutenant governor not later than October 1, 2003; two members of the house of representatives, appointed by the speaker of the house of representatives

not later than October 1, 2003; three members of the public, appointed by the governor not later than October 1, 2003. The HHSC commissioner serves as an ex officio member of the committee.

Section-by-Section Review of Article II of HB 2292	
2.01	Adds definition of CHIP to Government Code.
2.02	Adds Section 531.017 to the Government Code creating a Purchasing Division. This division is created to manage all purchasing functions for HHS agencies and the commission. If cost-effective, this function can be privatized. The HHSC shall develop and implement a plan for consolidating the purchasing functions of HHS agencies by January 1, 2004.
2.03	Blanket Authority for HHSC to Reduce Medicaid Provider rates. Directs HHSC to "include financial performance standards" for ICF-MR providers and home and community-based service providers, with "flexibility" to modify service delivery if provider rates are cut. ICF-MR and home and community-based Services must be provided in a manner that meets state and federal Medicaid requirements. Authorizes HHSC to cut Medicaid provider rates in response to "available levels of appropriated state and federal funds."
2.04	Amends Government Code 531.0335 to provide that no punitive actions shall be taken against a parent or guardian for failure to immunize a child per provisions in the Health and Safety Code at 161.004. Punitive actions defined to include an investigation (not a FINDING) that a person has abused or neglected a child. This means PRS may not investigate a parent or guardian for failure to immunize a child. (see also section 2.160.) EXCEPT that parents who are TANF recipients may still be sanctioned (Ch. 31 Human Resources).
2.05	(a) Appears to be intended to improve collection of Medicare payments for services to dually-eligible clients (Medicaid is supposed to pay only for services NOT covered by Medicare); however, the language is unclear.
2.06	Adds Section 531.063 to the Government Code establishing Call Centers. Provides for the use of up to four call centers statewide to determine eligibility, certify, and re-certify applicants for Food Stamps, Medicaid, CHIP, TANF, SSI (to the extent permitted by federal law), long-term care, and community-based support services. The bill directs the commissioner to contract with up to four vendors to operate the call center, if cost-effective. The law includes several improvements adopted by the Senate, including public hearing requirements, customer service and performance standards, methods for measuring call center performance, a requirement that the call centers be located in Texas, a requirement that call centers provide translation services as required by federal law, and the maintenance of a local network of HHS office to assist clients who cannot access a telephone system. Privatization raises concerns about client access; the loss of state employee jobs, particularly in rural areas; and the state's ability to protect client rights and hold private companies accountable for their performance in operating these programs. In addition, the center is concerned that arbitrarily limiting the number of call centers to four may create an operation that cannot be managed effectively, and result in call centers

	that are unable to satisfy the consumer service and performance standards established for them by the commission. Industry research on call centers has shown that when call centers become too large, operations tend to break down and customer service suffers. The center unsuccessfully advocated for a call center "network" that would not have prescribed a limit on the number of call centers, but rather would have directed HHSC to consider industry standards in determining how many call centers are needed.
2.07	Consolidation of Health Insurance Purchasing Programs (HIPP). Texas Medicaid has operated a program since 1994 (under federal law) in which the state can pay a Medicaid-eligible employee's share of employer-sponsored coverage when it is cost-effective to do so. Because very few persons in poverty are offered employee benefits, enrollment has been fairly low. However, under 2001 legislation, a similar program linked to CHIP is under development. This section directs consolidation of the two programs by 1/2004 and authorizes privatizing the administration of the program. http://www.main.org/txchip/Proposed%20Alternative%20Models%20for%20Medicaid%20and%20CHIP.doc
2.08	Public Assistance Health Benefit Review And Design Committee. Creates new HHSC committee to review benefits for Medicaid, CHIP, and other "income-based" health care programs. Review is to include drug coverage and policies for controlling utilization. The nine members consist entirely of health care providers (no consumer representation). HHSC may implement program to monitor and improve clinical and functional outcomes of Medicaid and CHIP enrollees. Must report to this committee on fiscal and savings findings.
2.09	HHSC and sub-agencies MAY take into account the recommendations of the committee created above.
2.10	Periodic Review of Vendor Drug Program. HHSC must periodically consider whether the Rx benefit should be included on Medicaid and CHIP managed care premiums (currently it is NOT); this calculation must take into account the value of rebates received by the state. (The state would NOT receive rebates for drugs delivered under HMO contracts; thus the current carve-out MAY be more cost-effective.)
2.11	Supplemental Drug Rebates. HHSC must pursue supplement rebates from drug manufacturers for drug provided by Medicaid, CHIP, and other state health programs (community mental health centers and mental hospitals specifically included) . (Note: All states receive rebates under federal Medicaid law, a number of states have negotiated additional rebates to increase their savings.) • Rebates defined as quarterly payments to state based on Medicaid utilization data; • allowing "in-kind" contributions ("certain program benefits in lieu of" rebates) by manufacturers as an alternative to rebates only if drug mfr. guarantees current-biennium direct GR savings to Texas Medicaid (or CHIP) and will post a bond in lieu of savings, also the in-kind services must be NEW. Performance bond must be accompanied by agreement to forfeit the bond if savings not achieved. • Options include disease management programs, drug donation programs, drug utilization control programs, prescriber/patient counseling and education, fraud and abuse prevention, or other programs with guaranteed savings. Savings from these in-kind programs would be treated in a manner to avoid having to share savings with the federal government, as rebates must be. Any in-kind or cash donations shall be considered in negotiating any supplemental rebate. • HHSC may enter into in-kind arrangements with more than one entity, agreements must be expressly time-limited, and may only apply to FDA-approved products.

	• Alternatives to supplemental rebates may include monetary donations which offset state expenditures other than for drugs, but they still must yield savings as least as great as a supplemental rebate. • HHSC may contract with an entity to negotiate rebates and related benefits. • In negotiating supplemental rebates, HHSC must utilize the Average Manufacturers Price, as defined in federal law. • Provides for annual reporting re: costs of administering preferred drug lists (see 2.13), utilization trends, impact on health outcomes, and numbers of approvals and denials.
2.12	Confidentiality of Information Regarding Drug Rebates, Pricing, and Negotiations. This section declares much of the information related to drug rebate amounts to be secret and not public information. Clarifies that this provision supercedes any state law to the contrary. However, general information about the aggregate costs of different classes of drugs is not confidential.
2.13	Preferred Drug Lists (PDL) for Medicaid and CHIP. Requires HHSC to establish a PDL favoring drugs for which supplemental rebates have been negotiated. A Pharmaceutical and Therapeutics Committee would be created to make recommendations about the contents of the PDL. PDL drug placement decisions must take into account P&T committee recommendation, clinical efficacy, and price (after rebates and in-kind offerings as described in section 2.11). HHSC must post PDL on internet, and mail lists to health care providers on request. The P&T committee must consider newly-approved "priority review" drugs at the next scheduled meeting , and must attempt to consider all other newly-approved drugs for inclusion at the next quarterly meeting. Drug or dosage denials are subject to client appeal via the Medicaid fair hearing process. March 2004 deadline for PDL adoption. Comment: A new report from the Kaiser Family Foundation looks at 5 states' experiences with PDLs and prior authorization: http://www.kff.org/content/2003/4094/4094.pdf
2.14	Prior Authorization. HHSC must require prior authorization (PA) for drugs not on the PDL. • PA must be obtained by prescribing physician or practitioner. (Presumably this means pharmacists may not make the request; not clear whether it prohibits a physician's staff from requesting prior authorization on the doctor's behalf.) • No PA allowed for drugs needed to treat conditions that are life-threatening, chronic, and "require complex medical management" UNTIL a study evaluation impact on recipients is completed. • 30-day prior internet posting and notice of PA system and detailed description of how it will work required before implementation.

	• subject to federal requirements for timely response and other standards, including: o no prior authorization required until a drug has been considered by the P&T committee o response for request for PA must occur within 24 hours o if no response within 24 hours, a 72-hour supply shall be dispensed • PA requirements do not apply to pre-implementation prescriptions until the prescription (including refills) expires. HHSC may also establish a timeline for phasing in prior authorization. • PA procedures and start-up must ensure continuity of care for clients . • HHSC is authorized to contract out for administration of prior authorization. • HHSC must ensure that prior authorization is implemented to minimize costs to state and administrative burden on providers.
2.15	Pharmaceutical and Therapeutics Committee. This "P & T" Committee would be created to make recommendations about the contents of the PDL. Governor appoints (by 11/2003) all 11 members: • 6 physicians participating in Medicaid; must include at least one actively engaged in providing treatment and care of severe mental illness in Texas Medicaid. Governor shall ensure they represent service to all segment of Medicaid (e.g., elderly, disabled, children, maternity care) • 5 pharmacists participating in Medicaid. • Members of the P&T committee may not have contractual, ownership, or other conflict of interest with any entity contracting to assist HHSC with the PDL or prior authorization. • Monthly meetings in first 6 months; at least quarterly meetings thereafter. • P&T must consider clinical efficacy, safety, and cost effectiveness (including price after rebates and in-kind offerings) • Rules for P&T must address how they will maintain the confidentiality of drug prices under section 2.12 in an open meeting setting. • If feasible, the PDL recommendations should be reviewed by drug class annually for updates
2.16	Prior Authorization For High-Cost Medical Services. Authorizes HHSC to implement a prior authorization requirement for certain high-cost medical services (to be defined later) in Medicaid (and presumably CHIP and other programs); also this function may be contracted out. Program shall recognize any prohibitions in federal law on limits in the amount duration or scope of benefits for children in Medicaid.
2.17	Estate Recovery from Medicaid Clients Using Long-Term Care Services. Requires Texas to implement a program of "estate recovery" from Medicaid clients using long-term care services (this would mean that in some circumstances, the state would seek reimbursement from the

	estate of a deceased recipient for the costs of Medicaid nursing home or community-based long term care). Creates an account for funds recovered, and provides for their re-appropriation for long-term care. (*Note: this has been mandatory under federal law for a decade, but never implemented in Texas for political reasons. Federal law defines a number of situations in which estates MUST be exempted, and states have some latitude to define additional exemptions.*)
2.18	Amends Govt. Code to provide that awards for reporting Medicaid fraud may not be made if HHSC or the AG had independent knowledge of the fraud, and that awards may not exceed 5% of the administrative penalty the state collects. Also, HHSC "may" consider whether the reporting person participated in the fraud.
2.19	Creates a new Office of Inspector General (OIG) for Health and Human Services. Governor-appointed, outlines process for evaluating fraud and abuse claims, referral to state A.G., holds on payments of Medicaid claims, powers of administrative penalties, investigative powers, etc.
2.20	Subpoena power is granted to new HHS OIG.
2.21	Describes relationship of HHS OIG with state Attorney General's Medicaid fraud division, and extends that relationship to fraud and abuse in TANF and Food Stamps. Describes responsibilities of the OIG and AG under a Memorandum of Understanding (MOU).
2.22	Specifies that the OIG-AG MOU must specify the type, scope, format and investigative support which the OIG will provide to the AG. Deletes current statue at Govt. Code 531.104(b) setting a maximum number of investigations per year which HHSC must support with investigations.
2.23	Adds Section 531.1063 to the Government Code establishing a Medicaid Fraud Pilot Program. Directs the commission to contract for a front-end Medicaid fraud reduction pilot program in one or more counties to reduce provider and recipient fraud. The program involves the use of "smart cards" and electronic finger imaging to verify the identity of Medicaid recipients and providers. The commission may extend the program to additional counties if deemed cost-effective. A report to the 79th legislature is required by February 1, 2005 with recommendations for taking the program statewide. Some notable improvements were made to this section and included in the final law: • Finger images for the "smart cards" may not reside in any other place than the card itself. • The HHSC commissioner has the authority to exempt children, seniors, and persons with disabilities from being finger-imaged and provides for the finger imaging of the non-recipient parents or caretakers of child recipients. Also directs the commission to consider the work schedules of recipients when imposing a finger imaging requirement. Concerns: Texas operates a similar fraud prevention program in the Food Stamp Program that since 1996 has cost the state over $11 million and only prevented $55,000 in fraud. While finger imaging and smart card technology has the potential to reduce provider fraud in the Medicaid program, the state should exercise care in implementing the program to ensure that the program works and is cost-effective prior to expanding the pilot.
2.24	Medicaid and Public Assistance Fraud Oversight Task Force. To this existing Task Force, adds an appointee of the Commissioner of Texas Department of Health, though that agency would eventually no longer exist under this bill.
2.25	Managed Care Organizations: Special Investigative Units or Contracts. Requires Medicaid and CHIP Managed Care Organizations (MCOs: e.g., HMOs) to include (or contract for) special units to investigate provider and client fraud and abuse. Describes required

	elements of these programs.
2.26	Financial Assistance Fraud. Transfers responsibility for fraud prevention and enforcement in the TANF program from DHS to HHSC and defines in statute the definitions and consequences of financial assistance fraud. Intentional misrepresentation of facts related to eligibility may result in prosecution and temporary or permanent exclusion from TANF.
2.27	Federal Felony Match. HHSC must periodically check benefit program eligibility files against a national database of fugitive felons. Note: provision of federal benefits to such person is prohibited by federal law.
2.28	Medicaid and CHIP providers are subject to Occupations Code 102 (prohibiting solicitation of patients) as a condition of participation.
2.29	Medicaid Managed Care. HHSC must pursue managed care implementation if it is found to be cost-effective. Managed care models include HMO including acute care portions of StarPlus, primary care case management (PCCM), pre-paid health plans, exclusive provider organizations, and "others". • The cost-effectiveness calculation must take into account scope, duration and types of benefits to be provided (which should be the same in all parts of the state), administrative costs, local market factors, and premium tax revenues the state will gain from the model of managed care pursued (see section 2.30). • Fee-for-service (traditional) Medicaid allowed if Medicaid Managed Care found not to be cost effective. • HMO model prohibited in Cameron, Hidalgo, and Maverick counties.
2.30	Premium taxes paid by Medicaid Managed Care health plans are to be treated as allowable expenses for purposes of calculating the experience rebates or profit sharing under contracts with HHSC.
2.31	Permanent Fund for Tobacco Education and Enforcement becomes the Permanent Fund for Health and Tobacco Education and Enforcement. Makes earnings from this funds available for provision of preventive medical and dental services for children's Medicaid.
2.32	Makes the name change described in Section 2.25 above.
2.33	Makes Permanent Fund for Children and Public Health available for funding of two additional purposes: (1) grants to schools of public health and (2) Early Childhood Intervention services (services for infants and toddlers with or at risk of developmental delay).
2.34	Unclaimed Lottery Proceeds. Unclaimed lottery prize money up to $20 million per year appropriated to the TDH State-owned multi-categorical teaching hospital account (for UT Medical Branch at Galveston. • allocates not more than $10 million per year for hospital services in the 15 counties of the Texas-Mexico border, to support provision of TEFRA cost-based reimbursement; • all remaining unclaimed lottery prize money to be deposited to general fund and is simply available for legislative appropriations for any purpose. The bill language says that these purposes may include "the provision of indigent health care services as specified in Chapter 61, Health and Safety Code," but this language has no real legal weight other than indicating some level of legislative intent. In other words, if additional unclaimed lottery prize money funds are available, appropriations for the County Indigent Health Care program can only be increased with LBB authorization, and this language does not direct LBB to increase that appropriation. • Under current law, all funds in excess of the first $40 million per biennium had gone to the TDH Tertiary Care Facility account (to assist

	hospitals with unreimbursed costs of providing trauma care); under HB 2292 this funding is eliminated. (However, new funding for trauma care is created under HB 3588.)
2.35	Medicaid Managed Care and payment for out-of-network services. Amends Govt. Code 533.005 to require that contracts with Medicaid Managed Care organizations include standards for maximum allowable proportions of services that may be provided by out-of network provider s (in other words, provider networks must be large enough so that very large percentages of enrollees will not have to access services out of network). If an MCO is found to violate those thresholds, they must pay out-of network providers at the Medicaid "allowable rate," interpreted to man the rate the state would have paid for the service if the patient were in traditional fee-for-service Medicaid. MCO contacts must require them to pay for and post-stabilization services (after and emergency) provided by an out-of network provider at the Medicaid "allowable rate." MCOs may not deny payment to out-of network provider for post-stabilization services provided because the MCO failed to arrange for transfer to an in-network provider.
2.36	Amends Govt. Code 533.012, requires information to be provided on all funds paid to Managed Care Organizations, including HMOs, PCCM, EPOs (exclusive provider organizations) needed for HHSC to determine actual cost of administering Medicaid Managed Care plans.
2.37, 2.37A	Adds a number of definitions to Govt. code 531 related to Medicaid provider fraud.
2.38-2.41	Amends Govt. Code to exempts HHS agencies from participation in electronic procurement, electronic commerce network, and electronic government program management; allows HHS agencies option to participate.
2.42	All licensing programs under TDH authority must charge fees sufficient to cover both direct and indirect costs of operating the licensure programs. All licenses are to be for two years. • this section will not apply to entity regulated under chapter 773 of Health and Safety code (Emergency Medical Services)
2.43	Deletes from CHIP statute several references to the (defunct) Texas Healthy Kids Corporation.
2.44	CHIP Third Party Billing Vendors. Requires firms that pursue CHIP reimbursement on behalf of CHIP health plans to have a contract with HHSC and comply with various documentation, reporting, and confidentiality standards. HHSC must audit each third-party billing vendor at least annually.
2.45	Eliminate Income Disregards in CHIP. Deletes reference to "net family income" for purposes of CHIP, Replaces with "gross family income" and deletes references to Medicaid program income deductions.
2.46	CHIP Assets Test for families above 150% of Poverty. Deletes more references to "net" family income, and authorizes establishment of asset limits for children with family incomes above 150% of the federal poverty income level. No specifics are given for the asset test. (Note: a fixed cap on CHIP enrollment to be placed in the General Appropriations Act, which was included in earlier versions of the bill, is NOT in the final version).
2.47	CHIP-like coverage for School Employees' Children is to be subject to the same standards and policies as the regular CHIP program. This means it is subject to the same 90-day waiting period, higher premiums and co-pays, six-month continuous eligibility period, and asset test as

	CHIP.
2.48	Reduce CHIP continuous eligibility period to six months (from current 12) in 2004-2005 ONLY. Earlier versions of HB 2292 would have made this change permanent; as adopted, coverage will be restored to 12 months in FY 2006 unless the 79th Legislature takes another action to remain at 6 months.
2.49	Statutory Authority to Cut the CHIP benefit package. Language in the original Texas CHIP law setting CHIP benefits standards is deleted. Under the law, the CHIP benchmark for actuarial value has been linked to HMO coverage for state employees, and the specific benefit package was linked to the recommendations of the original Legislative Interim study reported to the 76th Texas Legislature. Instead, the benefits would be set by the HHSC Commissioner, with "input" from the Public Assistance Health Benefit Review And Design Committee created in section 2.08. NOTE: CHIP benefits that would be eliminated include: dental, durable medical equipment (wheelchairs, crutches, leg braces, prostheses, etc.), chiropractic, hearing aids, home health, hospice, mental health, physical therapy, speech therapy, substance abuse services, vision care and eyeglasses. Only by changing to the "Secretary-Approved Coverage" benchmark option in federal law could Texas strip out proposed benefits from CHIP, leaving "federal minimum benefits, plus drug coverage." USDHHS has never approved such a bare-bones package before. Texas would be the only state not covering mental health in CHIP. CHIP appropriations levels are reduced on assume that the benefits above are eliminated. HHSC Rider #53 in HB 1 says that, within this lower per-child funding amount, HHSC and the health plans may be able to provide limited coverage of some of the otherwise-eliminated benefits, but this would be done only by reducing costs (coverage) of other services. The rider also proposes to try to have Community MHMR authorities provide mental health services to CHIP children, using their existing funds to draw the CHIP federal match. • Authorizes HHSC to limit CHIP children to four outpatient brand-name prescriptions per month and no more than a 34-day supply dispensed, "if…cost-effective." Provides that HHSC may allow exceptions to these limits in consultation with the child's doctor or nurse.
2.50	CHIP cost-sharing may be based on the federal maximum allowable amounts "in a manner that minimizes administrative costs." Based on this, increases in premiums and co-payments across the board will be proposed in rule. The administrative cost language will allow HHSC to standardize cost-sharing within income ranges, rather than (for example) having to charge each family a percentage of its income.
2.51	Imposes New 90-day wait for CHIP coverage to take effect. Rather than requiring children to have been uninsured for 90 days prior to being eligible (current law), the new policy would delay the effective date of coverage for 90 days after the child is found eligible. Clarifies that when a child is found eligible after the 15th of the month, the 90-day period will commence one the first of the next month. • Current exceptions to the 90-day-prior uninsured requirement (e.g., leaving Medicaid, end of COBRA coverage, job loss) will now apply to the 90-day delay. Also, a new exception is created for families opting into HIPP (see Section 2.07). (NOTE: federal law requires that a child be uninsured before he or she is enrolled in CHIP.) Comment: This is a source of some cost reductions to CHIP and the state budget, because the state will avoid paying initial costs of medical episodes that may prompt a parent to seek coverage for a child. By the same token, it will increase medical debt for low-income families, and/or uncompensated care for providers.

2.52	Modifies law governing number of health plans per CHIP service area. Requires that a choice of at least two plans per service area be provided (original statute referred to "metropolitan" areas), unless only one acceptable bidder exists in a given service area. (Also deletes obsolete Texas Healthy Kids Corp references.)
2.53	Premium taxes paid by CHIP health plans are to be treated as allowable expenses for purposes of calculating the experience rebates or profit sharing under contracts with HHSC.
2.54	Border Health Foundation Created. This foundation is created to raise private sector money for health programs in the US-Mexico border area. A board of 5 directors is to be appointed by the TDH Board (while it still exists) based on TDH Commissioner recommendations, shall meet at least twice per year, and will be staffed by TDH under MOU. TDH or any other state agency is authorized to contract with the foundation to finance border health programs.
2.55, 2.56	Amends Health and Safety code 142.003. Exempts home and community-based MR waiver program providers subject to standards and monitoring by TDMHMR from licensure as a home and community support service agency. Alters requirements for on-site surveys at 142.009.
2.57	Alternative JCAHO certification of Medicaid Nursing Homes. Amends Health & Safety code to allow JCAHO accreditation of Medicaid Nursing Homes as an alternative to state licensure and certification now required. The JCAHO must perform annual review, and Nursing Homes must give DHS a copy of the annual review. DHS must determine whether federal authorization or waiver is required (and obtain required authorizations) before accepting JCAHO accreditation. DHS must determine feasibility of this by 10/1/03. (BUT: See section 2.146)
2.58	TROs against Medicaid Nursing Homes. Temporary restraining orders or other injunctive relief against Nursing Homes must be sought in the "county in which the alleged violation occurs" instead of Travis County.
2.59	Penalties for Nursing Home standard violations. Deletes consideration of the gravity of a violation, the potential hazard the violation created for the health and safety of a client in determining the amount of the penalty charge to the facility.
2.60	Limit on Monetary Penalties for Nursing Home standard violations. No more than one monetary penalty may be assessed for the same Nursing Home standard violations; may be the greater of the DHS (Ch 32 Human Resources Code) or the TDH (Ch 242 Health and Safety Code) standard.
2.61	Repeals a number of Rx-handling and monitoring standards for Nursing Homes.
2.62	Also repeals other Rx-handling and monitoring standards for Nursing Homes.
2.63	Licensure of Facilities performing Abortions. Amends Health & Safety code 245.004(a), lowering the threshold for licensure as an abortion clinic from current law 300 abortions performed per year to 50.
2.64	MR Quality Assurance fee extended to state-owned MR facilities.
2.65	Changes formula for counting patient days in MR residential facilities (for purposes of assessing the Quality Assurance fee) to modify the [illegible] "hold"

	counting of beds that are on "hold."
2.66	Pushes filing date for MR residential facilities filing patient day report from 10th to 20th of month.
2.67	Quality Assurance funds may be used for MR residential facility rates, MR community care waiver rates, or for any HHS purpose approved by Governor & LBB.
2.68, 2.69	Amends Health and Safety code 253.008 to require that home and community-based MR waiver program providers must check all potential employees against registry of persons who have abused, neglected or exploited a client of a long-term care facility. Adds these exempt providers to a list of agencies subject to Human Resources code section 48.401, the Employee Misconduct Registry.
2.70	Authorization of Government entities and Hospital Districts to Provide Medical Care to Undocumented Immigrants. Clarifies that local governments (including hospital districts) can provide non-emergency care to residents without regard for citizenship status, provided the services are locally-funded. Says that persons who establish residency "solely" to obtain health care assistance are not considered residents. Note: this provision removes any legal obstacle for Texas local governments choosing to provide comprehensive health care to undocumented residents. Montgomery, Nueces, and Tarrant County Hospital Districts have limited care to this population based on legal interpretation that federal law prohibited that care. With passage of this provision, there is no federal prohibition. Districts may now choose to limit care, but there is no legal impediment to the provision of care.
2.71	Amends Health and Safety code 431.021 with long list of prohibited acts related to the sales of drugs. Related to recycling of unused drugs in certain limited circumstances, see sections 2.102, 2.126, and 2.147.
2.72	Eliminates TCADA compulsive gambling toll-free line. Requires TCADA to maintain a list of web pages and toll-free numbers of non-profits that provide assistance with compulsive gambling.
2.73	At Health and Safety code 533.034 (Authority to Contract for Community-Based Services), authorizes TDMHMR to implement annual and initial renewal compliance fees for home and community-based MR waiver program providers.
2.74	Privatization of ICF-MRs. Mandates that local mental health and mental retardation authorities (MHMRAs) may only serve as a provider of direct services (i.e., rather than a purchaser and coordinator of such services) as a "last resort," and only if the MHMRA has been unable to locate sufficient willing providers with which to contract for services. TDMHMR must develop a plan (with the local MHMRAs) to "privatize all services" of Intermediate Care Facilities for persons with mental retardation (ICF-MRs), as well as "all related waiver service programs." Services may NOT be transferred to private providers "on or before" 8/31/2006. Plan is to provide for consumer choice, least possible disruption for consumers, and no loss of level of service, and must be implemented by the MHMRAs in a "fiscally responsible manner."
2.75	Reduction of Community Mental Health Priority Population to 3 Disorders. This section re-defines the priority population for Local MH Authorities' services to include only persons with Schizophrenia, Bipolar disorder, and/or Major Depression. Local MH Authorities must create jail diversion programs for adults with major psychiatric disorders (bipolar disorder, schizophrenia, severe depression) and for children with serious emotional illness. TDMHMR must enter into performance contracts with the MHMRAs for 2004 and 2005 related to these practices.

	A December 2004 report is required, which must evaluate the impact of disease management, as well as the impact of per capita funding disparities for the MHMRAs on the new programs. Note: This may mean that persons with serious illnesses such as psychosis, non-suicidal depression, anxiety, autism, or personality disorders can no longer be served by the MHMRAs. According to the Mental Health Association in Texas, other diagnoses such as these accounted for over 12% of community center services in 2002, or services for over 16,890 persons out of about 139,000 served. Mental health advocates are concerned that the average cost per client of disease management programs may also result in a dramatic reduction in the numbers of persons who are served, including persons WITH the 3 diagnoses (schizophrenia, bipolar disorder, major depression). MHMRA funding is reduced in the budget, and Medicaid coverage of most mental health professional services have been eliminated as well. Serious reductions in access to care for chronically mentally ill persons, as well as for those experiencing acute MH crises, seem likely to develop in the next 2 years.
2.76	Mental retardation local authority waiver program: this amendment changes the distinct duties of the MHMRA, waiver providers, and TDMHMR. • Waiver providers must develop the client's plan of care and conduct case management. (Note: concern has been expressed that this may amount to writing waiver providers a blank check, by letting them decide how expensive an array of services to provide.) • Local Mental retardation authorities must manage waiting lists, perform functions related to consumer choice and enrollment and conduct case management with regard to funding disputes TDMHMR must perform surveying and certification, utilization reviews, and manage appeals processes related to client services. Must also review screening and assessment of level of care, case management fees paid to a community center, and administrative fees to service providers. Also requires TDMHMR to allocate case management funds between waiver providers and local MHMRAs.
2.77	Privatization of State School authorizes privatizing a state school (for persons with mental retardation) after 8/31/2004 and by 9/1/2005, IF a contractor makes an acceptable proposal which is at least 25% below the cost to TDMHMR to operate that facility. • Cost calculation must include employee benefit costs not appropriated to the department, and related funds would be transferred back to TDMHMR if needed to fund a contract. • Any contractor would be required to serve the same clients at equal "quality level" of care (per latest ICF-MR survey), and treat a population of the same characteristics and need levels as the facility operated by TDMHMR.
2.78 & 2.78A	Privatization of State Hospital authorizes privatizing a state hospital (for persons with mental illness) after 8/31/2004 and by 9/1/2005, IF a contractor makes an acceptable proposal which is at least 25% below the cost to TDMHMR. • Cost calculation must include employee benefit costs not appropriated to the department, and related funds would be transferred back to TDMHMR if needed to fund a contract. • Any contractor would be required to serve the same clients at equal "quality level" of care and treat a population of the same characteristics

	and acuity levels as the facility operated by TDMHMR.
2.79	Sales proceeds of surplus TDMHMR property before 9/2005 may be appropriated for any general governmental purpose (rather than dedicated to MHMR). This provision expires 9/1/2005.
2.80	MH Community Services account. This fund is created under Comptroller oversight, to be funded with donations and bequests, earnings to be used to fund Mental Health services by or under contract to TDMHMR. Interest earned is credited to the account, which is exempt from Govt. code section 403.095 (which governs uses of dedicated revenue).
2.81	MR Community Services account. This fund is created under Comptroller oversight, to be funded with donations and bequests, earnings to be used to fund Mental Retardation services by or under contract to TDMHMR. Interest earned is credited to the account, which is exempt from Govt. code section 403.095 (which governs uses of dedicated revenue)
2.82 & 2.82A	Related to section 2.74 and the mandate that local mental health and mental retardation authorities (MHMRAs) may not serve as providers of services if other providers are available.
2.83	Amends Health and Safety code 572.0025(f), allows psychiatric inpatient admissions to be made based on remote telemedicine examinations.
2.84	Increases licensure fees for a number of provider types licensed by TDH, and directs that such fees should be set at levels high enough to ensure that they fully funds the costs of administering licensure.
2.85	DHS may use third-party databases to verify the accuracy of asset and resource information provided by applicants for Medicaid, TANF, or Food Stamps. Databases include consumer reporting agencies, appraisal district data, and TXDOT vehicle registration records. Note: DHS has historically used such third-party checks for some other administered benefits and groups, and under this provision it will also be used in children's Medicaid.
2.86	**PRA and Sanctions Applied to TANF Child-Only Cases.** This section contains a significant policy change regarding the expectations of TANF "Payee" cases. A "payee" is an adult caring for a TANF-eligible child who is not themselves receiving any cash assistance. These are typically grandparents or other relatives, or a parent who has hit their state TANF time limits and is no longer receiving assistance. Section 2.86 defines a "Payee" and adds a new requirement that these caretakers sign a limited version of the **Personal Responsibility Agreement (PRA)** requiring them to: cooperate with child support enforcement, keep children up to date with health screens and immunizations, not abuse drugs or alcohol, and meet school attendance requirements for themselves and/or the children in their care. "Payee" cases are not currently subject to the requirements of the PRA. With this change "payee" cases will also be subject to the increased sanctions policies contained in Section 2.88 which would end all assistance for noncompliance with PRA requirements (see below).
2.87	Changes the defined standard for deciding the imposition of PRA-related sanctions and penalties from "comply" to "cooperate." It is unclear if this will change the determination or imposition of sanctions in any way.

2.88	TANF Payment of Assistance for Performance. This section implements a full-family sanction process in the TANF program for the first time in Texas. Currently, when a TANF client does not comply with the requirements of the Personal Responsibility Agreement (PRA) their assistance (the adult caretaker's) is terminated (for work and child support requirements) or reduced by a fixed dollar amount (for all other requirements). • The new "payment of assistance after performance" policy will terminate all cash assistance to both adults and children for any infraction of program requirements contained in the PRA – this is defined as "non-cooperation." Additionally, Medicaid benefits will also be cut off for any non-pregnant adult who does not "cooperate" with program requirements. • This new full-family sanction will be imposed for a minimum of one month or until a client "demonstrates' cooperation (whichever is longer). • Failure to "cooperate" for two consecutive months will result in the TANF case being closed. A sanctioned client and their family may reapply but must first demonstrate "cooperation" for a one-month period before assistance is reinstated. • This section also includes language requiring client notification of the imposition of these sanctions, clarifies that sanctions under this policy do not prohibit the delivery of other social or support services, and directs that procedures be developed for determining "non-cooperation." • There is a "good cause" process described in this section which outlines how (and within in what timeframes) a client may request a hearing to challenge a ruling that they did not "cooperate" with program requirements and will be sanctioned. This section clarifies that a client must continue to receive assistance if they have initiated a request for a good cause hearing. If the hearing upholds the agency's decision to impose a sanction, benefits will then be terminated. Additionally, good cause reasons for non-cooperation with child support enforcement activities are limited to situations that could endanger the parent or child or that result "from other circumstances the person could not control." It is not yet clear if this language will encompass current agency policies or be more restrictive. • Information about the number of persons sanctioned under this policy will be added to a required annual report on welfare reform efforts.
2.89	Temporary exclusion of New Spouse's income. In response to recent interest in "marriage promotion" activities in the TANF program, this section creates a new policy that will disregard the income of a new spouse of a TANF recipient for six months – thus allowing the family to continue receiving an assistance payment (as long as the combined income of the recipient and new spouse is less than 200% of the federal poverty level.
2.90	Changes a "noncompliance" reference to "failure to cooperate" and removes obsolete references for TANF work requirements and transitional benefits.
2.91	Creates a new **Healthy Marriage Development Program for TANF recipients** which will offer an ongoing monthly supplemental incentive payment to TANF clients who participate in classes offered through this program; outlines course topics and purposes.
2.92	Nursing Home Standards Related to Quality of care. Requires DHS to include clearly defined minimum standards for quality of care in Nursing Home contracts.
2.93	Employment Plan and Post-Employment Strategies. This section includes several new welfare-to-work related strategies and initiatives for implementation by the Texas Workforce Commission (TWC) and Local Workforce Development Boards (LWDBs). Each of the elements of this section had been developed as interim committee recommendations in the Senate Health and Human Services Committee and/or the

	House Human Services Committee and had been filed as separate pieces of legislation. A) Details requirements that an employment plan and specific post-employment strategies be developed for TANF recipients with the goal of employment at wages adequate for self-sufficiency; includes referral to additional education and training if necessary (SB 68). B) Requires that TWC and Local Workforce Boards shall develop a referral program for TANF client with barriers to employment. Referrals will be for pre-employment and post-employment services provided by community-based organizations (SB 69). C) Requires that TWC and LWDBs provide transportation assistance to TANF recipients and maximize the use of any available federal transportation funds for welfare-to-work efforts (SB 66). D) Emphasizes the importance of addressing housing problems faced by TANF recipients which may be creating barriers to their transition into stable employment. Also requires cooperation and cross-training with local housing authorities and other low-income housing programs and services in order to address housing barriers (SB 67).
2.94	Adds "mentoring" to the post-employment strategies employed by LWDBs for assisting TANF recipients in improving wages and maintaining stable employment.
2.95	Says HHSC must deliver acute care Medicaid (not Long-term or community care) via Medicaid Managed Care (see also section 2.29).
2.96	Medicaid Medically Needy Program is Subject to Availability of appropriated funds. Amends Human Resource code to make Texas' Medicaid Medically Needy spend-down program optional, "subject to availability of appropriated funds." Note: In September 2003, Texas will become the 16th state which offers no "Medically needy spend-down" program. All other states (plus D.C.) have these programs, and unlike Texas, their programs are available not only to poor families with children, but also to aged and disabled persons.
2.97	Medicaid Medical Transportation may serve Nursing Home clients if they do not require ambulance transportation. Authorizes HHSC to impose four brand-name Rx per month limits, as well as 34-day supply dispensing limits for brand-name drugs, to the extent it is cost-effective. Provides that HHSC may allow exceptions in consultation with client's doctor and/or nurse.
2.98	Section reserved. (No bill text.)
2.99	Modification to Children's Medicaid Simplification. Adds language stating that, in addition to allowing use of telephone and mail for Children's Medicaid renewals (current policy), DHS may require a face-to-face appointment if the information needed "cannot be obtained" via mail or phone. Specifies that the standards for requiring face-to-face meetings must be based on ""objective, risk-based factors" for a "targeted group of re-certification reviews for which there is a high probability that eligibility will not be re-certified." Note: this language is consistent with SB 1522 by Zaffirini, the original author of the SB 43 Children's Medicaid Simplification law. Reflects portions of compromise agreements reached by the HB 1 budget conferees.
2.100	Makes Medicaid payments to hospitals for Graduate Medical Education Optional, Subject to Availability of appropriated funds. This allows add-on payments for teaching hospitals to be eliminated under HB 1. HB 1 budget riders allow for restoration of these payments using federal

	fiscal relief funds or unclaimed lottery receipts, but in both cases it appears likely that other programs and priorities will consume all of any such funds, leaving none for GME.
2.101	Maintains Current Six-month Continuous Eligibility for Children's Medicaid until September 2005. This language is consistent with HB 728 (Delisi) and SB 1522 (Zaffirini). This makes the 6-month period temporary, and allows for automatic re-consideration by the next Legislature.
2.102	Nursing Home rate incentive for direct care staffing only will occur if funds are available after base Nursing Home rates are funded. Additional language clarifies that the qualify bonus program is voluntary and does not establish minimum spending limits for direct care staff for non-participating Nursing Homes, nor is the base payment rate to be higher for participating Nursing Homes. Also includes language re: the costs of re-stocking drugs in Nursing Home pharmacies.
2.103	Authorizes DHS to review claims prior to payment for fraud and abuse, and may delay payment up to 5 days for this reason. A hold may be placed on payment of future claims if DHS "has reliable evidence that the provider has committee fraud or willful misrepresentation regarding a claim;" provider must be notified not later than 5th working day after hold is imposed.
2.104	Adds "abuse" to existing Medicaid statute language regarding fraud.
2.105	DHS may require a Medicaid provider to file a Surety Bond if the Department determines provider's service record "indicates a need for protection against…fraud or abuse." • Extends surety bond requirement to providers (e.g. Nursing Homes) which establish trust fund accounts for residents, to cover any deficiencies in such accounts. Sets a maximum amount of such bonds based on the average monthly balance of all accounts held by the provider over a 12-month period. If a provider employee steals a resident's trust fund, the provider is liable for any payments from that fund which they would have otherwise received.
2.106	Medicaid providers MUST bill other insurers including Medicare before billing Medicaid, if the provider knows about, or "should know about" existence of the other insurance.
2.107	HHSC must determine the most cost-effective way to distribute over-the-counter medications and supplies to Medicaid clients. Currently this is done via prescription; HHSC may develop an alternative if that is less expensive. (Note: coverage of OTC drugs is needed to ensure that Medicaid clients can access things like ibuprofen and insulin, which may be the drug of choice, but do not require a prescription).
2.108	Long-term care (including Nursing Homes and community care) providers must bill Medicare before billing Medicaid. DHS will not pay a coinsurance amount if the Medicare payment rate for the service exceeds the Medicaid rate. Creates exceptions in certain Home Health cases (e.g., in which it is unclear that Medicare will not cover the service). DHS will not pay a coinsurance amount if the Medicare payment rate for the service exceeds the Medicaid rate.
2.109	Nursing Home Quality Assurance Team. Creates This Team To Make Recommendations To DHS For Standards Of Nursing Home Care, developing minimum standards for Nursing Homes that will ensure that all meet or exceed those standards, and that encourage provision of the highest standard of care. Standards must also include improved information for consumers, data system and reporting needs, policies to reduce lawsuits against nursing homes, and methods of identifying substandard homes. The costs of compliance with the standards, both for

	providers and for overall impact on appropriations, must be considered. Report the recommended guidelines developed due to Gov. and LBB by 10/1/2004.
2.110	Community Attendant Services Program. Re-names the Frail Elderly program, which serves persons with incomes above the SSI limit for provision of attendant care for elderly or disabled persons.
2.111	Medicaid Third Party Billing Vendors. Requires firms that pursue Medicaid reimbursement on behalf of Medicaid providers to have a contract with HHSC and comply with various documentation, reporting, and confidentiality standards. HHSC must audit each third-party billing vendor at least annually. (see also section 2.44)
2.112	Mandates HHSC to impose Medicaid cost-sharing to extent allowed under federal law. Lists options for cost sharing, including enrollment fees (not currently allowed or even "waivable" under federal law), deductibles, coinsurance, and premium sharing (there are no references to co-payments). • Cost sharing may be based on the federal maximum allowable amounts "in a manner that minimizes administrative costs." • Premiums may be paid to HHSC, an "agency" operating part of Medicaid, or a Medicaid Managed Care health plan.
2.113	Amends Human Resources code language related to exemption of waiver providers from licensure as home and community support services agencies. (See sections 2.55, etc.)
2.114	Early Childhood Intervention program may institute sliding scale co-payments.
2.115	Blindness education, screening and treatment program shall include transition services for blind individuals eligible for vocational rehabilitation services, if funds available.
2.116	References to Texas Rehab Commission (TRC) "extended rehabilitation services program" are deleted, along with reference to sheltered employment and community integrated employment. New language directs TRC to assess statewide need for transition assistance from school to employment, calling for relationships with schools and regional education service centers.
2.117	Comprehensive Rehabilitation Fund may be used for "general governmental purposes" if a shortfall between available revenue and appropriations develops during the upcoming biennium. Comptroller or LBB may determine this is called for.
2.118	Communities in Schools program moved to Texas Education Agency. Substitutes "eligible for free or reduced lunch (sic)" for "educationally disadvantaged" in definitions for CIS.
2.119-2.121	Deletes exemptions in Insurance code of Medicaid and CHIP health insurers and HMOs from premium taxes. Clarifies that certain non-HMO providers of Medicaid Managed Care shall be treated like HMOs for purposes of imposing premium tax.
2.122	Requires group health plans to allow persons losing Medicaid and CHIP to enroll without waiting for an open enrollment period (i.e., makes such transition a "qualifying event").

2.123	Mandates coverage in group health plans of services for children with developmental delay: Speech, Physical Occupational Therapies; not subject to annual or lifetime caps, may not be used to increase premiums or terminate coverage. Comment: SB 541 would essentially eliminate all such health insurance mandates.
2.124-2.125	Retains the current exemption of children's health insurance products authorized in 1997 with the creation of the now-defunct Texas Healthy Kids Corp, and clarifies that that exemption does NOT apply to Medicaid & CHIP MCOS serving children.
2.126	Provides for re-distribution of unused prescription drugs under certain circumstances. Drugs must be in sealed, unopened, tamper-evident packaging. Medicaid program must be credited for such returns; limits are placed on pharmacy liability. (See also 2.71, 2.102, 2.147)
2.127-2.134	All health and human service transportation functions to be operated under contract with Texas Department of Transportation. • Makes the transfer of transportation programs to TXDOT OPTIONAL for programs under Human Resources code 40.002, Protective and Regulatory Services only. • General language encourages the continued use of existing transportation providers, non-profit providers, and private sector transportation resources. Allows contracting with private providers including regional transportation brokers.
2.135	Would make SKIP (enhanced premium subsidy for low-income state employees' children , designed to mirror CHIP) subject to same policy limits as CHIP, i.e. six-month continuous, 90-day wait, and income eligibility cap. Note: Presumably the 90-day wait would only delay the effective date of subsidy for a child already covered in the E.R.S. system, but newly applying for SKIP. New state employees will now be subject to a 90-day delay in benefits under other new legislation, so this SKIP policy will parallel CHIP and ERS policy in those cases.
2.136- 2.139	Amend Penal Code to give state A.G. concurrent jurisdiction with local county and district attorneys in Medicaid fraud cases, with consent of those local officials.
2.140	TIF fund also available for HHSC technology initiatives.
2.141-2.142	Amends Code of Criminal Procedure 59.01 and 59.06. Includes state A.G. in jurisdiction related to seizure of assets in Medicaid fraud cases, provides for AG to transfer funds derived from seized property in such cases to HHSC to allow for recovery.
2.143	Study of identity verification for public benefits. Medicaid and Public Assistance Fraud Oversight Task Force must produce report by 12/2004 must identify any improvements in identity verification procedures needed to prevent fraud.
2.144	Study mandated on drug rebates. Study must include looking into exemption form federal law that now governs rebates, including feasibility of having to share less of the savings with the federal government as required under current law. Task force created to direct study. Report to Governor, leadership, budget committees by 12/1/2004.
2.145	Transportation programs transfer to TXDOT: Adds statement of intent of Legislature to improve access, efficiency, coordination, and control

	costs.
2.146	JCAHO accreditation for nursing homes is only available to nursing homes providing Medicaid services before 9/1/2003, and this option is a pilot program only, which sunsets 9/1/2007. (See section 2.57)
2.147	More timelines and rule-making related to re-distribution of unused prescription drugs under certain circumstances. (See 2.71, 2.102, 2.126)
2.148	Timeline for making changes mandated in new Human Resources Code 32.028 (i) and (j), rate incentives for improving nursing home direct care and wages. (See 2.102)
2.149	Medicaid Medical Transportation Program moved to HHSC (which must contract with TXDOT to operate the program).
2.150	All Medicaid related third-party recovery functions to be consolidated and operated by the current HHSC post-payment recovery contractor.
2.151	Only federally mandated advisory committees or those related to licensure/certification will be continued (all others abolished). Would abolish Aged and Disabled, Physician Payment, Hospital Payment, Texas Works advisory committees, to name a few. • Any advisory committees NOT abolished, or any newly created in future, must make recommendations to the appropriate agency E.D. and the HHSC commissioner regarding the elimination or reduction of overlapping functions or duties among HHSC agencies.
2.152	Allows Community Mental health Centers to coordinate with Federally Qualified Health Centers, Disproportionate Share Hospitals, or "other entities" for purposes of accessing favorable drug pricing (federal "340B" pricing), regardless of any statewide PDL which may be developed.
2.153	Medicaid-CHIP Choice Waiver. Directs HHSC to request a waiver from the US Department of Health and Human Services, to allow parents of children on Medicaid to "opt into" CHIP coverage instead of Medicaid. The state would still only get the Medicaid match rate for such children. Both the state's entitlement to federal matching funds, and the child's entitlement to Medicaid coverage is to be retained under any such waiver. Also, waiver shall allow on at least an annual basis parents who previously opted to move a Medicaid-eligible child into CHIP to return the child to Medicaid. Note: This concept is much improved over original language. Because the state and child must retain entitlement to Medicaid matching funds and eligibility, such a waiver should avoid converting Texas children's Medicaid entitlement coverage to a Block Grant. Because so many important benefits have been eliminated from CHIP, parents are now far less likely to choose CHIP over Medicaid for their children Still, ensuring that parents who choose CHIP over Medicaid will be able to change their mind later and return to Medicaid is a key improvement. It will remain important to ensure that children's Medicaid simplification is preserved reasonably well, so that Medicaid process hassles do not force parents into CHIP.
2.154	HHSC must ask federal approval to count employer contributions to HIPP as state matching funds for purpose of drawing CHIP federal match. (See section 2.07) Note: Thus far, CMS has required states to treat such funds as shared between the state and federal governments, but presumably this policy could change.

2.155	HHSC must ask federal approval to count employer contributions to HIPP as state matching funds for purpose of drawing Medicaid federal match. (See section 2.07, and note above)
2.156	Repealed: • Standards for contracting with defunct Texas Healthy Kids are deleted (Health and Safety code 62.055(b) and (c)); • Community-Based Organizations (CBOs) as a required part of CHIP outreach deleted (H&S 62.056); • CHIP Regional Advisory Committees (RACs) are deleted (H&S 62.057); • H&S 142.006(d), (e) and (f), re: licensure of home and community support services agencies. • H&S 142.009(i) exemption of home and community support services agency from surveys; • H&S 142.0176 which exempted home and community support services agency from certain administrative penalties, • H&S 242.0372 standards for liability insurance for nursing homes; • dedication of MR facility quality assurance funds to increasing ICF-MR rates is deleted (H&S 252.206(d)); • required rulemaking for the formula for use of the MR facility quality assurance funds is deleted (H&S 252.207(b)); • statutory directive for Medicaid coverage of podiatry, and services of licensed psychologists and licensed marriage and family therapists is deleted (Human Resources 32.027(b) and (e); and • provides that CHIP RACS are abolished on the effective date of the legislation. Note: Other Medicaid services eliminated for adults did not have mandating clauses in statute, and thus no repealer language is included (e.g., hearing aids and eyeglasses for elderly and disabled clients, and services of licensed professional counselors and social workers).
2.157	Prevailing Clause. This bill could supercede any conflicting bill that passes (unless that bill contains a prevailing clause, too).
2.158	Standard Waiver Authority. Agencies may request any waiver needed to implement the bill, and delay implementation until approval received.
2.159	Requires that funding for human services transportation provided by TXDOT per sections 2.127-2.134 to be accounted for and budgeted separately from other TXDOT funding and programs.
2.160-2.164	Amends Education Code Section 38.001, 51.933, and H&S 161.004(d), 161.0041, and Human Resources 42.043. Allows parents to opt out of immunizing their children as a requirement of public school attendance based on either a physician's statement that the immunization "poses a significant risk" to the child or a family member, or a parent's conscience or religious belief. This exemption is also available for attendance at day care facilities. The Commissioner of Health may declare situations of epidemic or emergency during which un-immunized children may be excluded from school or day care. An official affidavit form for the parent or guardian will be developed, but the only record the state will have is of the number of forms mailed out. The state is expressly forbidden to maintain a record of the parents who have requested the affidavits. Note: because the state will have no record of which children are subject to opt-out affidavits, any such action taken by a Commissioner

	during an epidemic or other health emergency will essentially be on the "honor system."
2.165	"Family Protection Fee." Authorizes counties to levy a fee not to exceed $15 for the filing of a divorce. Counties doing so must exempt divorce filings in connection with Domestic Violence and/or when a protective order is involved. Levying counties must create a Family Protection Account in which all fees are deposited. These funds MAY be granted to nonprofit organizations providing family violence prevention and intervention, mental health and counseling services, legal services, or marriage preservation services to families experiencing or at risk of family violence, or experiencing or at risk of abuse or neglect of a child.
2.166	Amends Gov't Code 531 to add section re: "Children with Multi-agency Needs." Sec. 531.421. Defines "Children with severe emotional disturbances" to include: (A) children who are at risk of incarceration or placement in a residential mental health facility; (B) children for whom a court may appoint the Department of Protective and Regulatory Services as managing conservator; (C) children who are students in a special education program under Subchapter A, Chapter 29, Education Code; and (D) children who have a substance abuse disorder or a developmental disability. Directs each community resource coordination group to evaluate the community resources available (as well as barriers and changes needed) to meet the needs of all such children. Reports on CRCG finding must be made to consortium that oversees the Texas Integrated Funding Initiative (TIFI). The consortium must produce a combined report on findings to the governor and the 79th Legislature by January 11, 2005.
2.167-2.191	Public Health Disasters, Powers of Quarantine, etc. Governor or health Commissioner may declare disaster if high risk of death, disability from communicable disease. • Authority to obtain information from DPS databases for purposes of diagnosis, treatment or evaluation of communicable disease. • In a disaster, Commission may require disease reporting without rule-making. • During disaster, private health information may be released to law enforcement personnel, "solely for the purpose of protecting the health or life of the person identified and "only the minimum necessary information may be released." • Clarifies that evidence found under inspection and search authority of public places (already in statute) limited to criminal proceedings related to this chapter. Refusing inspection of "an individual, animal, or object that is in isolation, detention, restriction, or quarantine instituted by the commissioner" is an offense. • Declarations of Public Health Disasters last 30 days, may be renewed for one additional 30-day period, and Governor may cancel at any time. • An individual may be subject to court orders if "infected or is reasonably suspected of being infected with a communicable disease that presents an immediate threat to the public health, " or if "the individual has indicated that the individual will not voluntarily comply with control measures." • In a public health disaster, the state may order a person who owns or controls to disinfect or decontaminate the property or, if technically feasible control measures are not available, may order the securing or the destruction of property. • Clarifies that quarantines may be ordered in order to determine whether or not communicable disease is present. • Individuals must report their immunization status to health authorities in a public health disaster, and for persons lacking needed immunizations "the department may take appropriate action during a quarantine to protect that individual and the public from the communicable disease."

	• Exemptions from autopsy and allowances for mandatory cremation are defined in a public health disaster.
2.192	The Statewide Health Coordinating Council. Adds an R.N. and a representative of a junior or community college with a nursing program.
2.193	Adds definitions of personal care services to Health and Safety Code, and defines these services to be a component of "personal assistance services."
2.194	Limits the use of the descriptor "personal assistance services" to individuals licensed to provide those services.
2.195	Home and community support agencies and their RN or LVN employees may possess flu vaccines.
2.196	Adjustments to Board of Nurse Examiners Advisory Board.
2.197	Investigations of alleged abuse, neglect or exploitation by a home and community support services agency may be conducted without an on-site survey.
2.198	Language change related to exemption of HCS waiver providers from licensure as home and community support services agency.
2.199	More on the confidentiality of drug price information disclosed to the state in the supplemental rebate-PDL process.
2.200	Increases upper limit for number of members of MHMR Community Center boards range from 9 to 13.
2.201	TANF resource upper limit reduced to $1,000. Conforms statutory references regarding TANF asset limits to the changes included in the FY 04-05 budget. That is, asset limits used for determining eligibility for TANF are rolled back to pre-1995 levels of only $1,000. Current policy allows $2,000 in assets, or $3,000 if there is an elderly or disabled person in the household. This does not affect Medicaid eligibility for low-income parents, children, or for aged or disabled persons.
2.202	"Consumer-directed Services Program." Directs DHS to create a program (in conjunction with TRC and Comptroller) in which certain clients in community care waiver programs may receive stipends with which they may purchase the services they need. Annual reports to state leadership required, waivers to be requested by 1/2004, and sunsets 9/1/2007.
2.203	More language related to adoption of standards and limits on the proportion of services in Medicaid Managed Care which may be provided by out-of-network providers (i.e., as a protection against inadequate provider networks). Provides for corrective plans if standards not met. HHSC must investigate and respond to provider complaints of health plan violations within 60 days; timeline for health plan payments if complaints are justified.(See section 2.35)
2.204	Any agency licensed to provide home health services under H&S code 142 (not just Medicare-certified providers) may provide home health services to children in Medicaid's Texas Health Steps comprehensive care program.
2.205- 2.206	Changes "Community Hospital Capital Improvement Fund" to "Permanent Hospital Fund for Capital Improvements and the Texas Center for Infectious Disease." Adds Texas Center for Infectious Disease to the 125-or-fewer-bed hospitals previously eligible for grants from the fund.

2.207	Reduces the personal needs allowance of Medicaid nursing home residents (the monthly amount that Medicaid nursing home residents may retain from the SSI, Social Security or other pension income, the remainder going to the nursing home) from $60 to $45.
2.208-2.217	Travis County Hospital District Enabled. Amend section 281 of the H&S code to provide for modifications to existing statute to be applicable to the possible creation of a hospital district in Travis County (the only major urban Texas county without such a district). Would limit the tax rate to 25 cents per hundred dollar valuation, well below the 75 cent limit applicable to older hospital districts. Allows for a board appointed by both county and city government. Mandates an offsetting reduction in city and county sales taxes if/when voters approve a district and health care responsibilities are transferred from city and county to district. Prohibits use of sales tax by this district.
2.218	Effective date: Except where otherwise noted, 9/1/2003.