GOVERNMENT CODE

TITLE 4. EXECUTIVE BRANCH

SUBTITLE I. HEALTH AND HUMAN SERVICES

CHAPTER 531. HEALTH AND HUMAN SERVICES COMMISSION

SUBCHAPTER A. GENERAL PROVISIONS; ORGANIZATION OF COMMISSION

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 2056, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.001. DEFINITIONS. In this subtitle:

(1) "Caseload standards" means the minimum and maximum number of cases that an employee can reasonably be expected to perform in a normal work month based on the number of cases handled by or the number of different job functions performed by the employee.

(1-a) "Child health plan program" means the child health plan program established under Chapters 62 and 63, Health and Safety Code.

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

(3) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(3-a) "Health and human services system" means the system for providing or otherwise administering health and human services in this state by the commission, including through an office or division of the commission or through another entity under the administrative and operational control of the executive commissioner.

(4) "Health and human services agencies" includes the:

(A) Department of Aging and Disability Services;

(B) Department of State Health Services; and

(C) Department of Assistive and Rehabilitative Services.

(4-a) "Home telemonitoring service" means a health service that requires scheduled remote monitoring of data related

to a patient's health and transmission of the data to a licensed home and community support services agency or a hospital, as those terms are defined by Section 531.02164(a).

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

(4-c) "Medicaid managed care organization" means a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients.

(4-d) "Platform" means the technology, system, software, application, modality, or other method through which a health professional remotely interfaces with a patient when providing a health care service or procedure as a telemedicine medical service or telehealth service.

(5) "Professional caseload standards" means caseload standards that are established or are recommended for establishment for employees of health and human services agencies by management studies conducted for health and human services agencies or by an authority or association, including the Child Welfare League of America, the National Eligibility Workers Association, the National Association of Social Workers, and associations of state health and human services agencies.

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

(7) "Telehealth service" has the meaning assigned by Section 111.001, Occupations Code.

(8) "Telemedicine medical service" has the meaning assigned by Section 111.001, Occupations Code.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.01, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 1022, Sec. 97, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 7, Sec. 2, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 899, Sec. 1, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 8.01, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 53, Sec. 1, eff. Sept. 1, 2001; Acts 2001, 77th

Leg., ch. 957, Sec. 6, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1429, Sec. 9.007, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 198, Sec. 1.01(a) to 1.01(c), 2.01, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 9.009, eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1205 (S.B. 293), Sec. 1, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.007, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.01, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. 1107), Sec. 8, eff. May 27, 2017.

Acts 2017, 85th Leg., R.S., Ch. 316 (H.B. 5), Sec. 22, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 1, eff. June 14, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 1, eff. September 1, 2019.

Sec. 531.0011. REFERENCES IN LAW MEANING COMMISSION OR APPROPRIATE DIVISION. (a) In this code or in any other law, a reference to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, means the commission or the division of the commission performing the function previously performed by the state agency or entity before the transfer, as appropriate:

(1) health and human services agency;

(2) the Department of State Health Services;

(3) the Department of Aging and Disability Services;

(4) the Department of Family and Protective Services; or

(5) the Department of Assistive and Rehabilitative Services.

(b) In this code or in any other law and notwithstanding any other law, a reference to any of the following state agencies or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, from the state agency that assumed the relevant function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, means the commission or the division of the commission performing the function previously performed by the agency that assumed the function before the transfer, as appropriate:

(1) the Texas Department on Aging;

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

(3) the Texas Commission for the Blind;

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

(5) the Texas Department of Health;

(6) the Texas Department of Human Services;

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

(8) the Texas Rehabilitation Commission;

(9) the Texas Health Care Information Council; or

(10) the Interagency Council on Early Childhood Intervention.

(c) In this code or in any other law and notwithstanding any other law, a reference to the Department of Protective and Regulatory Services in relation to a function transferred under Section 531.0201, 531.02011, or 531.02012, as applicable, from the Department of Family and Protective Services means the commission or the division of the commission performing the function previously performed by the Department of Family and Protective Services before the transfer.

(d) This section applies notwithstanding Section 531.001(4).

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.02, eff. September 1, 2015.

Sec. 531.0012. REFERENCES IN LAW MEANING EXECUTIVE COMMISSIONER OR DESIGNEE. (a) In this code or in any other law, a reference to any of the following persons in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, means the executive commissioner, the executive commissioner's designee, or the director of the division of the commission performing the function previously performed by the state agency from which it was transferred and that the person represented, as appropriate:

(1) the commissioner of aging and disability services;

(2) the commissioner of assistive and rehabilitative services;

(3) the commissioner of state health services; or

(4) the commissioner of the Department of Family and Protective Services.

(b) In this code or in any other law and notwithstanding any other law, a reference to any of the following persons or entities in relation to a function transferred to the commission under Section 531.0201, 531.02011, or 531.02012, as applicable, from the state agency that assumed or continued to perform the function in accordance with Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, means the executive commissioner or the director of the division of the commission performing the function performed before the enactment of Chapter 198 (H.B. 2292) by the state agency that was abolished or renamed by Chapter 198 (H.B. 2292) and that the person or entity represented:

(1) an executive director or other chief administrative officer of a state agency listed in Section 531.0011(b) or of the Department of Protective and Regulatory Services; or

(2) the governing body of a state agency listed in Section 531.0011(b) or of the Department of Protective and Regulatory Services.

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

function of that appropriate person:

(1) the Health and Human Services Council;

(2) the Aging and Disability Services Council;

(3) the Assistive and Rehabilitative Services Council;

(4) the Family and Protective Services Council; or

(5) the State Health Services Council.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.02, eff. September 1, 2015.

Sec. 531.002. HEALTH AND HUMAN SERVICES COMMISSION; RESPONSIBILITY. (a) The Health and Human Services Commission is an agency of the state.

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

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

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

(3) emphasizes coordination, flexibility, and decision-making at the local level.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.0025. RESTRICTIONS ON AWARDS TO FAMILY PLANNING SERVICE PROVIDERS. (a) Notwithstanding any other law, money appropriated to the Department of State Health Services for the purpose of providing family planning services must be awarded:

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

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

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

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

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

(b) Notwithstanding Subsection (a), the Department of State Health Services shall, in compliance with federal law, ensure distribution of funds for family planning services in a manner that does not severely limit or eliminate access to those services in any region of the state.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.19(a), eff. September 28, 2011.

Sec. 531.003. GOALS. The commission's goals are to:

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

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

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

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

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

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

(B) increasing the availability of health care services;

(C) improving the quality of health care services;

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

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

(F) improving knowledge of health care needs;

(G) reducing infant death and disease;

(H) reducing the impact of mental disorders in adults;

(I) reducing the impact of emotional disturbances in children;

(J) increasing participation in nutrition programs;

(K) increasing nutritional education; and

(L) reducing substance abuse;

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

(A) improving workforce skills;

(B) increasing employment, earnings, and benefits;

(C) increasing housing opportunities;

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

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

(F) reducing school dropouts;

(G) reducing teen pregnancy;

(H) improving parental effectiveness;

(I) increasing support services for people with disabilities;

(J) increasing services to help people with disabilities maintain or increase their independence;

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

(L) improving services to juvenile offenders;

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

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

(B) reducing extended dependency on basic support services; and

(C) increasing the availability and diversity of

long-term care provided to support people with chronic conditions in settings that focus on community-based services with options ranging from their own homes to total-care facilities;

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

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

(B) reducing child abuse and neglect;

(C) reducing family violence;

(D) increasing services to truants and runaways, children at risk of truancy or running away, and their families;

(E) reducing crime and juvenile delinquency;

(F) reducing community health risks; and

(G) improving regulation of human services providers; and

(7) improve the coordination and delivery of children's services.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.004. SUNSET PROVISION. The Health and Human Services Commission is subject to Chapter 325 (Texas Sunset Act). Unless continued in existence as provided by that chapter, the commission is abolished and this chapter expires September 1, 2027.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 1.01, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 1.02, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 928 (H.B. 3249), Sec. 3.01, eff. June 15, 2007.

Acts 2009, 81st Leg., 1st C.S., Ch. 2 (S.B. 2), Sec. 2.05, eff. July 10, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1232 (S.B. 652), Sec. 2.06, eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 4.01,

eff. September 1, 2015.

Sec. 531.005. EXECUTIVE COMMISSIONER. (a) The commission is governed by an executive commissioner appointed by the governor with the advice and consent of the senate.

(b) The executive commissioner shall be appointed without regard to race, color, disability, sex, religion, age, or national origin.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 1.02A, eff. Sept. 1, 2003.

Sec. 531.0051. HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL. (a) The Health and Human Services Commission Executive Council is established to receive public input and advise the executive commissioner regarding the operation of the commission. The council shall seek and receive public comment on:

(1) proposed rules;

(2) recommendations of advisory committees;

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

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

(5) other items the executive commissioner determines appropriate.

(b) The council does not have authority to make administrative or policy decisions.

(c) The council is composed of:

(1) the executive commissioner;

(2) the director of each division established by the executive commissioner under Section 531.008(c);

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

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

(5) other individuals appointed by the executive

commissioner as the executive commissioner determines necessary.

(c-1) To the extent the executive commissioner appoints members to the council under Subsection (c)(4), the executive commissioner shall make every effort to ensure that those appointments result in a council membership that includes:

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

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

(d) The executive commissioner serves as the chair of the council and shall adopt rules for the operation of the council.

(e) Members of the council appointed under Subsection (c)(4):

(1) are subject to the restrictions applicable to service on the council provided by Section 531.006(a-1); and

(2) serve at the pleasure of the executive commissioner.

(f) The council shall meet at the call of the executive commissioner at least quarterly. The executive commissioner may call additional meetings as the executive commissioner determines necessary.

(g) The council shall comply with the requirements of Section 531.0165. The archived video and audio of a council meeting must be made available through the commission's Internet website.

(h) A majority of the members of the council constitute a quorum for the transaction of business.

(i) A council member appointed under Subsection (c)(4) may not receive compensation for service as a member of the council but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the council as provided by the General Appropriations Act.

(j) The executive commissioner shall develop and implement policies that provide the public with a reasonable opportunity to appear before the council which may include holding meetings in various geographic areas across this state, or through allowing public comment at teleconferencing centers in various geographic

areas across this state and to speak on any issue under the jurisdiction of the commission.

(k) A meeting of individual members of the council that occurs in the ordinary course of commission operation is not a meeting of the council, and the requirements of Subsection (g) do not apply.

(l) This section does not limit the authority of the executive commissioner to establish additional advisory committees or councils.

(m) Except as provided by Section 531.0165(d), Chapters 551 and 2110 do not apply to the council.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.03(a), eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 81 (H.B. 630), Sec. 3, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 312 (S.B. 1021), Sec. 1, eff. May 29, 2017.

Sec. 531.0055. EXECUTIVE COMMISSIONER: GENERAL RESPONSIBILITY FOR HEALTH AND HUMAN SERVICES SYSTEM. (a) In this section and in Section 531.0056, "agency director" means the commissioner of a health and human services agency.

(b) The commission shall:

(1) supervise the administration and operation of Medicaid, including the administration and operation of the Medicaid managed care system in accordance with Section 531.021;

(2) perform information systems planning and management for the health and human services system under Section 531.0273, with:

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

(B) an emphasis on research and implementation on a demonstration or pilot basis of appropriate and efficient uses of

new and existing technology to improve the operation of the health and human services system and delivery of health and human services;

(3) monitor and ensure the effective use of all federal funds received for the health and human services system in accordance with Section 531.028 and the General Appropriations Act;

(4) implement Texas Integrated Enrollment Services as required by Subchapter F, except that notwithstanding Subchapter F, determining eligibility for benefits under the following programs is the responsibility of and must be centralized by the commission:

(A) the child health plan program;

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

(C) Medicaid;

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

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

(F) community-based support services identified or provided in accordance with Section 531.02481; and

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

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

(c) The commission shall implement the powers and duties given to the commission under Sections 531.0246, 531.0247, 2155.144, and 2167.004.

(d) After implementation of the commission's duties under Subsections (b) and (c), the commission shall implement the powers and duties given to the commission under Section 531.0248. Nothing in the priorities established by this section is intended to limit the authority of the commission to work simultaneously to achieve the multiple tasks assigned to the commission in this section, when such an approach is beneficial in the judgment of the commission. The commission shall plan and implement an efficient and effective centralized system of administrative support services for the health and human services system in accordance

with Section 531.00553.

(e) Notwithstanding any other law, the executive commissioner shall adopt rules and policies for the operation of and provision of health and human services by the health and human services system. In addition, the executive commissioner, as necessary to perform the functions described by Subsections (b), (c), and (d) and Section 531.00553 in implementation of applicable policies established for a health and human services system agency or division, as applicable, by the executive commissioner, shall:

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

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

(3) be responsible for the administrative supervision of the internal audit program for the health and human services system agencies, including:

(A) selecting the director of internal audit;

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

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

(f) The operational authority and responsibility of the executive commissioner for purposes of Subsection (e) for each health and human services system agency or division, as applicable, includes authority over and responsibility for the:

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

(2) allocation of resources within the agency or division, including use of federal funds received by the agency or division;

(3) personnel and employment policies;

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

(5) information resources systems used by the agency or division;

(6) location of facilities; and

(7) coordination of agency or division activities with activities of other components of the health and human services system and state agencies.

(g) Notwithstanding any other law, the operational authority and responsibility of the executive commissioner for purposes of Subsection (e) for each health and human services system agency or division, as applicable, includes the authority and responsibility to adopt or approve, subject to applicable limitations, any rate of payment or similar provision required by law to be adopted or approved by a health and human services system agency.

(h) For each health and human services system agency and division, as applicable, the executive commissioner shall implement a program to evaluate and supervise daily operations. The program must include measurable performance objectives for each agency or division director and adequate reporting requirements to permit the executive commissioner to perform the duties assigned to the executive commissioner under this section.

(i) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec. 1.23(d), eff. September 1, 2017.

(j) The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section.

(k) The executive commissioner and each agency director shall enter into a memorandum of understanding in the manner prescribed by Section 531.0163 that:

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

(A) the responsibility of the agency director to report to the governor and to report to and implement policies of the executive commissioner; and

(B) the extent to which the agency director acts as a liaison between the agency and the commission;

(2) establishes the program of evaluation and supervision of daily operations required by Subsection (h);

(3) describes each delegation of a power or duty made to an agency director; and

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

(l) Notwithstanding any other law, the executive commissioner has the authority to adopt policies and rules governing the delivery of services to persons who are served by the health and human services system and the rights and duties of persons who are served or regulated by the system.

(m) The executive commissioner shall establish standards for the use of electronic signatures in accordance with the Uniform Electronic Transactions Act (Chapter 322, Business & Commerce Code), with respect to any transaction, as defined by Section 322.002, Business & Commerce Code, in connection with the administration of health and human services programs.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 2.01, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 1.03, eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 11.009, eff. September 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.008, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.04, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.05, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.23(d), eff. September 1, 2017.

Sec. 531.00551. PROCEDURES FOR ADOPTING RULES AND POLICIES. (a) The executive commissioner shall develop procedures for adopting rules for the health and human services agencies. The

procedures must specify the manner in which the health and human services agencies may participate in the rulemaking process.

(b) A health and human services agency shall assist the executive commissioner in the development of policies and guidelines needed for the administration of the agency's functions and shall submit any proposed policies and guidelines to the executive commissioner. The agency may implement a proposed policy or guideline only if the executive commissioner approves the policy or guideline.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.009, eff. April 2, 2015.

Sec. 531.00552. CONSOLIDATED INTERNAL AUDIT PROGRAM. (a) Notwithstanding Section 2102.005, the commission shall operate the internal audit program required under Chapter 2102 for the commission and each health and human services agency as a consolidated internal audit program.

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

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.02, eff. September 1, 2015.

Sec. 531.00553. ADMINISTRATIVE SUPPORT SERVICES. (a) In this section, the term "administrative support services" includes strategic planning and evaluation, audit, legal, human resources, information resources, purchasing, contracting, financial management, and accounting services.

(b) Subject to Subsection (c), the executive commissioner shall plan and implement an efficient and effective centralized system of administrative support services for the health and human services system and the Department of Family and Protective Services, as applicable. The performance of administrative support services for the health and human services system is the responsibility of the commission.

(c) The executive commissioner shall plan and implement the centralized system of administrative support services in

accordance with the following principles and requirements:

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

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

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

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

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

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

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

(E) any other item determined by the executive commissioner to be critical for maintaining accountability.

(d) The memorandum of understanding or other agreement required under Subsection (c), if appropriate, may be combined with the memorandum of understanding required under Section 531.0055(k).

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.06, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 316 (H.B. 5), Sec. 23, eff. September 1, 2017.

Sec. 531.00554. CRIMINAL BACKGROUND CHECKS. (a) In this

section, "eligible person" means a person whose criminal history record information the executive commissioner, or the executive commissioner's designee, is entitled to obtain from the Department of Public Safety under Section 411.1106.

(b) The executive commissioner may require an eligible person to submit fingerprints in a form and of a quality acceptable to the Department of Public Safety and the Federal Bureau of Investigation for use in conducting a criminal history background check by obtaining criminal history record information under Sections 411.1106 and 411.087.

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

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

Added by Acts 2015, 84th Leg., R.S., Ch. 1209 (S.B. 1540), Sec. 3, eff. June 19, 2015.

Redesignated from Government Code, Section 531.00553 by Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 24.001(16), eff. September 1, 2017.

Sec. 531.0056. APPOINTMENT OF AGENCY DIRECTOR BY EXECUTIVE COMMISSIONER. (a) The executive commissioner shall appoint an agency director for each health and human services agency with the approval of the governor.

(b) An agency director appointed by the executive commissioner serves at the pleasure of the executive commissioner.

(c) In addition to the requirements of Section 531.0055(k)(1), the memorandum of understanding required by that section must clearly define the responsibilities of the agency director.

(d) The terms of the memorandum of understanding shall

outline specific performance objectives, as defined by the executive commissioner, to be fulfilled by the agency director, including the performance objectives outlined in Section 531.0055(h).

(e) Based upon the performance objectives outlined in the memorandum of understanding, the executive commissioner shall perform an employment evaluation of the agency director.

(f) The executive commissioner shall submit the evaluation to the governor not later than January 1 of each even-numbered year.

(g) The requirements of this section apply with respect to a state agency listed in Section 531.001(4) only until the agency is abolished under Section 531.0202.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 2.01, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 1.04, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.07, eff. September 1, 2015.

Sec. 531.00561. APPOINTMENT AND QUALIFICATIONS OF DIVISION DIRECTORS. (a) The executive commissioner shall appoint a director for each division established within the commission under Section 531.008, except that the director of the office of inspector general is appointed in accordance with Section 531.102(a-1).

(b) The executive commissioner shall:

(1) develop clear qualifications for the director of each division appointed under this section that ensure that an individual appointed director has:

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

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

(2) ensure the qualifications developed under Subdivision (1) are publicly available.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.08(a), eff. September 1, 2015.

Sec. 531.00562. DIVISION DIRECTOR DUTIES. (a) The executive commissioner shall clearly define the duties and responsibilities of a division director and develop clear policies for the delegation of specific decision-making authority, including budget authority, to division directors.

(b) The delegation of decision-making authority should be significant enough to ensure the efficient administration of the commission's programs and services.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.08(a), eff. September 1, 2015.

Sec. 531.0057. MEDICAL TRANSPORTATION SERVICES. (a) The commission shall provide medical transportation services for clients of eligible health and human services programs.

(b) The commission may contract with any public or private transportation provider or with any regional transportation broker for the provision of public transportation services.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 3(b), eff. September 1, 2007.

Sec. 531.006. ELIGIBILITY FOR APPOINTMENT AS EXECUTIVE COMMISSIONER; EMPLOYEE RESTRICTIONS. (a) In this section, "Texas trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(a-1) A person may not be appointed as executive commissioner, may not serve on the commission's executive council, and may not be a commission employee employed in a "bona fide executive, administrative, or professional capacity," as that phrase is used for purposes of establishing an exemption to the overtime provisions of the federal Fair Labor Standards Act of 1938 (29 U.S.C. Section 201 et seq.) if:

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

human services; or

(2) the person's spouse is an officer, manager, or paid consultant of a Texas trade association in the field of health and human services.

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

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

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

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

(3) a community center.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.010, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.03, eff. September 1, 2015.

Sec. 531.007. TERM. The executive commissioner serves a two-year term expiring February 1 of each odd-numbered year.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.011, eff. April 2, 2015.

For expiration of Subsections (c) and (d), see Subsection (d).

Sec. 531.008. DIVISIONS OF COMMISSION. (a) The executive commissioner shall establish divisions within the commission along functional lines as necessary for effective administration and for

the discharge of the commission's functions.

(b) The executive commissioner may allocate and reallocate functions among the commission's divisions.

(c) Notwithstanding Subsections (a) and (b), the executive commissioner shall establish the following divisions and offices within the commission:

(1) a medical and social services division;

(2) the office of inspector general to perform fraud and abuse investigation and enforcement functions as provided by Subchapter C and other law;

(3) a regulatory division;

(4) an administrative division; and

(5) a facilities division for the purpose of administering state facilities, including state hospitals and state supported living centers.

(d) Subsection (c) does not prohibit the executive commissioner from establishing additional divisions under Subsection (a) as the executive commissioner determines appropriate. This subsection and Subsection (c) expire September 1, 2023.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 1.05, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.012, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.09(a), eff. September 1, 2015.

Sec. 531.0081. MEDICAL TECHNOLOGY.

(b) The commission shall explore and evaluate new developments in medical technology and propose implementing the technology in Medicaid, if appropriate and cost-effective.

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

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 10, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.013, eff. April 2, 2015.

Sec. 531.0082. DATA ANALYSIS UNIT. (a) The executive commissioner shall establish a data analysis unit within the commission to establish, employ, and oversee data analysis processes designed to:

(1) improve contract management;

(2) detect data trends; and

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

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

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

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.014, eff. April 2, 2015.

Sec. 531.0083. OFFICE OF POLICY AND PERFORMANCE. (a) In this section, "office" means the office of policy and performance established by this section.

(b) The executive commissioner shall establish the office of policy and performance as an executive-level office designed to

coordinate policy and performance efforts across the health and human services system. To coordinate those efforts, the office shall:

(1) develop a performance management system;

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

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

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

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

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

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

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

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

(A) establishing timelines and milestones for any transition;

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

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

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

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

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

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

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

(f) The executive commissioner may otherwise develop the office's structure and duties as the executive commissioner determines appropriate.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.10(a), eff. September 1, 2015.

Sec. 531.0084. INVESTIGATION UNIT FOR ILLEGALLY OPERATING CHILD-CARE FACILITIES. The executive commissioner shall maintain a unit within the child-care licensing division of the commission consisting of investigators whose primary responsibility is to:

(1) identify child-care facilities that are operating without a license, certification, registration, or listing required by Chapter 42, Human Resources Code; and

(2) initiate appropriate enforcement actions against those facilities.

Added by Acts 2019, 86th Leg., R.S., Ch. 968 (S.B. 706), Sec. 1, eff. September 1, 2019.

Sec. 531.009. PERSONNEL. (a) The executive commissioner shall employ a medical director to provide medical expertise to the executive commissioner and the commission and may employ other personnel necessary to administer the commission's duties.

(b) The executive commissioner shall develop an intra-agency career ladder program, one part of which must require the intra-agency posting of all non-entry-level positions concurrently with any public posting.

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

(d) The executive commissioner shall provide to commission employees as often as is necessary information regarding their qualifications under this chapter and their responsibilities under applicable laws relating to standards of conduct for state employees.

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

(f) The policy statement described by Subsection (e) must include:

(1) personnel policies, including policies relating to recruitment, evaluation, selection, training, and promotion of personnel, that show the intent of the commission to avoid the unlawful employment practices described by Chapter 21, Labor Code; and

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

(g) The policy statement described by Subsection (e) must:

(1) be updated annually;

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

(3) be filed with the governor's office.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.18, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1460, Sec. 1.02, eff.

Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.015, eff. April 2, 2015.

Sec. 531.010. MERIT SYSTEM. (a) The commission may establish a merit system for its employees.

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

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.011. PUBLIC INPUT INFORMATION AND COMPLAINTS. (a) The commission shall develop and implement policies that provide the public a reasonable opportunity to appear before the commission and to speak on any issue under the commission's jurisdiction.

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

(1) receive consumer input;

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

(3) communicate to the public regarding the input received by the commission under this section and actions taken in response to that input.

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

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

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

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

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

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

(1) a license holder or entity regulated by the commission; or

(2) a service delivered by the commission.

(f) If a written complaint is filed with the commission relating to a license holder or entity regulated by the commission or a service delivered by the commission, the commission, at least quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless notice would jeopardize an undercover investigation.

(g) In addition to the information file maintained under Subsection (e), the commission shall maintain an information file on a complaint received by the commission relating to any matter or agency under the jurisdiction of the commission.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.02(a), eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1460, Sec. 1.03, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.016, eff. April 2, 2015.

Sec. 531.012. ADVISORY COMMITTEES. (a) The executive commissioner shall establish and maintain advisory committees to consider issues and solicit public input across all major areas of the health and human services system which may be from various geographic areas across the state, which may be done either in person or through teleconferencing centers, including relating to the following issues:

(1) Medicaid and other social services programs;

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

(3) health care quality initiatives;

(4) aging;

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

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

(7) children;

(8) public health;

(9) behavioral health;

(10) regulatory matters;

(11) protective services; and

(12) prevention efforts.

(b) Chapter 2110 applies to an advisory committee established under this section.

(c) The executive commissioner shall adopt rules:

(1) in compliance with Chapter 2110 to govern an advisory committee's purpose, tasks, reporting requirements, and date of abolition; and

(2) related to an advisory committee's:

(A) size and quorum requirements;

(B) membership, including:

(i) qualifications to be a member, including any experience requirements;

(ii) required geographic representation;

(iii) appointment procedures; and

(iv) terms of members; and

(C) duty to comply with the requirements for open meetings under Chapter 551.

Text of subsection as added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.02

(d) An advisory committee established under this section shall:

(1) report any recommendations to the executive

commissioner at a meeting of the Health and Human Services Commission Executive Council established under Section 531.0051; and

(2) submit a written report to the legislature of any policy recommendations made to the executive commissioner under Subdivision (1).

Text of subsection as added by Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.02

(d) An advisory committee established under this section shall:

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

(2) submit a written report to the legislature of any policy recommendations made to the executive commissioner under Subdivision (1).

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.017, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.02(a), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.02(a), eff. January 1, 2016.

Reenacted by Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 8.009, eff. September 1, 2017.

Sec. 531.0121. PUBLIC ACCESS TO ADVISORY COMMITTEE MEETINGS. (a) This section applies to an advisory committee established under Section 531.012.

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

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

(1) the master calendar;

(2) all meeting materials for an advisory committee

meeting; and

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

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

(e) The commission shall ensure that advisory committee meetings are broadcast, are archived on the Internet website of the agency to which the advisory committee provides advice, and are subject to public notice requirements to the same extent and in the same manner that the broadcast, archiving, and notice of agency meetings are required under Section 531.0165.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.03, eff. January 1, 2016.

Added by Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.03, eff. January 1, 2016.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 81 (H.B. 630), Sec. 1, eff. September 1, 2017.

Sec. 531.013. ELECTRONIC AVAILABILITY OF TECHNICAL ASSISTANCE. (a) Health and human services agencies shall, in conjunction with the Department of Information Resources, coordinate and enhance their existing Internet sites to provide technical assistance for human services providers. The commission shall take the lead and ensure involvement of agencies with the greatest potential for cost savings.

(b) Assistance under this section may include information in the following subjects:

(1) case management;

(2) contract management;

(3) financial management;

(4) performance measurement and evaluation;

(5) research; and

(6) other matters the commission considers appropriate.

(c) Assistance under this section must include information on the impact of federal and state welfare reform changes on human

services providers.

(d) Assistance under this section may not include any confidential information regarding a client of a human services provider.

(e) Expired.

Added by Acts 1997, 75th Leg., ch. 147, Sec. 1, eff. Sept. 1, 1997.

Sec. 531.014. CONSOLIDATION OF REPORTS. The commission may consolidate any annual or biennial reports required to be made under this chapter or another law if:

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

(2) each person required to receive a component of the consolidated report receives the consolidated report and the consolidated report identifies the component of the report the person was required to receive.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 1.04, eff. Sept. 1, 1999.

Sec. 531.0141. APPLICATION REQUIREMENT FOR COLONIAS PROJECTS. (a) In this section, "colonia" means a geographic area that:

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

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

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

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 3.01(2), eff. September 1, 2019.

(c) Repealed by Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 3.01(2), eff. September 1, 2019.

(d) Regarding any projects funded by the commission that provide assistance to colonias, the commission shall require an applicant for the funds to submit to the commission a colonia

classification number, if one exists, for each colonia that may be served by the project proposed in the application. If a colonia does not have a classification number, the commission may contact the secretary of state or the secretary of state's representative to obtain the classification number. On request of the commission, the secretary of state or the secretary of state's representative shall assign a classification number to the colonia.

Added by Acts 2007, 80th Leg., R.S., Ch. 341 (S.B. 99), Sec. 3, eff. June 15, 2007.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 2.05, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 2.06, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 3.01(2), eff. September 1, 2019.

Sec. 531.015. NEW FACILITIES IN CERTAIN COUNTIES. A health and human services agency is prohibited from establishing a new facility in a county with a population of less than 200,000 until the agency provides notification about the facility, its location, and its purpose to each state representative and state senator that represents all or part of the county, the county judge that represents the county, and the mayor of any municipality in which the facility would be located.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 1.05, eff. Sept. 1, 1999.

Sec. 531.0161. NEGOTIATED RULEMAKING AND ALTERNATIVE DISPUTE PROCEDURES. (a) The commission shall develop and implement a policy, for the commission and each health and human services agency, to encourage the use of:

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

(2) appropriate alternative dispute resolution procedures under Chapter 2009 to assist in the resolution of

internal and external disputes under the commission's or agency's jurisdiction.

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

(c) The commission shall:

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

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

(3) collect data concerning the effectiveness of those procedures.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.06, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.04, eff. September 1, 2015.

Sec. 531.0162. USE OF TECHNOLOGY. (a) The commission shall develop and implement a policy requiring the agency commissioner and employees of each health and human services agency to research and propose appropriate technological solutions to improve the agency's ability to perform its functions. The technological solutions must:

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

(2) ensure that persons who want to use a health and human services agency's services are able to:

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

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

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

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

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

(c) Subject to available appropriations, the commission shall use technology whenever possible in connection with the adult protective services program of the Department of Family and Protective Services to:

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

(2) consequently reduce the time that caseworkers and other service providers are required to use in gathering and reporting information necessary for program evaluation.

(d) The commission shall include representatives of the private sector in the technology planning process used to determine appropriate technology for the adult protective services program of the Department of Family and Protective Services.

(e) The executive commissioner shall ensure that:

(1) all information systems available for use by the commission or a health and human services agency in sending protected health information to a health care provider or receiving protected health information from a health care provider, and for which planning or procurement begins on or after September 1, 2015, are capable of sending or receiving that information in accordance with the applicable data exchange standards developed by the appropriate standards development organization accredited by the American National Standards Institute;

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

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

with health care providers.

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

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

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

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.06, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 268 (S.B. 6), Sec. 2.17, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1085 (H.B. 2641), Sec. 2, eff. September 1, 2015.

Sec. 531.0163. MEMORANDUM OF UNDERSTANDING. (a) The memorandum of understanding under Section 531.0055(k) must be adopted by the executive commissioner by rule in accordance with the procedures prescribed by Subchapter B, Chapter 2001, for adopting rules, except that the requirements of Section 2001.033(a)(1)(A) or (C) do not apply with respect to any part of the memorandum of understanding that:

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

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

(b) The memorandum of understanding may be amended only by following the procedures prescribed under Subsection (a).

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.06, eff. Sept. 1, 2003.

Sec. 531.0164. HEALTH AND HUMAN SERVICES SYSTEM INTERNET WEBSITE COORDINATION. The commission shall establish a process to ensure Internet websites across the health and human services system are developed and maintained according to standard criteria for uniformity, efficiency, and technical capabilities. Under the process, the commission shall:

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

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

(A) determine whether any of the Internet websites should be consolidated to improve public access to those websites' content; and

(B) ensure the Internet websites comply with the standard criteria; and

(3) if appropriate, consolidate the websites identified under Subdivision (2)(A).

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.05(a), eff. September 1, 2015.

Sec. 531.0165. INTERNET BROADCAST AND ARCHIVE OF OPEN MEETINGS. (a) In this section, "agency" means the commission or a health and human services agency.

(b) Each agency shall:

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

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

(3) provide access to the archived video and audio on the agency's Internet website.

(c) Not later than the seventh day after the date an open meeting is broadcast under this section, the agency shall make available through the agency's Internet website archived video and audio of the open meeting. The agency shall maintain the archived video and audio of the open meeting on the agency's Internet website for not less than two years after the date the archived video and audio was first made available on the website.

(d) Each agency shall provide on the agency's Internet website the same notice of the open meeting that the agency is required to post under Subchapter C, Chapter 551. The notice must be posted on the agency's Internet website within the time required for posting notice under Subchapter C, Chapter 551.

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

(f) Each agency is exempt from the requirements of this section to the extent a catastrophe, as defined by Section 551.0411, or a technical breakdown prevents the agency from complying with this section. Following the catastrophe or technical breakdown, the agency shall make all reasonable efforts to make the required video and audio of the open meeting available in a timely manner.

(g) The commission shall consider contracting through competitive bidding with a private individual or entity to broadcast and archive an open meeting subject to this section to minimize the cost of complying with this section.

(h) The requirements of this section also apply to the meetings of any advisory body that advises the executive commissioner or an agency. The archived video and audio of an advisory body's meeting must be made available through the Internet website of the agency to which the advisory body provides advice.

Added by Acts 2017, 85th Leg., R.S., Ch. 81 (H.B. 630), Sec. 2, eff. September 1, 2017.

Sec. 531.017. PURCHASING UNIT. (a) The commission shall establish a purchasing unit for the management of administrative activities related to the purchasing functions within the health

and human services system.

(b) The purchasing unit shall:

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

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

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.02(a), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.11, eff. September 1, 2015.

Sec. 531.0171. OFFICE OF OMBUDSMAN. (a) The executive commissioner shall establish the commission's office of the ombudsman with authority and responsibility over the health and human services system in performing the following functions:

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

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

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

(B) obtaining information regarding a filed complaint; and

(3) collecting inquiry and complaint data related to the health and human services system.

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

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

human services system offices.

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

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.06(a), eff. September 1, 2015.

Sec. 531.018. CERTAIN CONTRACTS FOR HEALTH CARE PURPOSES; REVIEW BY ATTORNEY GENERAL. (a) This section applies to any contract with a contract amount of $250 million or more:

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

(2) entered into by the person and:

(A) the commission;

(B) a health and human services agency; or

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

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

(c) An agency described by Subsection (a)(2) must notify the office of the attorney general at the time the agency initiates the planning phase of the contracting process. A representative of the office of the attorney general or another attorney advising the agency under Subsection (d) may participate in negotiations or discussions with proposed contractors and may be physically present during those negotiations or discussions.

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

(e) The state agency shall provide to the office of the attorney general any information the office of the attorney general determines is necessary to administer this section.

Added by Acts 2005, 79th Leg., Ch. 1011 (H.B. 880), Sec. 1, eff. September 1, 2005.

Sec. 531.019. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN DECISIONS. (a) In this section, "public assistance benefits" means benefits provided under a public assistance program under Chapter 31, 32, or 33, Human Resources Code.

(b) The proceedings of a hearing related to a decision regarding public assistance benefits contested by an applicant for or recipient of the benefits that is conducted by the commission or a health and human services agency to which the commission delegates a function related to the benefits must be recorded electronically. Notwithstanding Section 2001.177, the cost of preparing the record and transcript required to be sent to a reviewing court may not be charged to the applicant for or recipient of the benefits.

(c) Before an applicant for or recipient of public assistance benefits may appeal a decision of a hearing officer for the commission or a health and human services agency related to those benefits, the applicant or recipient must request an administrative review by an appropriate attorney of the commission or a health and human services agency, as applicable, in accordance with rules of the executive commissioner. Not later than the 15th business day after the date the attorney receives the request for administrative review, the attorney shall complete an administrative review of the decision and notify the applicant or recipient in writing of the results of that review.

(d) Except as provided by this section, Subchapters G and H, Chapter 2001, govern an appeal of a decision made by a hearing officer for the commission or a health and human services agency related to public assistance benefits brought by an applicant for or recipient of the benefits.

(e) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits has exhausted all available administrative remedies and a decision, including a decision under Section 31.034 or 32.035, Human Resources Code, is final and appealable on the date that, after a hearing:

(1) the hearing officer for the commission or a health and human services agency reaches a final decision related to the benefits; and

(2) the appropriate attorney completes an administrative review of the decision and notifies the applicant or recipient in writing of the results of that review.

(f) For purposes of Section 2001.171, an applicant for or recipient of public assistance benefits is not required to file a motion for rehearing with the commission or a health and human services agency, as applicable.

(g) Judicial review of a decision made by a hearing officer for the commission or a health and human services agency related to public assistance benefits is under the substantial evidence rule and is instituted by filing a petition with a district court in Travis County, as provided by Subchapter G, Chapter 2001.

(h) An appeal described by Subsection (d) takes precedence over all civil cases except workers' compensation and unemployment compensation cases.

(i) The appellee is the commission.

Added by Acts 2007, 80th Leg., R.S., Ch. 1161 (H.B. 75), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1351 (S.B. 408), Sec. 10(a), eff. September 1, 2009.

Sec. 531.0191. SERVICES PROVIDED BY CONTRACTOR TO PERSONS WITH LIMITED ENGLISH PROFICIENCY. (a) Each contract with the

commission or a health and human services agency that requires the provision of call center services or written communications related to call center services must include performance standards that measure the effectiveness, promptness, and accuracy of the contractor's oral and written communications with persons with limited English proficiency. Each person who seeks to enter into a contract described by this subsection shall include in the bid or other applicable expression of interest for the contract a proposal for providing call center services or written communications related to call center services to persons with limited English proficiency.

(b) The proposal required under Subsection (a) must include a language access plan that describes how the contractor will achieve any performance standards described in the request for bids, proposals, or other applicable expressions of interest. The plan must also describe how the contractor will:

(1) identify persons who need language assistance;

(2) provide language assistance measures, including the translation of forms into languages other than English and the provision of translators and interpreters;

(3) inform persons with limited English proficiency of the language services available to them and how to obtain them;

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

(5) monitor compliance with the language access plan.

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

(d) In determining the extent to which a proposal will provide meaningful access under Subsection (c), the agency shall consider:

(1) the language access plan developed under Subsection (b);

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

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

(4) the importance of the services provided by the agency's programs; and

(5) the resources available to the agency.

(e) The agency must avoid selecting a contractor that the agency reasonably believes will:

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

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

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

(f) This section does not apply to 2-1-1 services provided by the Texas Information and Referral Network.

Added by Acts 2007, 80th Leg., R.S., Ch. 1110 (H.B. 3575), Sec. 1, eff. June 15, 2007.

Renumbered from Government Code, Section 531.019 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(35), eff. September 1, 2009.

Sec. 531.0192. HEALTH AND HUMAN SERVICES SYSTEM HOTLINE AND CALL CENTER COORDINATION. (a) The commission shall establish a process to ensure all health and human services system hotlines and call centers are necessary and appropriate. Under the process, the commission shall:

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

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

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

(4) develop an approval process designed to ensure

that a newly established hotline or call center, including the telephone system and contract terms for the hotline or call center, meets policies and standards established by the commission; and

(5) develop policies and standards for hotlines and call centers that include both quality and quantity performance measures and benchmarks and may include:

(A) client satisfaction with call resolution;

(B) accuracy of information provided;

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

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

(E) call abandonment rates.

(a-1) In developing policies and standards under Subsection (a)(5), the commission may allow varied performance measures and benchmarks for a hotline or call center based on factors affecting the capacity of the hotline or call center, including factors such as staffing levels and funding.

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

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.07(a), eff. September 1, 2015.

Sec. 531.020. OFFICE OF COMMUNITY ACCESS AND SERVICES. The executive commissioner shall establish within the commission an office of community access and services. The office is responsible for:

(1) collaborating with community, state, and federal stakeholders to improve the elements of the health care system that are involved in the delivery of Medicaid services; and

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

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.018, eff. April 2, 2015.

For expiration of this subchapter, see Section 531.0207.

SUBCHAPTER A-1. CONSOLIDATION OF HEALTH AND HUMAN SERVICES SYSTEM

Sec. 531.02001. CONSOLIDATION OF HEALTH AND HUMAN SERVICES SYSTEM GENERALLY. In accordance with this subchapter, the functions of the health and human services system described under Sections 531.0201, 531.02011, and 531.02012 are consolidated through a phased transfer of those functions under which:

(1) the initial transfers required under Section 531.0201 occur:

(A) on or after the date on which the executive commissioner submits the transition plan to the required persons under Section 531.0204(e); and

(B) not later than September 1, 2016;

(2) the final transfers required under Section 531.02011 occur:

(A) on or after September 1, 2016; and

(B) not later than September 1, 2017; and

(3) transfers of administrative support services functions occur in accordance with Section 531.02012.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.02002. MEANING OF FUNCTION IN RELATION TO TRANSFERS. For purposes of the transfers mandated by this subchapter, "function" includes a power, duty, program, or activity of a state agency or entity.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.0201. PHASE ONE: INITIAL TRANSFERS. (a) On the dates specified in the transition plan required under Section 531.0204, the following functions are transferred to the commission as provided by this subchapter:

(1) all functions, including any remaining administrative support services functions, of each state agency and entity subject to abolition under Section 531.0202(a); and

(2) except as provided by Section 531.02013, all client services of the health and human services system, including client services functions performed by the following:

(A) the state agency and entity subject to abolition under Section 531.0202(b);

(B) the Department of Family and Protective Services; and

(C) the Department of State Health Services.

(b) On the dates specified in the transition plan required under Section 531.0204, all functions in the health and human services system related to prevention and early intervention services, including the Nurse-Family Partnership Competitive Grant Program under Subchapter C, Chapter 265, Family Code, are transferred to the Department of Family and Protective Services.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.02011. PHASE TWO: FINAL TRANSFERS TO COMMISSION. On the dates specified in the transition plan required under Section 531.0204, the following functions are transferred to the commission as provided by this subchapter:

(1) all functions of each state agency and entity subject to abolition under Section 531.0202(b) that remained with the agency or entity after the initial transfer of functions under Section 531.0201 or a transfer of administrative support services functions under Section 531.02012;

(2) regulatory functions and functions related to state-operated institutions of the Department of State Health Services; and

(3) regulatory functions of the Department of Family and Protective Services.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.02012. TRANSFER AND CONSOLIDATION OF ADMINISTRATIVE SUPPORT SERVICES FUNCTIONS. (a) In this section, "administrative support services" has the meaning assigned under Section 531.00553.

(b) As soon as practicable after the first day of the period prescribed by Section 531.02001(1) and not later than the last day of the period prescribed by Section 531.02001(2), in accordance with and on the dates specified in the transition plan required under Section 531.0204, the executive commissioner shall, after consulting with affected state agencies and divisions, transfer and consolidate within the commission administrative support services functions of the health and human services system to the extent consolidation of those support services functions is feasible and contributes to the effective performance of the system. Consolidation of an administrative support services function under this section must be conducted in accordance with the principles and requirements for organization of administrative support services under Section 531.00553(c).

(c) Consultation with affected state agencies and divisions under Subsection (b) must be conducted in a manner that ensures client services are, at most, only minimally affected, and must result in a memorandum of understanding or other agreement between the commission and each affected agency or division that:

(1) details measurable performance goals that the commission is expected to meet;

(2) identifies a means by which the agency or division may seek permission from the executive commissioner to find an alternative way to address the needs of the agency or division, as appropriate;

(3) identifies steps to ensure that programs under the health and human services system, whether large or small, receive administrative support services that are adequate to meet the program's needs; and

(4) if appropriate, specifies that staff responsible for providing administrative support services consolidated within the commission are located in the area where persons requiring those services are located to ensure the staff understands related

program needs and can respond to those needs in a timely manner.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.02013. FUNCTIONS REMAINING WITH CERTAIN AGENCIES. The following functions are not subject to transfer under Sections 531.0201 and 531.02011:

(1) the functions of the Department of Family and Protective Services, including the statewide intake of reports and other information, related to the following:

(A) child protective services, including services that are required by federal law to be provided by this state's child welfare agency;

(B) adult protective services, other than investigations of the alleged abuse, neglect, or exploitation of an elderly person or person with a disability:

(i) in a facility operated, or in a facility or by a person licensed, certified, or registered, by a state agency; or

(ii) by a provider that has contracted to provide home and community-based services;

(C) prevention and early intervention services; and

(D) investigations of alleged abuse, neglect, or exploitation occurring at a child-care facility, including a residential child-care facility, as those terms are defined by Section 42.002, Human Resources Code; and

(2) the public health functions of the Department of State Health Services, including health care data collection and maintenance of the Texas Health Care Information Collection program.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 316 (H.B. 5), Sec. 24(a), eff. May 31, 2017.

Acts 2017, 85th Leg., R.S., Ch. 319 (S.B. 11), Sec. 23(a),

eff. May 31, 2017.

Acts 2017, 85th Leg., R.S., Ch. 1136 (H.B. 249), Sec. 7, eff. September 1, 2017.

Reenacted and amended by Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 8.014, eff. September 1, 2019.

Sec. 531.02014. RELATED TRANSFERS; EFFECT OF CONSOLIDATION. (a) All of the following that relate to a function that is transferred under Section 531.0201, 531.02011, or 531.02012 are transferred to the commission or the Department of Family and Protective Services, as applicable, on the date the related function is transferred as specified in the transition plan required under Section 531.0204:

(1) all obligations and contracts, including obligations and contracts related to a grant program;

(2) all property and records in the custody of the state agency or entity from which the function is transferred;

(3) all funds appropriated by the legislature and other money; and

(4) all complaints, investigations, or contested cases that are pending before the state agency or entity from which the function is transferred or a governing person or entity of the state agency or entity, without change in status.

(b) A rule, policy, or form adopted by or on behalf of a state agency or entity from which functions are transferred under Section 531.0201, 531.02011, or 531.02012 that relates to a function that is transferred under one of those sections becomes a rule, policy, or form of the receiving state agency upon transfer of the related function and remains in effect:

(1) until altered by the commission or other receiving state agency, as applicable; or

(2) unless it conflicts with a rule, policy, or form of the receiving state agency.

(c) A license, permit, or certification in effect that was issued by a state agency or entity from which functions are transferred under Section 531.0201 or 531.02011 that relates to a function that is transferred under either of those sections is

continued in effect as a license, permit, or certification of the commission upon transfer of the related function until the license, permit, or certification expires, is suspended or revoked, or otherwise becomes invalid.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.0202. ABOLITION OF STATE AGENCIES AND ENTITIES; EFFECT OF TRANSFERS.

(a) Each of the following state agencies and entities is abolished on a date that is within the period prescribed by Section 531.02001(1), that is specified in the transition plan required under Section 531.0204 for the abolition of the agency or entity, and that occurs after all of the agency's or entity's functions have been transferred in accordance with Section 531.0201:

(1) the Department of Assistive and Rehabilitative Services;

(2) the Health and Human Services Council;

(3) the Aging and Disability Services Council;

(4) the Assistive and Rehabilitative Services Council;

(5) the State Health Services Council; and

(6) the Texas Council on Autism and Pervasive Developmental Disorders.

(b) The following state agency and entity are abolished on a date that is within the period prescribed by Section 531.02001(2), that is specified in the transition plan required under Section 531.0204 for the abolition of the state agency or entity, and that occurs after all of the state agency's or entity's functions have been transferred to the commission in accordance with Sections 531.0201 and 531.02011:

(1) the Department of Aging and Disability Services; and

(2) the Office for the Prevention of Developmental Disabilities.

(c) The abolition of a state agency or entity listed in Subsection (a) or (b) and the transfer of its functions and related

obligations, rights, contracts, records, property, and funds as provided by this subchapter and the transfer of functions and related obligations, rights, contracts, records, property, and funds to or from the Department of Family and Protective Services and from the Department of State Health Services as provided by this subchapter do not affect or impair an act done, any obligation, right, order, permit, certificate, rule, criterion, standard, or requirement existing, or any penalty accrued under former law, and that law remains in effect for any action concerning those matters.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 316 (H.B. 5), Sec. 25, eff. September 1, 2017.

Sec. 531.0203. HEALTH AND HUMAN SERVICES TRANSITION LEGISLATIVE OVERSIGHT COMMITTEE. (a) In this section, "committee" means the Health and Human Services Transition Legislative Oversight Committee established under this section.

(b) The Health and Human Services Transition Legislative Oversight Committee is created to facilitate the transfer of functions under Sections 531.0201, 531.02011, and 531.02012 with minimal negative effect on the delivery of services to which those functions relate.

(c) The committee is composed of 11 voting members, as follows:

(1) four members of the senate, appointed by the lieutenant governor;

(2) four members of the house of representatives, appointed by the speaker of the house of representatives; and

(3) three members of the public, appointed by the governor.

(d) The executive commissioner serves as an ex officio, nonvoting member of the committee.

(e) A member of the committee serves at the pleasure of the appointing official.

(f) The lieutenant governor and the speaker of the house of

representatives shall each designate a presiding co-chair from among their respective appointments.

(g) A member of the 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.

(h) The committee shall:

(1) facilitate the transfer of functions under Sections 531.0201, 531.02011, and 531.02012 with minimal negative effect on the delivery of services to which those functions relate;

(2) with assistance from the commission and the state agencies and entities from which functions are transferred under Sections 531.0201, 531.02011, and 531.02012, advise the executive commissioner concerning:

(A) the functions to be transferred under this subchapter and the funds and obligations that are related to the functions;

(B) the transfer of the functions and related records, property, funds, and obligations by the state agencies and entities as provided by this subchapter; and

(C) the reorganization of the commission's administrative structure in accordance with this subchapter, Sections 531.0055, 531.00553, 531.00561, 531.00562, and 531.008, and other provisions enacted by the 84th Legislature that become law; and

(3) meet:

(A) during the period between the establishment of the committee and September 1, 2017, at least quarterly at the call of either chair, in addition to meeting at other times as determined appropriate by either chair;

(B) during the period between September 2, 2017, and December 31, 2019, at least semiannually at the call of either chair, in addition to meeting at other times as determined appropriate by either chair; and

(C) during the period between January 1, 2020, and August 31, 2023, at least annually at the call of either chair,

in addition to meeting at other times as determined appropriate by either chair.

(i) Chapter 551 applies to the committee.

(j) The committee shall submit a report to the governor, lieutenant governor, speaker of the house of representatives, and legislature not later than December 1 of each even-numbered year. The report must include an update on the progress of and issues related to:

(1) the transfer of functions under Sections 531.0201, 531.02011, and 531.02012 to the commission and the Department of Family and Protective Services, including the need for any additional statutory changes required to complete the transfer of prevention and early intervention services functions to the department in accordance with this subchapter; and

(2) the reorganization of the commission's administrative structure in accordance with this subchapter, Sections 531.0055, 531.00553, 531.00561, 531.00562, and 531.008, and other provisions enacted by the 84th Legislature that become law.

(k) The committee is abolished September 1, 2023.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1138 (S.B. 208), Sec. 27(a), eff. September 1, 2015.

Sec. 531.02031. STUDY ON CONTINUING NEED FOR CERTAIN STATE AGENCIES. (a) Not later than July 31, 2018, the executive commissioner shall conduct a study and submit a report and recommendations to the Health and Human Services Transition Legislative Oversight Committee that include:

(1) a recommendation regarding the need to continue the Department of Family and Protective Services as a state agency separate from the commission, unless a determination on the continuation is made before that date;

(2) a recommendation regarding the need to continue the Department of State Health Services as a state agency separate

from the commission;

(3) an assessment of the quality and consistency of data sharing, communication, and coordination between the Department of Family and Protective Services and the commission; and

(4) an assessment of any known or potential conflicts of interest concerning licensing and regulation activities by the Department of Family and Protective Services or the commission, including the process by which known conflicts of interest are mitigated or managed by those agencies.

(b) Not later than December 1, 2018, the Health and Human Services Transition Legislative Oversight Committee shall review the report and recommendations submitted under Subsection (a) and submit a report and recommendations to the legislature that include:

(1) a recommendation regarding the need to continue the Department of Family and Protective Services as a state agency separate from the commission, unless a determination on the continuation is made before that date;

(2) a recommendation regarding the need to continue the Department of State Health Services as a state agency separate from the commission; and

(3) an assessment of and any necessary recommendations concerning data sharing, communication, and coordination between the Department of Family and Protective Services and the commission.

(c) The Health and Human Services Transition Legislative Oversight Committee shall include the following in the report submitted to the legislature under Subsection (b):

(1) an evaluation of the transfer of prevention and early intervention services functions to the Department of Family and Protective Services as provided by this subchapter, including an evaluation of:

(A) any increased coordination and efficiency in the operation of the programs achieved as a result of the transfer;

(B) the department's coordination with other state agency programs providing similar prevention and early

intervention services; and

(C) the department's interaction with stakeholders and other interested parties in performing the department's functions; and

(2) any recommendations concerning the transfer of prevention and early intervention services functions of the department to another state agency.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 312 (S.B. 1021), Sec. 2, eff. May 29, 2017.

Sec. 531.0204. TRANSITION PLAN FOR IMPLEMENTATION OF CONSOLIDATION. (a) The transfers of functions under Sections 531.0201, 531.02011, and 531.02012 must be accomplished in accordance with a transition plan developed by the executive commissioner that ensures that the transfers and provision of health and human services in this state are accomplished in a careful and deliberative manner. The transition plan must:

(1) include an outline of the commission's reorganized structure, including its divisions, in accordance with this subchapter, Sections 531.00561, 531.00562, and 531.008, and other provisions enacted by the 84th Legislature that become law;

(2) include details regarding movement of functions and a timeline that, subject to the periods prescribed by Section 531.02001, specifies the dates on which:

(A) the transfers under Sections 531.0201, 531.02011, and 531.02012 are to be made;

(B) each state agency or entity subject to abolition under Section 531.0202 is abolished; and

(C) each division of the commission is created and the division's director is appointed;

(3) for purposes of Sections 531.0201, 531.02011, and 531.02013, define:

(A) client services functions;

(B) regulatory functions;

(C) public health functions; and

(D) functions related to:

(i) state-operated institutions;

(ii) child protective services;

(iii) adult protective services; and

(iv) prevention and early intervention services; and

(4) include an evaluation and determination of the feasibility and potential effectiveness of consolidating administrative support services into the commission in accordance with Section 531.02012, including a report of:

(A) the specific support services that will be consolidated within the commission;

(B) a timeline that details when specific support services will be consolidated, including a description of the support services that will transfer by the last day of each period prescribed by Section 531.02001; and

(C) measures the commission will take to ensure information resources and contracting support services continue to operate properly across the health and human services system under any consolidation of administrative support services.

(b) In defining the transferred functions under Subsection (a)(3), the executive commissioner shall ensure that:

(1) not later than the last day of the period prescribed by Section 531.02001(1), all functions of a state agency or entity subject to abolition under Section 531.0202(a) are transferred to the commission or the Department of Family and Protective Services, as applicable;

(2) the transferred prevention and early intervention services functions to the Department of Family and Protective Services include:

(A) prevention and early intervention services as defined under Section 265.001, Family Code; and

(B) programs that:

(i) provide parent education;

(ii) promote healthier parent-child relationships; or

(iii) prevent family violence; and

(3) not later than the last day of the period prescribed by Section 531.02001(2), all functions of the state agency and entity subject to abolition under Section 531.0202(b) are transferred to the commission.

(c) In developing the transition plan, the executive commissioner shall, before submitting the plan to the Health and Human Services Transition Legislative Oversight Committee, the governor, and the Legislative Budget Board as required by Subsection (e):

(1) hold public hearings in various geographic areas in this state regarding the plan; and

(2) solicit and consider input from appropriate stakeholders.

(d) Within the periods prescribed by Section 531.02001:

(1) the commission shall begin administering the respective functions assigned to the commission under Sections 531.0201 and 531.02011, as applicable; and

(2) the Department of Family and Protective Services shall begin administering the functions assigned to the department under Section 531.0201.

(d-1) The assumption of the administration of the functions transferred to the commission and the Department of Family and Protective Services under Sections 531.0201 and 531.02011, as applicable, must be accomplished in accordance with the transition plan.

(e) The executive commissioner shall submit the transition plan to the Health and Human Services Transition Legislative Oversight Committee, the governor, and the Legislative Budget Board not later than March 1, 2016. The Health and Human Services Transition Legislative Oversight Committee shall comment on and make recommendations to the executive commissioner regarding any concerns or adjustments to the transition plan the committee determines appropriate. The executive commissioner may not finalize the transition plan until the executive commissioner has reviewed and considered the comments and recommendations of the committee regarding the transition plan.

(f) The executive commissioner shall publish in the Texas Register:

(1) the transition plan developed under this section;

(2) any adjustments to the transition plan recommended by the Health and Human Services Transition Legislative Oversight Committee;

(3) a statement regarding whether the executive commissioner adopted or otherwise incorporated the recommended adjustments; and

(4) if the executive commissioner did not adopt a recommended adjustment, the justification for not adopting the adjustment.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.02041. REQUIRED REPORTS AFTER TRANSITION PLAN SUBMISSION. If, at any time after the executive commissioner submits the transition plan in accordance with Section 531.0204(e), the executive commissioner proposes to make a substantial organizational change to the health and human services system that was not included in the transition plan, the executive commissioner shall, before implementing the proposed change, submit a report detailing the proposed change to the Health and Human Services Transition Legislative Oversight Committee.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Sec. 531.0205. APPLICABILITY OF FORMER LAW. An action brought or proceeding commenced before the date of a transfer prescribed by this subchapter in accordance with the transition plan required under Section 531.0204, including a contested case or a remand of an action or proceeding by a reviewing court, is governed by the laws and rules applicable to the action or proceeding before the transfer.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 713, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.0206. LIMITED-SCOPE SUNSET REVIEW. (a) The Sunset Advisory Commission shall conduct a limited-scope review of the commission during the state fiscal biennium ending August 31, 2023, in the manner provided by Chapter 325 (Texas Sunset Act). The review must provide:

(1) an update on the commission's progress with respect to the consolidation of the health and human services system mandated by this subchapter, including the commission's compliance with the transition plan required under Section 531.0204;

(2) an evaluation and recommendations regarding the need to continue the Department of State Health Services as a state agency separate from the commission;

(3) an evaluation and recommendations regarding the need to continue the Department of Family and Protective Services as a state agency separate from the commission; and

(4) any additional information the Sunset Advisory Commission determines appropriate, including information regarding any additional organizational changes the Sunset Advisory Commission recommends.

(b) The commission is not abolished solely because the commission is not explicitly continued following the review required by this section.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 316 (H.B. 5), Sec. 26, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 596 (S.B. 619), Sec. 2.01, eff. June 10, 2019.

Sec. 531.0207. EXPIRATION OF SUBCHAPTER. This subchapter expires September 1, 2023.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 1.01(a), eff. September 1, 2015.

SUBCHAPTER B. POWERS AND DUTIES

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

(b) The commission shall:

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

(2) establish requirements for and define the scope of the ongoing evaluation of the Medicaid managed care system conducted in conjunction with the Department of State Health Services under Section 108.0065, Health and Safety Code.

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

(c) The executive commissioner in the adoption of reasonable rules and standards under Subsection (b-1) shall include financial performance standards that, in the event of a proposed rate reduction, provide private ICF-IID facilities and home and community-based services providers with flexibility in determining how to use Medicaid payments to provide services in the most cost-effective manner while continuing to meet the state and federal requirements of Medicaid.

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

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

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

(3) economic conditions that substantially and

materially affect provider participation in Medicaid, as determined by the executive commissioner; or

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

(e) Notwithstanding any other provision of Chapter 32, Human Resources Code, Chapter 533, or this chapter, the commission may adjust the fees, charges, and rates paid to Medicaid providers as necessary to achieve the objectives of Medicaid in a manner consistent with the considerations described by Subsection (d).

(f) In adopting rates for Medicaid payments under Subsection (b-1), the executive commissioner may adopt reimbursement rates for appropriate nursing services provided to recipients with certain health conditions if those services are determined to provide a cost-effective alternative to hospitalization. A physician must certify that the nursing services are medically appropriate for the recipient for those services to qualify for reimbursement under this subsection.

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

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 1262, Sec. 1, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1460, Sec. 3.01, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 2.03, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 11(a), eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.019, eff. April 2, 2015.

Sec. 531.0211. MANAGED CARE MEDICAID PROGRAM: RULES; EDUCATION PROGRAMS. (a) In adopting rules to implement a managed care Medicaid program, the executive commissioner shall establish guidelines for, and require managed care organizations to provide, education programs for providers and clients using a variety of

techniques and mediums.

(b) A provider education program must include information on:

(1) Medicaid policies, procedures, eligibility standards, and benefits;

(2) the specific problems and needs of Medicaid clients; and

(3) the rights and responsibilities of Medicaid clients under the bill of rights and the bill of responsibilities prescribed by Section 531.0212.

(c) A client education program must present information in a manner that is easy to understand. A program must include information on:

(1) a client's rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section 531.0212;

(2) how to access health care services;

(3) how to access complaint procedures and the client's right to bypass the managed care organization's internal complaint system and use the notice and appeal procedures otherwise required by Medicaid;

(4) Medicaid policies, procedures, eligibility standards, and benefits;

(5) the policies and procedures of the managed care organization; and

(6) the importance of prevention, early intervention, and appropriate use of services.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.03(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.020, eff. April 2, 2015.

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

(b) The report must include:

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

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

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

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

(ii) the amount of any funds appropriated by the legislature to the agency for each of those components; and

(iii) the amount of Medicaid payments and related expenditures made by or in connection with each of those components; and

(2) for each Medicaid component identified in the report:

(A) the amount and source of funds or other revenue received by or made available to the agency for the component;

(B) the amount spent on each type of service or benefit provided by or under the component;

(C) the amount spent on component operations, including eligibility determination, claims processing, and case management; and

(D) the amount spent on any other administrative costs.

(c) The report must cover the three-year period ending on the last day of the previous fiscal year.

(d) The commission may request from any appropriate state agency information necessary to complete the report. Each agency shall cooperate with the commission in providing information for the report.

(e) Not later than December 1 of each even-numbered year, the commission shall submit the report to the governor, the lieutenant governor, the speaker of the house of representatives, the presiding officer of each standing committee of the senate and

house of representatives having jurisdiction over health and human services issues, and the state auditor.

Added by Acts 2001, 77th Leg., ch. 209, Sec. 1, eff. May 21, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.021, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.08(a), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1203 (S.B. 1455), Sec. 7, eff. September 1, 2015.

Sec. 531.02113. OPTIMIZATION OF MEDICAID FINANCING. The commission shall ensure that the Medicaid finance system is optimized to:

(1) maximize the state's receipt of federal funds;

(2) create incentives for providers to use preventive care;

(3) increase and retain providers in the system to maintain an adequate provider network;

(4) more accurately reflect the costs borne by providers; and

(5) encourage the improvement of the quality of care.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 2(a), eff. September 1, 2005.

Sec. 531.021135. COMMISSION'S AUTHORITY TO RETAIN CERTAIN MONEY TO ADMINISTER CERTAIN MEDICAID PROGRAMS; REPORT REQUIRED. (a) In this section, "directed payment program" means a delivery system and provider patient initiative implemented by this state under 42 C.F.R. Section 438.6(c).

(b) This section applies only to money the commission receives from a source other than the general revenue fund to operate a waiver program established under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) or a directed payment program or successor program as determined by the commission.

(c) Subject to Subsection (e), the commission may retain

from money to which this section applies an amount equal to the estimated costs necessary to administer the program for which the money is received, but not to exceed $8 million for a state fiscal year.

(d) The commission shall spend money retained under this section to assist in paying the costs necessary to administer the program for which the money is received, except that the commission may not use the money to pay any type of administrative cost that, before June 1, 2019, was funded with general revenue.

(e) If the commission determines that the commission needs additional money to administer a program described by Subsection (b), the commission may retain an additional amount with the approval of the governor and the Legislative Budget Board, but not to exceed a total retained amount equal to 0.25 percent of the total amount estimated to be received for the program.

(f) The commission shall submit an annual report to the governor and the Legislative Budget Board that:

(1) details the amount of money retained and spent by the commission under this section during the preceding state fiscal year, including a separate detail of any increase in the amount of money retained for a program under Subsection (e);

(2) contains a transparent description of how the commission used the money described by Subdivision (1); and

(3) assesses the extent to which the money retained by the commission under this section covered the estimated costs to administer the applicable program and states whether, based on that assessment, the commission adjusted or considered adjustments to the amount retained.

(g) The executive commissioner shall adopt rules necessary to implement this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 680 (S.B. 2138), Sec. 1, eff. June 10, 2019.

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

Examiners.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.09, eff. September 1, 2015.

Sec. 531.02115. MARKETING ACTIVITIES BY PROVIDERS PARTICIPATING IN MEDICAID OR CHILD HEALTH PLAN PROGRAM. (a) A provider participating in Medicaid or the child health plan program, including a provider participating in the network of a managed care organization that contracts with the commission to provide services under Medicaid or the child health plan program, may not engage in any marketing activity, including any dissemination of material or other attempt to communicate, that:

(1) involves unsolicited personal contact, including by door-to-door solicitation, solicitation at a child-care facility or other type of facility, direct mail, or telephone, with a Medicaid client or a parent whose child is enrolled in Medicaid or the child health plan program;

(2) is directed at the client or parent solely because the client or the parent's child is receiving benefits under Medicaid or the child health plan program; and

(3) is intended to influence the client's or parent's choice of provider.

(b) In addition to the requirements of Subsection (a), a provider participating in the network of a managed care organization described by that subsection must comply with the marketing guidelines established by the commission under Section 533.008.

(c) Nothing in this section prohibits:

(1) a provider participating in Medicaid or the child health plan program from:

(A) engaging in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to influence the choice of provider by a Medicaid client or a parent whose child is enrolled in Medicaid or the child health plan program, if the marketing activity:

(i) is conducted at a community-sponsored educational event, health fair, outreach activity, or other similar

community or nonprofit event in which the provider participates and does not involve unsolicited personal contact or promotion of the provider's practice; or

(ii) involves only the general dissemination of information, including by television, radio, newspaper, or billboard advertisement, and does not involve unsolicited personal contact;

(B) as permitted under the provider's contract, engaging in the dissemination of material or another attempt to communicate with a Medicaid client or a parent whose child is enrolled in Medicaid or the child health plan program, including communication in person or by direct mail or telephone, for the purpose of:

(i) providing an appointment reminder;

(ii) distributing promotional health materials;

(iii) providing information about the types of services offered by the provider; or

(iv) coordinating patient care; or

(C) engaging in a marketing activity that has been submitted for review and obtained a notice of prior authorization from the commission under Subsection (d); or

(2) a provider participating in the STAR + PLUS Medicaid managed care program from, as permitted under the provider's contract, engaging in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to educate a Medicaid client about available long-term care services and supports.

(d) The commission shall establish a process by which providers may submit proposed marketing activities for review and prior authorization to ensure that providers are in compliance with the requirements of this section and, if applicable, Section 533.008, or to determine whether the providers are exempt from a requirement of this section and, if applicable, Section 533.008. The commission may grant or deny a provider's request for authorization to engage in a proposed marketing activity.

(e) The executive commissioner shall adopt rules as

necessary to implement this section, including rules relating to provider marketing activities that are exempt from the requirements of this section and, if applicable, Section 533.008.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 2, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.023, eff. April 2, 2015.

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

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

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

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

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

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

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.10(a), eff. September 1, 2015.

Sec. 531.021182. USE OF NATIONAL PROVIDER IDENTIFIER

NUMBER. (a) In this section, "national provider identifier number" means the national provider identifier number required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The commission shall transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.

(c) The commission shall implement a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid.

(d) The commission shall implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 2, eff. September 1, 2019.

Sec. 531.021191. MEDICAID ENROLLMENT OF CERTAIN EYE HEALTH CARE PROVIDERS. (a) This section applies only to:

(1) an optometrist who is licensed by the Texas Optometry Board;

(2) a therapeutic optometrist who is licensed by the Texas Optometry Board;

(3) an ophthalmologist who is licensed by the Texas Medical Board; and

(4) an institution of higher education that provides an accredited program for:

(A) training as a Doctor of Optometry or an optometrist residency; or

(B) training as an ophthalmologist or an ophthalmologist residency.

(b) The commission may not prevent a provider to whom this section applies from enrolling as a Medicaid provider if the provider:

(1) either:

(A) joins an established practice of a health

care provider or provider group that has a contract with a managed care organization to provide health care services to recipients under Chapter 533; or

(B) is employed by or otherwise compensated for providing training at an institution of higher education described by Subsection (a)(4);

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

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

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

(c) The commission may not prevent an institution of higher education from enrolling as a Medicaid provider if the institution:

(1) has a contract with a managed care organization to provide health care services to recipients under Chapter 533;

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

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

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

Added by Acts 2017, 85th Leg., R.S., Ch. 901 (H.B. 3675), Sec. 2, eff. September 1, 2017.

Sec. 531.0212. MEDICAID BILL OF RIGHTS AND BILL OF RESPONSIBILITIES. (a) The executive commissioner by rule shall adopt a bill of rights and a bill of responsibilities for each person enrolled in Medicaid.

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

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

(2) a reasonable opportunity to choose a health care plan and primary care provider and to change to another plan or provider in a reasonable manner;

(3) consent to or refuse treatment and actively participate in treatment decisions;

(4) ask questions and receive complete information relating to the client's medical condition and treatment options, including specialty care;

(5) access each available complaint process, receive a timely response to a complaint, and receive a fair hearing; and

(6) timely access to care that does not have any communication or physical access barriers.

(c) The bill of responsibilities must address a client's responsibility to:

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

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

(3) share information relating to the client's health status with the primary care provider and become fully informed about service and treatment options; and

(4) actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain the client's health.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.03(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.024, eff. April 2, 2015.

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

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

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

(1) the commission's office of the ombudsman or other

division of the commission designated by the executive commissioner to coordinate the network;

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

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

(4) area agencies on aging;

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

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

(c) The commission may provide support and information services by contracting with nonprofit organizations that are not involved in providing health care, health insurance, or health benefits.

(d) As a part of the support and information services required by this section, the commission shall:

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

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

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

(4) educate persons so that they:

(A) understand the concept of managed care;

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

(C) are able to advocate for themselves;

(5) collect and maintain statistical information on a

regional basis regarding calls received by the assistance lines and publish quarterly reports that:

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

(B) identify trends in delivery and access problems;

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

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

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

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

(A) STAR Medicaid managed care program;

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

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

(D) STAR Health program;

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

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

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

resolution.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.03(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.025, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1272 (S.B. 760), Sec. 3, eff. September 1, 2015.

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) The commission shall adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within the commission to ensure all grievances are managed consistently.

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

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

(d) The commission shall establish a procedure for expedited resolution of a grievance related to Medicaid that allows the commission to:

(1) identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution; and

(2) resolve the grievance within a specified period.

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

(f) The commission shall:

(1) aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances; and

(2) make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 2, eff. September 1, 2019.

Sec. 531.0214. MEDICAID DATA COLLECTION SYSTEM. (a) The commission and each health and human services agency that administers a part of Medicaid shall jointly develop a system to coordinate and integrate state Medicaid databases to:

(1) facilitate the comprehensive analysis of Medicaid data; and

(2) detect fraud perpetrated by a program provider or client.

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

(1) the efforts of the agencies that are participating in the development of the system required by Subsection (a); and

(2) the efforts of those agencies with the efforts of other agencies involved in a statewide health care data collection system provided for by Section 108.006, Health and Safety Code, including avoiding duplication of expenditure of state funds for computer hardware, staff, or services.

(c) On the request of the executive commissioner, a state agency that administers any part of Medicaid shall assist the commission in developing the system required by this section.

(d) The commission shall develop the database system in a manner that will enable a complete analysis of the use of prescription medications, including information relating to:

(1) Medicaid clients for whom more than three medications have been prescribed; and

(2) the medical effect denial of Medicaid coverage for more than three medications has had on Medicaid clients.

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

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.03(a), eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 215, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.026, eff.

April 2, 2015.

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

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

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

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

(4) allows for analysis of multiple issues within the program to determine whether any programmatic or policy issues overlap or are in conflict;

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

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

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

(b) The commission shall ensure that all Medicaid data sets created or identified by the decision support system are made

available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist or arise with respect to making the data sets available on the Internet, the system and the commission shall make every effort to make the data available through that means either by removing information by which particular individuals may be identified or by aggregating the data in a manner so that individual records cannot be associated with particular individuals.

(c) The commission shall regularly evaluate data submitted by managed care organizations that contract with the commission under Chapter 533 to determine whether:

(1) the data continues to serve a useful purpose; and

(2) additional data is needed to oversee contracts or evaluate the effectiveness of Medicaid.

(d) The commission shall collect Medicaid managed care data that effectively captures the quality of services received by Medicaid recipients.

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

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 3(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.027, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.11(a), eff. September 1, 2015.

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) To the extent permitted by federal law, the commission in consultation and collaboration with the appropriate advisory committees related to Medicaid shall make available to the public on the commission's Internet website in an easy-to-read format data relating to the quality of health care received by Medicaid

recipients and the health outcomes of those recipients. Data made available to the public under this section must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing its duties under this section, the commission may collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 2, eff. September 1, 2019.

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

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

Added by Acts 2019, 86th Leg., R.S., Ch. 417 (S.B. 195), Sec. 3, eff. January 1, 2020.

Sec. 531.0215. COMPILATION OF STATISTICS RELATING TO FRAUD. The commission and each health and human services agency that administers a part of Medicaid shall maintain statistics on the number, type, and disposition of fraudulent claims for benefits submitted under the part of the program the agency administers.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 6.02(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.028, eff. April 2, 2015.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 2056 and H.B. 4, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.0216. PARTICIPATION AND REIMBURSEMENT OF

TELEMEDICINE MEDICAL SERVICE PROVIDERS AND TELEHEALTH SERVICE PROVIDERS UNDER MEDICAID. (a) The executive commissioner by rule shall develop and implement a system to reimburse providers of services under Medicaid for services performed using telemedicine medical services or telehealth services.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(1), eff. September 1, 2019.

(c) The commission shall encourage health care providers and health care facilities to provide telemedicine medical services and telehealth services in the health care delivery system. The commission may not require that a service be provided to a patient through telemedicine medical services or telehealth services.

(c-1) The commission shall explore opportunities to increase STAR Health program providers' use of telemedicine medical services in medically underserved areas of this state.

(d) Subject to Section 153.004, Occupations Code, the executive commissioner may adopt rules as necessary to implement this section. In the rules adopted under this section, the executive commissioner shall:

(1) refer to the site where the patient is physically located as the patient site; and

(2) refer to the site where the physician or health professional providing the telemedicine medical service or telehealth service is physically located as the distant site.

(e) Repealed by Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(1), eff. September 1, 2019.

(f) Not later than December 1 of each even-numbered year, the commission shall report to the speaker of the house of representatives and the lieutenant governor on the effects of telemedicine medical services, telehealth services, and home telemonitoring services on Medicaid in the state, including the number of physicians, health professionals, and licensed health care facilities using telemedicine medical services, telehealth services, or home telemonitoring services, the geographic and demographic disposition of the physicians and health professionals, the number of patients receiving telemedicine medical services, telehealth services, and home telemonitoring

services, the types of services being provided, the cost of utilization, and the cost savings of telemedicine medical services, telehealth services, and home telemonitoring services to Medicaid.

(g) The commission shall ensure that a Medicaid managed care organization:

(1) does not deny reimbursement for a covered health care service or procedure delivered by a health care provider with whom the managed care organization contracts to a Medicaid recipient as a telemedicine medical service or a telehealth service solely because the covered service or procedure is not provided through an in-person consultation;

(2) does not limit, deny, or reduce reimbursement for a covered health care service or procedure delivered by a health care provider with whom the managed care organization contracts to a Medicaid recipient as a telemedicine medical service or a telehealth service based on the health care provider's choice of platform for providing the health care service or procedure; and

(3) ensures that the use of telemedicine medical services or telehealth services promotes and supports patient-centered medical homes by allowing a Medicaid recipient to receive a telemedicine medical service or telehealth service from a provider other than the recipient's primary care physician or provider, except as provided by Section 531.0217(c-4), only if:

(A) the telemedicine medical service or telehealth service is provided in accordance with the law and contract requirements applicable to the provision of the same health care service in an in-person setting, including requirements regarding care coordination; and

(B) the provider of the telemedicine medical service or telehealth service gives notice to the Medicaid recipient's primary care physician or provider regarding the telemedicine medical service or telehealth service, including a summary of the service, exam findings, a list of prescribed or administered medications, and patient instructions, for the purpose of sharing medical information, provided that the recipient has a primary care physician or provider and the recipient or, if appropriate, the recipient's parent or legal guardian, consents to

the notice.

(h) The commission shall develop, document, and implement a monitoring process to ensure that a Medicaid managed care organization ensures that the use of telemedicine medical services or telehealth services promotes and supports patient-centered medical homes and care coordination in accordance with Subsection (g)(3). The process must include monitoring of the rate at which a telemedicine medical service or telehealth service provider gives notice in accordance with Subsection (g)(3)(B).

(i) The executive commissioner by rule shall ensure that a federally qualified health center as defined by 42 U.S.C. Section 1396d(l)(2)(B) may be reimbursed for the originating site facility fee or the distant site practitioner fee or both, as appropriate, for a covered telemedicine medical service or telehealth service delivered by a health care provider to a Medicaid recipient. The commission is required to implement this subsection only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement this subsection using other money available to the commission for that purpose.

(j) In complying with state and federal requirements to provide access to medically necessary services under the Medicaid managed care program, a Medicaid managed care organization determining whether reimbursement for a telemedicine medical service or telehealth service is appropriate shall continue to consider other factors, including whether reimbursement is cost-effective and whether the provision of the service is clinically effective.

Added by Acts 1997, 75th Leg., ch. 1244, Sec. 1, eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 62, Sec. 18.22, eff; Sept. 1, 1999. Renumbered from Sec. 531.0215 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(46), eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1255, Sec. 1, eff. June 15, 2001; Acts 2001, 77th Leg., ch. 1420, Sec. 14.765, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 370 (S.B. 1340), Sec. 1, eff.

September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 525 (S.B. 760), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 371 (S.B. 219), Sec. 2, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1205 (S.B. 293), Sec. 2, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.029, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.04, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.04, eff. January 1, 2016.

Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. 1107), Sec. 9, eff. May 27, 2017.

Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 2, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(1), eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1061 (H.B. 1063), Sec. 1, eff. September 1, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 2056, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.02162. MEDICAID SERVICES PROVIDED THROUGH TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS. (a) In this section, "child with special health care needs" has the meaning assigned by Section 35.0022, Health and Safety Code.

(b) The executive commissioner by rule shall establish policies that permit reimbursement under Medicaid and the child health plan program for services provided through telemedicine medical services and telehealth services to children with special health care needs.

(c) The policies required under this section must:

(1) be designed to:

(A) prevent unnecessary travel and encourage efficient use of telemedicine medical services and telehealth services for children with special health care needs in all suitable circumstances; and

(B) ensure in a cost-effective manner the availability to a child with special health care needs of services appropriately performed using telemedicine medical services and telehealth services that are comparable to the same types of services available to that child without the use of telemedicine medical services and telehealth services; and

(2) provide for reimbursement of multiple providers of different services who participate in a single telemedicine medical services and telehealth services session for a child with special health care needs, if the commission determines that reimbursing each provider for the session is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services and telehealth services, including the costs of transportation and lodging and other direct costs.

Added by Acts 2001, 77th Leg., ch. 959, Sec. 2, eff. June 14, 2001. Renumbered from Government Code Sec. 531.02161 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(63), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.031, eff. April 2, 2015.

For expiration of this section, see Subsection (b).

Sec. 531.02163. STUDY ON PROVIDING CERTAIN MATERNAL CARE MEDICAID SERVICES THROUGH TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES. (a) Not later than September 1, 2020, the commission shall conduct a study on the benefits and costs of permitting reimbursement under Medicaid for prenatal and postpartum care delivered through telemedicine medical services and telehealth services.

(b) This section expires September 1, 2021.

Added by Acts 2019, 86th Leg., R.S., Ch. 973 (S.B. 748), Sec. 7,

eff. September 1, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 4, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.02164. MEDICAID SERVICES PROVIDED THROUGH HOME TELEMONITORING SERVICES. (a) In this section:

(1) "Home and community support services agency" means a person licensed under Chapter 142, Health and Safety Code, to provide home health, hospice, or personal assistance services as defined by Section 142.001, Health and Safety Code.

(2) "Hospital" means a hospital licensed under Chapter 241, Health and Safety Code.

(b) If the commission determines that establishing a statewide program that permits reimbursement under Medicaid for home telemonitoring services would be cost-effective and feasible, the executive commissioner by rule shall establish the program as provided under this section.

(c) The program required under this section must:

(1) provide that home telemonitoring services are available only to persons who:

(A) are diagnosed with one or more of the following conditions:

(i) pregnancy;

(ii) diabetes;

(iii) heart disease;

(iv) cancer;

(v) chronic obstructive pulmonary disease;

(vi) hypertension;

(vii) congestive heart failure;

(viii) mental illness or serious emotional disturbance;

(ix) asthma;

(x) myocardial infarction; or

(xi) stroke; and

(B) exhibit two or more of the following risk factors:

(i) two or more hospitalizations in the prior 12-month period;

(ii) frequent or recurrent emergency room admissions;

(iii) a documented history of poor adherence to ordered medication regimens;

(iv) a documented history of falls in the prior six-month period;

(v) limited or absent informal support systems;

(vi) living alone or being home alone for extended periods of time; and

(vii) a documented history of care access challenges;

(2) ensure that clinical information gathered by a home and community support services agency or hospital while providing home telemonitoring services is shared with the patient's physician; and

(3) ensure that the program does not duplicate disease management program services provided under Section 32.057, Human Resources Code.

(c-1) Notwithstanding Subsection (c)(1), the program required under this section must also provide that home telemonitoring services are available to pediatric persons who:

(1) are diagnosed with end-stage solid organ disease;

(2) have received an organ transplant; or

(3) require mechanical ventilation.

(d) If, after implementation, the commission determines that the program established under this section is not cost-effective, the commission may discontinue the program and stop providing reimbursement under Medicaid for home telemonitoring services, notwithstanding Section 531.0216 or any other law.

(e) The commission shall determine whether the provision of home telemonitoring services to persons who are eligible to receive benefits under both Medicaid and the Medicare program achieves cost savings for the Medicare program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1205 (S.B. 293), Sec. 5,

eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.033, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1061 (H.B. 1063), Sec. 2, eff. September 1, 2019.

Sec. 531.0217. REIMBURSEMENT FOR CERTAIN MEDICAL CONSULTATIONS. (a) In this section:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(3) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1205, Sec. 10(2), eff. September 1, 2011.

(4) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1205, Sec. 10(2), eff. September 1, 2011.

(b) The executive commissioner by rule shall require each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a telemedicine medical service initiated or provided by a physician.

(c) The commission shall ensure that reimbursement is provided only for a telemedicine medical service initiated or provided by a physician.

(c-1) Repealed by Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(3), eff. September 1, 2019.

(c-2) Repealed by Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(3), eff. September 1, 2019.

(c-3) Repealed by Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(3), eff. September 1, 2019.

(c-4) The commission shall ensure that Medicaid reimbursement is provided to a physician for a telemedicine medical service provided by the physician, even if the physician is not the patient's primary care physician or provider, if:

(1) the physician is an authorized health care provider under Medicaid;

(2) the patient is a child who receives the service in a primary or secondary school-based setting; and

(3) the parent or legal guardian of the patient provides consent before the service is provided.

(d) The commission shall require reimbursement for a telemedicine medical service at the same rate as Medicaid reimburses for the same in-person medical service. A request for reimbursement may not be denied solely because an in-person medical service between a physician and a patient did not occur. The commission may not limit a physician's choice of platform for providing a telemedicine medical service or telehealth service by requiring that the physician use a particular platform to receive reimbursement for the service.

(e) A health care facility that receives reimbursement under this section for a telemedicine medical service provided by a physician who practices in that facility or a health professional who participates in a telemedicine medical service under this section shall establish quality of care protocols and patient confidentiality guidelines to ensure that the telemedicine medical service meets legal requirements and acceptable patient care standards.

(f) Repealed by Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(3), eff. September 1, 2019.

(g) If a patient receiving a telemedicine medical service has a primary care physician or provider and consents or, if appropriate, the patient's parent or legal guardian consents to the notification, the commission shall require that the primary care physician or provider be notified of the telemedicine medical service for the purpose of sharing medical information. In the

case of a service provided to a child in a school-based setting as described by Subsection (c-4), the notification, if any, must include a summary of the service, including exam findings, prescribed or administered medications, and patient instructions.

(g-1) If a patient receiving a telemedicine medical service in a school-based setting as described by Subsection (c-4) does not have a primary care physician or provider, the commission shall require that the patient's parent or legal guardian receive:

(1) the notification required under Subsection (g); and

(2) a list of primary care physicians or providers from which the patient may select the patient's primary care physician or provider.

(h) The commission in consultation with the Texas Medical Board shall monitor and regulate the use of telemedicine medical services to ensure compliance with this section. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this section.

(i) The Texas Medical Board, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services; and

(2) prevent abuse and fraud through the use of telemedicine medical services, including rules relating to filing of claims and records required to be maintained in connection with telemedicine.

(i-1) Repealed by Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. 1107), Sec. 12, eff. May 27, 2017.

(j) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(1), and Ch. 946 (S.B. 277), Sec. 2.37(b)(1), eff. January 1, 2016.

(k) This section does not affect any requirement relating to:

(1) a rural health clinic; or

(2) physician delegation of the authority to carry out or sign prescription drug orders to an advanced practice nurse or

physician assistant.

Added by Acts 1997, 75th Leg., ch. 1251, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.25, eff. Sept. 1, 1999. Renumbered from Sec. 531.047 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(48), eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 661, Sec. 3, eff. June 13, 2001; Acts 2001, 77th Leg., ch. 959, Sec. 10, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1255, Sec. 3, eff. June 15, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 370 (S.B. 1340), Sec. 3, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1293 (S.B. 24), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1205 (S.B. 293), Sec. 10(2), eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.034, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 544 (H.B. 1878), Sec. 1, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(1), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(b)(1), eff. January 1, 2016.

Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. 1107), Sec. 10, eff. May 27, 2017.

Acts 2017, 85th Leg., R.S., Ch. 205 (S.B. 1107), Sec. 12, eff. May 27, 2017.

Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 3, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 964 (S.B. 670), Sec. 6(3), eff. September 1, 2019.

Sec. 531.02171. REIMBURSEMENT FOR CERTAIN TELEHEALTH SERVICES. (a) In this section, "health professional" means an individual who is:

(1) licensed, registered, certified, or otherwise authorized by this state to practice as a social worker,

occupational therapist, or speech-language pathologist;

(2) a licensed professional counselor;

(3) a licensed marriage and family therapist; or

(4) a licensed specialist in school psychology.

(b) The commission shall ensure that Medicaid reimbursement is provided to a school district or open-enrollment charter school for telehealth services provided through the school district or charter school by a health professional, even if the health professional is not the patient's primary care provider, if:

(1) the school district or charter school is an authorized health care provider under Medicaid; and

(2) the parent or legal guardian of the patient provides consent before the service is provided.

Added by Acts 2017, 85th Leg., R.S., Ch. 589 (S.B. 922), Sec. 1, eff. September 1, 2017.

Sec. 531.02174. ADDITIONAL AUTHORITY REGARDING TELEMEDICINE MEDICAL SERVICES. (a) In addition to the authority granted by other law regarding telemedicine medical services, the executive commissioner may review rules and procedures applicable to reimbursement of telemedicine medical services provided through any government-funded health program subject to the commission's oversight.

(b) The executive commissioner may modify rules and procedures described by Subsection (a) as necessary to ensure that reimbursement for telemedicine medical services is provided in a cost-effective manner and only in circumstances in which the provision of those services is clinically effective.

(c) This section does not affect the commission's authority or duties under other law regarding reimbursement of telemedicine medical services under Medicaid.

Added by Acts 2003, 78th Leg., ch. 870, Sec. 1, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.037, eff. April 2, 2015.

Sec. 531.02175. REIMBURSEMENT FOR ONLINE MEDICAL

CONSULTATIONS. (a) In this section, "physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(b) Subject to the requirements of this subsection, the executive commissioner by rule may require the commission and each health and human services agency that administers a part of Medicaid to provide Medicaid reimbursement for a medical consultation that is provided by a physician or other health care professional using the Internet as a cost-effective alternative to an in-person consultation. The executive commissioner may require the commission or a health and human services agency to provide the reimbursement described by this subsection only if the Centers for Medicare and Medicaid Services develop an appropriate Current Procedural Terminology code for medical services provided using the Internet.

(c) The executive commissioner may develop and implement a pilot program in one or more sites chosen by the executive commissioner under which Medicaid reimbursements are paid for medical consultations provided by physicians or other health care professionals using the Internet. The pilot program must be designed to test whether an Internet medical consultation is a cost-effective alternative to an in-person consultation under Medicaid. The executive commissioner may modify the pilot program as necessary throughout its implementation to maximize the potential cost-effectiveness of Internet medical consultations. If the executive commissioner determines from the pilot program that Internet medical consultations are cost-effective, the executive commissioner may expand the pilot program to additional sites or may implement Medicaid reimbursements for Internet medical consultations statewide.

(d) The executive commissioner is not required to implement the pilot program authorized under Subsection (c) as a prerequisite to providing Medicaid reimbursement authorized by Subsection (b) on a statewide basis.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 11(b), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.038, eff. April 2, 2015.

Sec. 531.0218. LONG-TERM CARE MEDICAID PROGRAMS. (a) To the extent authorized by state and federal law, the commission shall make uniform the functions relating to the administration and delivery of Section 1915(c) waiver programs, including:

(1) rate-setting;

(2) the applicability and use of service definitions;

(3) quality assurance; and

(4) intake data elements.

(b) Subsection (a) does not apply to functions of a Section 1915(c) waiver program that is operated in conjunction with a federally funded program of the state under Medicaid that is authorized under Section 1915(b) of the federal Social Security Act (42 U.S.C. Section 1396n(b)).

(c) The commission shall ensure that information on individuals seeking to obtain services from Section 1915(c) waiver programs is maintained in a single computerized database that is accessible to staff of each of the state agencies administering those programs.

Added by Acts 1999, 76th Leg., ch. 899, Sec. 2, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.040, eff. April 2, 2015.

Sec. 531.02191. PUBLIC INPUT. In complying with the requirements of Section 531.0218, the commission shall regularly consult with and obtain input from:

(1) consumers and family members;

(2) providers;

(3) advocacy groups;

(4) state agencies that administer a Section 1915(c) waiver program; and

(5) other interested persons.

Added by Acts 1999, 76th Leg., ch. 899, Sec. 2, eff. Sept. 1, 1999.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 759 (S.B. 705), Sec. 2, eff. September 15, 2009.

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

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

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

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

(b) Notwithstanding any provision of this chapter, Chapter 32, Human Resources Code, or any other law, the commission shall:

(1) promote Medicaid recipient access to federally qualified health center services or rural health clinic services; and

(2) ensure that payment for federally qualified health center services or rural health clinic services is in accordance with 42 U.S.C. Section 1396a(bb).

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 1, eff. September 1, 2007.

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

Added by Acts 2015, 84th Leg., R.S., Ch. 1236 (S.B. 1296), Sec. 19.015(a), eff. September 1, 2015.

Sec. 531.02194. REIMBURSEMENT METHODOLOGY FOR RURAL HOSPITALS. (a) In this section, "rural hospital" has the meaning assigned by commission rules for purposes of the reimbursement of

hospitals for providing inpatient or outpatient services under Medicaid.

(b) To the extent allowed by federal law and subject to limitations on appropriations, the executive commissioner by rule shall adopt a prospective reimbursement methodology for the payment of rural hospitals participating in Medicaid that ensures the rural hospitals are reimbursed on an individual basis for providing inpatient and general outpatient services to Medicaid recipients by using the hospitals' most recent cost information concerning the costs incurred for providing the services. The commission shall calculate the prospective cost-based reimbursement rates once every two years.

(c) In adopting rules under Subsection (b), the executive commissioner may:

(1) adopt a methodology that requires:

(A) a managed care organization to reimburse rural hospitals for services delivered through the Medicaid managed care program using a minimum fee schedule or other method for which federal matching money is available; or

(B) both the commission and a managed care organization to share in the total amount of reimbursement paid to rural hospitals; and

(2) require that the amount of reimbursement paid to a rural hospital is subject to any applicable adjustments made by the commission for payments to or penalties imposed on the rural hospital that are based on a quality-based or performance-based requirement under the Medicaid managed care program.

(d) Not later than September 1 of each even-numbered year, the commission shall, for purposes of Subsection (b), determine the allowable costs incurred by a rural hospital participating in the Medicaid managed care program based on the rural hospital's cost reports submitted to the federal Centers for Medicare and Medicaid Services and other available information that the commission considers relevant in determining the hospital's allowable costs.

(e) Notwithstanding Subsection (b) and subject to Subsection (f), the executive commissioner shall adopt and the commission shall implement, beginning with the state fiscal year

ending August 31, 2022, a true cost-based reimbursement methodology for inpatient and general outpatient services provided to Medicaid recipients at rural hospitals that provides:

(1) prospective payments during a state fiscal year to the hospitals using the reimbursement methodology adopted under Subsection (b); and

(2) to the extent allowed by federal law, in the subsequent state fiscal year a cost settlement to provide additional reimbursement as necessary to reimburse the hospitals for the true costs incurred in providing inpatient and general outpatient services to Medicaid recipients during the previous state fiscal year.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 416 (S.B. 170), Sec. 1, eff. September 1, 2019.

Sec. 531.022. COORDINATED STRATEGIC PLAN FOR HEALTH AND HUMAN SERVICES. (a) The executive commissioner shall develop a coordinated, six-year strategic plan for health and human services in this state and shall update the plan biennially.

(b) The executive commissioner shall submit each biennial update of the plan to the governor, the lieutenant governor, and the speaker of the house of representatives not later than October 1 of each even-numbered year.

(c) The plan must include the following goals:

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

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

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

(4) the maximization of existing resources through

effective funds management and the sharing of administrative functions;

(5) the effective use of management information systems to continually improve service delivery;

(6) the provision of systemwide accountability through effective monitoring mechanisms;

(7) the promotion of teamwork among the health and human services agencies and the provision of incentives for creativity;

(8) the fostering of innovation at the local level; and

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

(d) In developing a plan and plan updates under this section, the executive commissioner shall consider:

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

(2) health and human services priorities and plans submitted by governmental entities under Subsection (e);

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

(4) public comment, including comment documented through public hearings conducted under Section 531.036; and

(5) budgetary issues, including projected agency needs and projected availability of funds.

(e) The executive commissioner shall identify the governmental entities that coordinate the delivery of health and human services in regions, counties, and municipalities and request that each entity:

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

(2) develop a coordinated plan for the delivery of health and human services in the jurisdiction, including transition services that prepare special education students for adulthood; and

(3) make the information requested under Subdivisions (1) and (2) available to the commission.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.04(a), eff. Sept. 1, 1997; Acts 2001, 77th Leg., ch. 256, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.041, eff. April 2, 2015.

For expiration of this section, see Subsection (j).

Sec. 531.0221. INITIATIVE TO INCREASE MENTAL HEALTH SERVICES CAPACITY IN RURAL AREAS. (a) In this section, "local mental health authority group" means a group of local mental health authorities established under Subsection (b)(2).

(b) Not later than January 1, 2020, the commission, using existing resources, shall:

(1) identify each local mental health authority that is located in a county with a population of 250,000 or less or that the commission determines provides services predominantly in a county with a population of 250,000 or less;

(2) in a manner that the commission determines will best achieve the reductions described by Subsection (d), assign the authorities identified under Subdivision (1) to regional groups of at least two authorities; and

(3) notify each authority identified under Subdivision (1):

(A) that the commission has identified the authority under that subdivision; and

(B) which local mental health authority group the commission assigned the authority to under Subdivision (2).

(c) The commission, using existing resources, shall develop a mental health services development plan for each local mental health authority group that will increase the capacity of the authorities in the group to provide access to needed services.

(d) In developing a plan under Subsection (c), the commission shall focus on reducing:

(1) the cost to local governments of providing services to persons experiencing a mental health crisis;

(2) the transportation of persons served by an authority in the local mental health authority group to mental health facilities;

(3) the incarceration of persons with mental illness in county jails that are located in an area served by an authority in the local mental health authority group; and

(4) the number of hospital emergency room visits by persons with mental illness at hospitals located in an area served by an authority in the local mental health authority group.

(e) In developing a plan under Subsection (c):

(1) the commission shall assess the capacity of the authorities in the local mental health authority group to provide access to needed services; and

(2) the commission and the local mental health authority group shall evaluate:

(A) whether and to what degree increasing the capacity of the authorities in the local mental health authority group to provide access to needed services would offset the cost to state or local governmental entities of:

(i) the transportation of persons for mental health services to facilities that are not local providers;

(ii) admissions to and inpatient hospitalizations at state hospitals or other treatment facilities;

(iii) the provision of services by hospital emergency rooms to persons with mental illness who are served by or reside in an area served by an authority in the local mental health authority group; and

(iv) the incarceration in county jails of persons with mental illness who are served by or reside in an area served by an authority in the local mental health authority group;

(B) whether available state funds or grant funding sources could be used to fund the plan; and

(C) what measures would be necessary to ensure that the plan aligns with the statewide behavioral health strategic plan and the comprehensive inpatient mental health plan.

(f) In each mental health services development plan produced under this section, the commission, in collaboration with

the local mental health authority group, shall determine a method of increasing the capacity of the authorities in the local mental health authority group to provide access to needed services.

(g) The commission shall compile and evaluate each mental health services development plan produced under this section and determine:

(1) the cost-effectiveness of each plan; and

(2) how each plan would improve the delivery of mental health treatment and care to residents in the service areas of the authorities in the local mental health authority group.

(h) Not later than December 1, 2020, the commission, using existing resources, shall produce and publish on its Internet website a report containing:

(1) the commission's evaluation of each plan under Subsection (g);

(2) each mental health services development plan evaluated by the commission under Subsection (g); and

(3) a comprehensive statewide analysis of mental health services in counties with a population of 250,000 or less, including recommendations to the legislature for implementing the plans developed under this section.

(i) The commission and the authorities in each local mental health authority group may implement a mental health services development plan evaluated by the commission under this section if the commission and the local mental health authority group to which the plan applies identify a method of funding that implementation.

(j) This section expires September 1, 2021.

Added by Acts 2019, 86th Leg., R.S., Ch. 963 (S.B. 633), Sec. 1, eff. June 14, 2019.

Sec. 531.0224. PLANNING AND POLICY DIRECTION OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM. (a) The commission shall:

(1) plan and direct the financial assistance program under Chapter 31, Human Resources Code, including the procurement, management, and monitoring of contracts necessary to implement the program; and

(2) establish requirements for and define the scope

of the ongoing evaluation of the financial assistance program under Chapter 31, Human Resources Code.

(b) The executive commissioner shall adopt rules and standards governing the financial assistance program under Chapter 31, Human Resources Code.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.07, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.043, eff. April 2, 2015.

For expiration of this section, see Subsection (p).

Sec. 531.02241. PILOT PROGRAM FOR SELF-SUFFICIENCY OF CERTAIN PERSONS RECEIVING FINANCIAL ASSISTANCE OR SUPPLEMENTAL NUTRITION ASSISTANCE BENEFITS. (a) In this section:

(1) "Financial assistance benefits" means money payments under the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code, or under the state temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Self-sufficiency" means being employed in a position that pays a sufficient wage, having financial savings in an amount that is equal to at least $1,000 per member of a family's household, and maintaining a debt-to-income ratio that does not exceed 43 percent.

(3) "Slow reduction scale" means a graduated plan for reducing financial assistance or supplemental nutrition assistance benefits that correlates with a phase of the pilot program's progressive stages toward self-sufficiency.

(4) "Sufficient wage" means an amount of money, determined by a market-based calculation that uses geographically specific expenditure data, that is sufficient to meet a family's minimum necessary spending on basic needs, including food, child care, health insurance, housing, and transportation.

(5) "Supplemental nutrition assistance benefits" means money payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code.

(b) The commission shall develop and implement a pilot program for assisting not more than 500 eligible families to gain permanent self-sufficiency and no longer require financial assistance, supplemental nutrition assistance, or other means-tested public benefits, notwithstanding the limitations and requirements of Section 31.043, Human Resources Code. If the number of families participating in the program during a year reaches capacity for that year as determined by the commission, the number of families that may be served under the program in the following year may be increased by 20 percent.

(c) The pilot program will test extending, for at least 24 months but not more than 60 months, financial assistance and supplemental nutrition assistance benefits by waiving the application of income and asset limit eligibility requirements for those benefits and the time limits under Section 31.0065, Human Resources Code, for financial assistance benefits to allow for continuation of financial assistance and supplemental nutrition assistance benefits and reduction of the benefits using a slow reduction scale. The commission shall freeze a participating family's eligibility status for the benefits beginning on the date the participating family enters the pilot program and ending on the date the family ceases participating in the program. The waiver of the application of any asset limit requirement must allow the family to have assets in an amount that is at least $1,000 per member of the family's household.

(d) The pilot program must be designed to allow social services providers, public benefit offices, and other community partners to refer potential participating families to the program.

(e) A family is eligible to participate in the pilot program established under this section if the family:

(1) includes one or more members who are recipients of financial assistance or supplemental nutrition assistance benefits, at least one of whom is:

(A) at least 18 but not more than 62 years of age; and

(B) willing, and physically and legally able, to be employed; and

(2) has a total household income that is less than a sufficient wage based on the family's makeup and geographical area of residence.

(f) The pilot program must be designed to assist eligible participating families in attaining self-sufficiency by:

(1) identifying eligibility requirements for the continuation of financial assistance or supplemental nutrition assistance benefits and time limits for the benefits, the application of which may be waived for a limited period and that, if applied, would impede self-sufficiency;

(2) implementing strategies, including waiving the application of the eligibility requirements and time limits identified in Subdivision (1), to remove barriers to self-sufficiency; and

(3) moving eligible participating families through progressive stages toward self-sufficiency that include the following phases:

(A) an initial phase in which a family moves out of an emergent crisis by securing housing, medical care, and financial assistance and supplemental nutrition assistance benefits, as necessary;

(B) a second phase in which:

(i) the family moves toward stability by securing employment and, if necessary, child care and by participating in services that build the financial management skills necessary to meet financial goals; and

(ii) the family's financial assistance and supplemental nutrition assistance benefits are reduced according to the following scale:

(a) on reaching 25 percent of the family's sufficient wage, the amount of benefits is reduced by 10 percent;

(b) on reaching 50 percent of the family's sufficient wage, the amount of benefits is reduced by 25 percent; and

(c) on reaching 75 percent of the family's sufficient wage, the amount of benefits is reduced by 50

percent;

(C) a third phase in which the family:

(i) transitions to self-sufficiency by securing employment that pays a sufficient wage, reducing debt, and building savings; and

(ii) becomes ineligible for financial assistance and supplemental nutrition assistance benefits on reaching 100 percent of the family's sufficient wage; and

(D) a final phase in which the family attains self-sufficiency by retaining employment that pays a sufficient wage, amassing at least $1,000 per member of the family's household, and having manageable debt so that the family will no longer be dependent on financial assistance, supplemental nutrition assistance, or other means-tested public benefits for at least six months following the date the family stops participating in the program.

(g) A person from a family that wishes to participate in the pilot program must attend an in-person intake meeting with a program case manager. During the intake meeting the case manager shall:

(1) determine whether:

(A) the person's family meets the eligibility requirements under Subsection (e); and

(B) the application of income or asset limit eligibility requirements for continuation of financial assistance and supplemental nutrition assistance benefits and the time limits under Section 31.0065, Human Resources Code, for financial assistance benefits may be waived under the program;

(2) review the family's demographic information and household financial budget;

(3) assess the family members' current financial and career situations;

(4) collaborate with the person to develop and implement strategies for removing barriers to the family attaining self-sufficiency, including waiving the application of income and asset limit eligibility requirements and time limits described by Subdivision (1)(B) to allow for continuation of financial

assistance and supplemental nutrition assistance benefits; and

(5) if the person's family is determined to be eligible for and chooses to participate in the program, schedule a follow-up meeting to further assess the family's crisis, review available referral services, and create a service plan.

(h) A participating family must be assigned a program case manager who shall:

(1) if the family is determined to be eligible, provide the family with a verification of the waived application of asset, income, and time limits described by Subsection (c), allowing the family to continue receiving financial assistance and supplemental nutrition assistance benefits on a slow reduction scale;

(2) assess, at the follow-up meeting scheduled under Subsection (g)(5), the family's crisis, review available referral services, and create a service plan; and

(3) during the initial phase of the program, create medium- and long-term goals consistent with the strategies developed under Subsection (g)(4).

(i) The pilot program must provide each participating family placed in the research group described by Subsection (j)(3)(C) with holistic, wraparound case management services that meet all applicable program requirements under 7 C.F.R. Section 273.7(e) or 45 C.F.R. Section 261.10, as applicable. Case management services provided under this subsection must include the strategic use of financial assistance and supplemental nutrition assistance benefits to ensure that the goals included in the family's service plan are achieved. The wraparound case management services must be provided through a community-based provider.

(j) The pilot program must operate for at least 24 months. The program shall also include 16 additional months for:

(1) planning and designing the program before the program begins operation;

(2) recruiting eligible families to participate in the program;

(3) randomly placing each participating family in one of at least three research groups, including:

(A) a control group;

(B) a group consisting of families for whom the application of income, asset, and time limits described by Subsection (c) is waived; and

(C) a group consisting of families for whom the application of income, asset, and time limits described by Subsection (c) is waived and who receive wraparound case management services under the program; and

(4) after the program begins operation, collecting and sharing data that allows for:

(A) obtaining participating families' eligibility and identification data before a family is randomly placed in a research group under Subdivision (3);

(B) conducting surveys or interviews of participating families to obtain information that is not contained in records related to a family's eligibility for financial assistance, supplemental nutrition assistance, or other means-tested public benefits;

(C) providing quarterly reports for not more than 60 months after a participating family is enrolled in the pilot program regarding the program's effect on the family's labor market participation and income and need for means-tested public benefits;

(D) assessing the interaction of the program's components with the desired outcomes of the program using data collected during the program and data obtained from state agencies concerning means-tested public benefits; and

(E) a third party to conduct a rigorous experimental impact evaluation of the pilot program.

(k) The commission shall develop and implement the pilot program with the assistance of the Texas Workforce Commission, local workforce development boards, faith-based and other relevant public or private organizations, and any other entity or person the commission determines appropriate.

(l) The commission shall monitor and evaluate the pilot program in a manner that allows for promoting research-informed results of the program.

(m) On the conclusion of the pilot program but not later

than 48 months following the date the last participating family is enrolled in the program, the commission shall report to the legislature on the results of the program. The report must include:

(1) an evaluation of the program's effect on participating families in achieving self-sufficiency and no longer requiring means-tested public benefits;

(2) the impact to this state on the costs of the financial assistance and supplemental nutrition assistance programs and of the child-care services program operated by the Texas Workforce Commission;

(3) a cost-benefit analysis of the program; and

(4) recommendations on the feasibility and continuation of the program.

(n) During the operation of the pilot program, the commission shall provide to the legislature additional reports concerning the program that the commission determines to be appropriate.

(o) The executive commissioner and the Texas Workforce Commission may adopt rules to implement this section.

(p) This section expires September 1, 2026.

Added by Acts 2019, 86th Leg., R.S., Ch. 242 (H.B. 1483), Sec. 1, eff. May 27, 2019.

Sec. 531.0225. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES. (a) To ensure appropriate delivery of mental health and substance abuse services, the commission shall regularly evaluate program contractors and subcontractors that provide or arrange for the services for persons enrolled in:

(1) the Medicaid managed care program; and

(2) the state child health plan program.

(b) The commission shall monitor:

(1) penetration rates, as they relate to mental health and substance abuse services provided by or through contractors and subcontractors;

(2) utilization rates, as they relate to mental health and substance abuse services provided by or through contractors and

subcontractors; and

(3) provider networks used by contractors and subcontractors to provide mental health or substance abuse services.

Added by Acts 2003, 78th Leg., ch. 358, Sec. 2, eff. June 18, 2003. Renumbered from Government Code, Section 531.0224 by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(32), eff. September 1, 2005.

Sec. 531.02251. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE. (a) In this section, "ombudsman" means the individual designated as the ombudsman for behavioral health access to care.

(b) The executive commissioner shall designate an ombudsman for behavioral health access to care.

(c) The ombudsman is administratively attached to the office of the ombudsman for the commission.

(d) The commission may use an alternate title for the ombudsman in consumer-facing materials if the commission determines that an alternate title would be beneficial to consumer understanding or access.

(e) The ombudsman serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

(f) The ombudsman shall:

(1) interact with consumers and behavioral health care providers with concerns or complaints to help the consumers and providers resolve behavioral health care access issues;

(2) identify, track, and help report potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to quantitative and nonquantitative treatment limitations;

(3) report concerns, complaints, and potential

violations described by Subdivision (2) to the appropriate regulatory or oversight agency;

(4) receive and report concerns and complaints relating to inappropriate care or mental health commitment;

(5) provide appropriate information to help consumers obtain behavioral health care;

(6) develop appropriate points of contact for referrals to other state and federal agencies; and

(7) provide appropriate information to help consumers or providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies.

(g) The ombudsman shall participate in the mental health condition and substance use disorder parity work group established under Section 531.02252 and provide summary reports of concerns, complaints, and potential violations described by Subsection (f)(2) to the work group. This subsection expires September 1, 2021.

(h) The Texas Department of Insurance shall appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations described by Subsection (f)(2) from the ombudsman, consumers, or behavioral health care providers.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 1, eff. September 1, 2017.

For expiration of this section, see Subsection (h).

Sec. 531.02252. MENTAL HEALTH CONDITION AND SUBSTANCE USE DISORDER PARITY WORK GROUP. (a) The commission shall establish and facilitate a mental health condition and substance use disorder parity work group at the office of mental health coordination to increase understanding of and compliance with state and federal rules, regulations, and statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions and substance use disorders.

(b) The work group may be a part of or a subcommittee of the behavioral health advisory committee.

(c) The work group is composed of:

(1) a representative of:

(A) Medicaid and the child health plan program;

(B) the office of mental health coordination;

(C) the Texas Department of Insurance;

(D) a Medicaid managed care organization;

(E) a commercial health benefit plan;

(F) a mental health provider organization;

(G) physicians;

(H) hospitals;

(I) children's mental health providers;

(J) utilization review agents; and

(K) independent review organizations;

(2) a substance use disorder provider or a professional with co-occurring mental health and substance use disorder expertise;

(3) a mental health consumer;

(4) a mental health consumer advocate;

(5) a substance use disorder treatment consumer;

(6) a substance use disorder treatment consumer advocate;

(7) a family member of a mental health or substance use disorder treatment consumer; and

(8) the ombudsman for behavioral health access to care.

(d) The work group shall meet at least quarterly.

(e) The work group shall study and make recommendations on:

(1) increasing compliance with the rules, regulations, and statutes described by Subsection (a);

(2) strengthening enforcement and oversight of these laws at state and federal agencies;

(3) improving the complaint processes relating to potential violations of these laws for consumers and providers;

(4) ensuring the commission and the Texas Department of Insurance can accept information on concerns relating to these laws and investigate potential violations based on de-identified information and data submitted to providers in addition to individual complaints; and

(5) increasing public and provider education on these laws.

(f) The work group shall develop a strategic plan with metrics to serve as a roadmap to increase compliance with the rules, regulations, and statutes described by Subsection (a) in this state and to increase education and outreach relating to these laws.

(g) Not later than September 1 of each even-numbered year, the work group shall submit a report to the appropriate committees of the legislature and the appropriate state agencies on the findings, recommendations, and strategic plan required by Subsections (e) and (f).

(h) The work group is abolished and this section expires September 1, 2021.

Added by Acts 2017, 85th Leg., R.S., Ch. 769 (H.B. 10), Sec. 1, eff. September 1, 2017.

Sec. 531.02253. TELEHEALTH TREATMENT FOR SUBSTANCE USE DISORDERS. The executive commissioner by rule shall establish a program to increase opportunities and expand access to telehealth treatment for substance use disorders in this state.

Added by Acts 2019, 86th Leg., R.S., Ch. 1167 (H.B. 3285), Sec. 3, eff. September 1, 2019.

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

(1) meet established income and other eligibility criteria; and

(2) are eligible to receive services through the county for chronic health conditions.

(b) In establishing the waiver program under this section, the commission shall:

(1) ensure that the state is a prudent purchaser of the

health care services that are needed for the individuals described by Subsection (a);

(2) solicit broad-based input from interested persons;

(3) ensure that the benefits received by an individual through the county are not reduced once the individual is enrolled in the waiver program; and

(4) employ the use of intergovernmental transfers and other procedures to maximize the receipt of federal Medicaid matching funds.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 4 (S.B. 1), Sec. 71.01, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.044, eff. April 2, 2015.

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

Added by Acts 2011, 82nd Leg., R.S., Ch. 272 (H.B. 1481), Sec. 3, eff. September 1, 2011.

Sec. 531.023. SUBMISSION OF PLANS AND UPDATES BY AGENCIES. (a) All health and human services agencies shall submit to the commission strategic plans and biennial updates on a date to be determined by commission rule. The commission shall review and comment on the strategic plans and biennial updates.

(b) Not later than January 1 of each even-numbered year, the commission shall begin formal discussions with each health and human services agency regarding that agency's strategic plan or biennial update.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.05(a), eff.

Sept. 1, 1997.

Sec. 531.024. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES; DATA SHARING. (a) The executive commissioner shall:

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

(A) compliance with the coordinated strategic plan;

(B) co-location of services;

(C) integrated intake; and

(D) coordinated referral and case management;

(2) develop with the Department of Information Resources automation standards for computer systems to enable health and human services agencies, including agencies operating at a local level, to share pertinent data;

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

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

(5) perform independent special-outcome evaluations of health and human services programs and activities;

(6) at the request of a governmental entity identified under Section 531.022(e), assist that entity in implementing a coordinated plan that may include co-location of services, integrated intake, and coordinated referral and case management and is tailored to the needs and priorities of that entity; and

(7) promulgate uniform fair hearing rules for all Medicaid-funded services.

(a-1) To the extent permitted under applicable federal law and notwithstanding any provision of Chapter 191 or 192, Health and Safety Code, the commission and other health and human services agencies shall share data to facilitate patient care coordination, quality improvement, and cost savings in Medicaid, the child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund.

(b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services and to a

Medicaid recipient who seeks a Medicaid service, including a service that requires prior authorization. The rules must provide the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:

(1) the written notice to an individual of the individual's right to a hearing must:

(A) contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and

(B) be delivered by mail, and postmarked at least 10 business days, before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by 42 C.F.R. Section 431.213 or 431.214; and

(2) if a hearing is requested before the date a Medicaid recipient's service, including a service that requires prior authorization, is scheduled to be terminated, suspended, or reduced, the agency may not take that proposed action before a decision is rendered after the hearing unless:

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

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

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

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

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

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.06, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 342, Sec. 1, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 62, Sec. 8.11, eff. Sept. 1, 1999.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 713 (H.B. 2256), Sec. 1, eff. September 1, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 6.01, eff.

September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 6.02, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.046, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 2, eff. September 1, 2019.

Sec. 531.0241. STREAMLINING DELIVERY OF SERVICES. To integrate and streamline service delivery and facilitate access to services, the executive commissioner may request a health and human services agency to take a specific action and may recommend the manner in which the streamlining is to be accomplished, including requesting each health and human services agency to:

(1) simplify agency procedures;

(2) automate agency procedures;

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

(4) reallocate staff resources;

(5) waive existing rules; or

(6) take other necessary actions.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.07(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.047, eff. April 2, 2015.

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in Medicaid and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of Medicaid by any method the commission determines is cost-effective, including:

(1) expanding the utilization of the electronic claims payment system;

(2) developing an Internet portal system for prior authorization requests;

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

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

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

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

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

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

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

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

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

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

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 4(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.048, eff. April 2, 2015.

Sec. 531.024115. SERVICE DELIVERY AREA ALIGNMENT. Notwithstanding Section 533.0025(e) or any other law, to the extent possible, the commission shall align service delivery areas under Medicaid and the child health plan program.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 6.03, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.049, eff. April 2, 2015.

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. (a) The commission shall make every effort to ensure the integrity of Medicaid. To ensure that integrity, the commission shall:

(1) perform risk assessments of every element of the program and audit those elements of the program that are determined to present the greatest risks;

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

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

(4) evaluate Medicaid with respect to use of the metrics developed through the Texas Health Steps performance improvement plan to guide changes and improvements to the program.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 4(a), eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 32(f), eff. September 1, 2008.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.050, eff. April 2, 2015.

Sec. 531.02413. BILLING COORDINATION SYSTEM. (a) If cost-effective and feasible, the commission shall, on or before March 1, 2008, contract through an existing procurement process for the implementation of an acute care Medicaid billing coordination system for the fee-for-service and primary care case management

delivery models that will, upon entry in the claims system, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the entity the system determines is the primary payor. The system may not increase Medicaid claims payment error rates.

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

(b) If cost-effective, the executive commissioner shall adopt rules for the purpose of enabling the system described by Subsection (a) to identify an entity with primary responsibility for paying a claim that is processed by the system under Subsection (a) and establish reporting requirements for any entity that may have a contractual responsibility to pay for the types of services that are provided under Medicaid and the claims for which are processed by the system under Subsection (a).

(c) An entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state must allow a contractor under this section access to databases to allow the contractor to carry out the purposes of this section, subject to the contractor's contract with the commission and rules adopted under this section, and is subject to an administrative penalty or other sanction as provided by the law applicable to the permit, license, or certificate of authority for a violation by the entity of a rule adopted under this section.

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

(e) Information obtained under this section is confidential. The contractor may use the information only for the

purposes authorized under this section. A person commits an offense if the person knowingly uses information obtained under this section for any purpose not authorized under this section. An offense under this subsection is a Class B misdemeanor and all other penalties may apply.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 2, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 745 (S.B. 531), Sec. 1, eff. September 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.051, eff. April 2, 2015.

Sec. 531.024131. EXPANSION OF BILLING COORDINATION AND INFORMATION COLLECTION ACTIVITIES. (a) If cost-effective, the commission may:

(1) contract to expand all or part of the billing coordination system established under Section 531.02413 to process claims for services provided through other benefits programs administered by the commission or a health and human services agency;

(2) expand any other billing coordination tools and resources used to process claims for health care services provided through Medicaid to process claims for services provided through other benefits programs administered by the commission or a health and human services agency; and

(3) expand the scope of persons about whom information is collected under Section 32.042, Human Resources Code, to include recipients of services provided through other benefits programs administered by the commission or a health and human services agency.

(b) Notwithstanding any other state law, each health and human services agency shall provide the commission with any information necessary to allow the commission or the commission's designee to perform the billing coordination and information collection activities authorized by this section.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.10,

eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.052, eff. April 2, 2015.

Sec. 531.02414. NONEMERGENCY TRANSPORTATION SERVICES UNDER MEDICAL TRANSPORTATION PROGRAM. (a) In this section:

(1) "Medical transportation program" means the program that provides nonemergency transportation services to recipients under Medicaid, subject to Subsection (a-1), the children with special health care needs program, and the transportation for indigent cancer patients program, who have no other means of transportation.

(1-a) "Nonemergency transportation service" means nonemergency medical transportation services authorized under:

(A) for a Medicaid recipient, the state Medicaid plan; and

(B) for a recipient under another program described by Subdivision (1), that program.

(2) "Regional contracted broker" means an entity that contracts with the commission to provide or arrange for the provision of nonemergency transportation services under the medical transportation program.

(3) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

(a-1) Subject to Section 533.002571(i), this section does not apply to the provision of nonemergency transportation services on or after September 1, 2020, to a Medicaid recipient who is enrolled in a managed care plan offered by a Medicaid managed care organization.

(b) Notwithstanding any other law, the commission shall directly supervise the administration and operation of the medical transportation program under this section.

(c) Notwithstanding any other law, the commission may not delegate the commission's duty to supervise the medical transportation program to any other person, including through a contract with the Texas Department of Transportation for the

department to assume any of the commission's responsibilities relating to the provision of services through that program.

(d) Subject to Section 533.00257, the commission may 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.

(e) The executive commissioner shall adopt rules to ensure the safe and efficient provision of nonemergency transportation services under this section. The rules must include:

(1) minimum standards regarding the physical condition and maintenance of motor vehicles used to provide the services, including standards regarding the accessibility of motor vehicles by persons with disabilities;

(2) a requirement that a regional contracted broker verify that each motor vehicle operator providing the services or seeking to provide the services has a valid driver's license;

(3) a requirement that a regional contracted broker check the driving record information maintained by the Department of Public Safety under Subchapter C, Chapter 521, Transportation Code, of each motor vehicle operator providing the services or seeking to provide the services;

(4) a requirement that a regional contracted broker check the public criminal record information maintained by the Department of Public Safety and made available to the public through the department's Internet website of each motor vehicle operator providing the services or seeking to provide the services; and

(5) training requirements for motor vehicle operators providing the services through a regional contracted broker, including training on the following topics:

(A) passenger safety;

(B) passenger assistance;

(C) assistive devices, including wheelchair lifts, tie-down equipment, and child safety seats;

(D) sensitivity and diversity;

(E) customer service;

(F) defensive driving techniques; and

(G) prohibited behavior by motor vehicle operators.

(f) Except as provided by Subsection (j), the commission shall require compliance with the rules adopted under Subsection (e) in any contract entered into with a regional contracted broker to provide nonemergency transportation services under the medical transportation program.

(g) The commission shall enter into a memorandum of understanding with the Texas Department of Motor Vehicles and the Department of Public Safety for purposes of obtaining the motor vehicle registration and driver's license information of a provider of medical transportation services, including a regional contracted broker and a subcontractor of the broker, to confirm that the provider complies with applicable requirements adopted under Subsection (e).

(h) The commission shall establish a process by which providers of medical transportation services, including providers under a managed transportation delivery model, that contract with the commission may request and obtain the information described under Subsection (g) for purposes of ensuring that subcontractors providing medical transportation services meet applicable requirements adopted under Subsection (e).

(i) Emergency medical services personnel and emergency medical services vehicles, as those terms are defined by Section 773.003, Health and Safety Code, may not provide nonemergency transportation services under the medical transportation program.

(j) A regional contracted broker may subcontract with a transportation network company to provide services under this section. A rule or other requirement adopted by the executive commissioner under Subsection (e) does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. The commission or the regional contracted broker may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide

services under this section.

(k) The commission or a regional contracted broker that subcontracts with a transportation network company under Subsection (j) may require the transportation network company or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

(l) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a regional contracted broker under Subsection (j) and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this section. The commission and the regional contracted broker may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this section.

(m) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 3(a), eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 997 (H.B. 2136), Sec. 1, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 3, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.053, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 2, eff. June 14, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 3, eff. June 14, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 4, eff. June 14, 2019.

For expiration of this section, see Subsection (i).

Sec. 531.024141. PILOT PROGRAM FOR PROVIDING MEDICAL TRANSPORTATION PROGRAM SERVICES TO PREGNANT WOMEN AND NEW MOTHERS. (a) In this section:

(1) "Demand response transportation services" means medical transportation program services that are provided by dispatching a transportation service provider's vehicle in response to a request from a client or by a shared one-way trip.

(2) "Managed transportation organization" has the meaning assigned by Section 533.00257.

(3) "Medicaid managed care organization" means a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients.

(4) "Medical transportation program" has the meaning assigned by Section 531.02414.

(b) The commission, in collaboration with the Maternal Mortality and Morbidity Task Force established under Chapter 34, Health and Safety Code, shall develop and, not later than September 1, 2020, implement a pilot program in at least one health care service region, as defined by Section 533.001, that allows for a managed transportation organization that participates in the pilot program to arrange for and provide medical transportation program services to:

(1) a woman who is enrolled in the STAR Medicaid managed care program during the woman's pregnancy and after she delivers; and

(2) the child of a woman described by Subdivision (1) who accompanies the woman.

(c) A managed transportation organization that participates in the pilot program shall:

(1) arrange for and provide the medical transportation program services described by Subsection (b) in a manner that does not result in additional costs to Medicaid or the commission;

(2) arrange for and provide demand response transportation services, including, to the extent allowed by law, through a transportation network company as defined by Section 2402.001, Occupations Code, to a woman described by Subsection (b) if:

(A) the request for transportation services is made during a period of time determined by commission rules before the woman requires transportation in order to receive a covered health care service; or

(B) the woman receiving medical transportation program services needs to travel directly to and from a location to receive a covered health care service and cannot be a participant in a shared trip; and

(3) ensure that the managed transportation organization and the managed care organization through which a woman described by Subsection (b) receives health care services effectively share information and coordinate services for the woman.

(d) In developing the pilot program, the commission shall ensure that a managed transportation organization participating in the pilot program provides medical transportation services in a safe and efficient manner.

(e) Not later than December 1, 2020, the commission shall report to the legislature on the implementation of the pilot program.

(f) The commission shall evaluate the results of the pilot program and determine whether the program:

(1) is cost-effective;

(2) improves the efficiency and quality of services provided under the medical transportation program; and

(3) is effective in:

(A) increasing access to prenatal and postpartum health care services;

(B) reducing pregnancy-related complications; and

(C) decreasing the rate of missed appointments for covered health care services by women enrolled in the STAR

Medicaid managed care program.

(g) Not later than December 1, 2022, the commission shall submit a report to the legislature on the results of the pilot program. The commission shall include in the report a recommendation regarding whether the pilot program should continue, be expanded, or terminate.

(h) The executive commissioner:

(1) shall adopt rules specifying the number of days or hours before transportation services are needed that a request for the services must be made for purposes of Subsection (c)(2)(A); and

(2) may adopt other rules to implement this section.

(i) This section expires September 1, 2023.

Added by Acts 2019, 86th Leg., R.S., Ch. 705 (H.B. 25), Sec. 1, eff. September 1, 2019.

Sec. 531.02415. ELECTRONIC ELIGIBILITY INFORMATION PILOT PROJECT. (a) The commission shall establish a pilot project in at least one urban area of this state to determine the feasibility, costs, and benefits of accepting, for the purpose of establishing eligibility for benefits under state and federal health and human services programs administered by the commission, the direct importation of electronic eligibility information from an electronic system operated by a regional safety net provider collaborative organization.

(a-1) Not later than September 1, 2010, the commission shall expand the pilot project to at least one additional urban area of this state if the commission has implemented the Texas Integrated Eligibility Redesign System (TIERS) in the area selected for the expansion.

(b) An area selected for the pilot project under this section must possess a functioning safety net provider collaborative organization that includes a network of providers and assesses eligibility for health and human services programs using electronic systems. The electronic systems used by the collaborative organization must be able to interface with electronic systems managed by the commission to enable the commission to import application and eligibility information

regarding applicants for health and human services programs.

(c) In establishing a pilot project under this section, the commission shall:

(1) create a project in which regional indigent care networks interface with the commission through the Texas Integrated Eligibility Redesign System (TIERS) or another state electronic eligibility system, as appropriate, to share electronic applications for indigent care created by the care network with the commission to facilitate enrollment in health and human services programs administered by the commission;

(2) automatically import the application information submitted under Subdivision (1) with minimal human intervention to eliminate double data entry and data entry errors and to ensure most appropriate use of commission resources while maintaining program integrity;

(3) solicit and obtain support for the project from local officials and indigent care providers;

(4) ensure that all identifying and descriptive information of recipients in each health and human services program included in the project can only be accessed by providers or other entities participating in the project; and

(5) ensure that the storage and communication of all identifying and descriptive information included in the project complies with existing federal and state privacy laws governing individually identifiable information for recipients of public benefits programs.

(d) In implementing the project under Subsection (c), the commission shall review and process applications in a timely manner and, to the extent allowed by federal law and regulations, work directly with each organization to obtain missing documents and resolve issues that impede enrollment. Each organization must be authorized by the applicant to receive information concerning the applicant directly from the commission.

(e) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 1312, Sec. 99(15), eff. September 1, 2013.

Added by Acts 2007, 80th Leg., R.S., Ch. 605 (H.B. 321), Sec. 1, eff. June 15, 2007.

Renumbered from Government Code, Section 531.02413 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(36), eff. September 1, 2009.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 312 (H.B. 583), Sec. 1, eff. June 19, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 99(15), eff. September 1, 2013.

Sec. 531.024161. REIMBURSEMENT CLAIMS FOR CERTAIN MEDICAID OR CHILD HEALTH PLAN SERVICES INVOLVING SUPERVISED PROVIDERS. (a) If a provider, including a nurse practitioner or physician assistant, under Medicaid or the child health plan program provides a referral for or orders health care services for a recipient or enrollee, as applicable, at the direction or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the recipient or enrollee, the names and associated national provider identifier numbers of the supervised provider and the supervising provider must be included on any claim for reimbursement submitted by a provider based on the referral or order. For purposes of this section, "national provider identifier" means the national provider identifier required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The executive commissioner shall adopt rules necessary to implement this section.

Added by Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 2, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.054, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.055, eff. April 2, 2015.

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

or a Medicaid managed care organization to a Medicaid recipient or provider regarding the denial, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

(1) information required by federal and state law and applicable regulations;

(2) for the recipient:

(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;

(B) a copy of the information sent to the provider; and

(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and a description of the role of an external medical review; and

(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as applicable, information required under Subsection (b).

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the Medicaid recipient on whose behalf the request was submitted. The notice issued under this subsection must:

(1) include a section specifically for the provider that contains:

(A) a clear and specific list and description of the documentation necessary for the commission or organization to make a final determination on the request;

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process described by Section 533.00284, if applicable; and

(C) information on the manner through which a provider may contact a Medicaid managed care organization or other

entity as required by Section 531.024163; and

(2) be sent:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the extent practicable using existing resources.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING MEDICAID PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's Internet website in an easily searchable and accessible format:

(1) the applicable timelines for prior authorization requirements, including:

(A) the time within which the organization or entity must make a determination on a prior authorization request;

(B) a description of the notice the organization or entity provides to a provider and Medicaid recipient on whose behalf the request was submitted regarding the documentation required to complete a determination on a prior authorization request; and

(C) the deadline by which the organization or entity is required to submit the notice described by Paragraph (B); and

(2) an accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including:

(A) for a prior authorization requirement first imposed on or after September 1, 2019, the effective date of the

requirement;

(B) a list or description of any supporting or other documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each review of the prior authorization requirement conducted under Section 533.00283, if applicable.

(b) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to:

(1) adopt and maintain a process for a provider or Medicaid recipient to contact the organization or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request; and

(2) ensure that the process described by Subdivision (1) is not arduous or overly burdensome to a provider or recipient.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

Sec. 531.024164. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" and "reviewer" mean a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with applicable state law and rules.

(b) The commission shall contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a Medicaid recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) a denial by the commission of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs.

(c) A Medicaid managed care organization may not have a

financial relationship with or ownership interest in the external medical reviewer with which the commission contracts.

(d) The external medical reviewer with which the commission contracts must:

(1) be overseen by a medical director who is a physician licensed in this state; and

(2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.

(e) The commission shall establish a common procedure for reviews. To the greatest extent possible, the procedure must reduce administrative burdens on providers and the submission of duplicative information or documents. Medical necessity under the procedure must be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The reviewer shall conduct the review within a period specified by the commission. The commission shall also establish a procedure and time frame for expedited reviews that allows the reviewer to:

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

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

(f) A Medicaid recipient or applicant, or the recipient's or applicant's parent or legally authorized representative, must affirmatively request an external medical review. If requested:

(1) an external medical review described by Subsection (b)(1) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing and is granted when a Medicaid recipient contests the internal appeal decision of the Medicaid managed care organization; and

(2) an external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing.

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

ordering health care provider.

(h) The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

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

(b) If cost-effective, the commission shall develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services. If the commission develops an objective assessment process under this section, the commission shall require that:

(1) the assessment be conducted:

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

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

(2) the process include:

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

(B) an assessment of whether the recipient should be referred for additional assessments regarding the recipient's

needs for therapy services, as defined by Section 531.024171, attendant care services, and durable medical equipment; and

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

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

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

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

(d) Unless the commission determines that the assessment is feasible and beneficial, an assessment under Subsection (b)(2)(B) of whether a recipient should be referred for additional therapy services shall be waived if the recipient's need for therapy services has been established by a recommendation from a therapist providing care prior to discharge of the recipient from a licensed hospital or nursing home. The assessment may not be waived if the recommendation is made by a therapist who will deliver any services to the recipient or is affiliated with a person who will deliver those services when the recipient is discharged from the licensed hospital or nursing home.

(e) The executive commissioner shall adopt rules providing for a process by which a provider of acute nursing services who disagrees with the results of the assessment conducted under Subsection (b) may request and obtain a review of those results.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.01(a), eff. September 28, 2011.

Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) In this section, "therapy services" includes occupational, physical, and speech therapy services.

(b) After implementing the objective assessment process for acute nursing services in accordance with Section 531.02417, the

commission shall consider whether implementing age- and diagnosis-appropriate objective assessment processes for assessing the needs of a Medicaid recipient for therapy services would be feasible and beneficial.

(c) If the commission determines that implementing age- and diagnosis-appropriate processes with respect to one or more types of therapy services is feasible and would be beneficial, the commission may implement the processes within:

(1) the Medicaid fee-for-service model;

(2) the primary care case management Medicaid managed care model; and

(3) the STAR and STAR + PLUS Medicaid managed care programs.

(d) An objective assessment process implemented under this section must include a process that allows a provider of therapy services to request and obtain a review of the results of an assessment conducted as provided by this section that is comparable to the process implemented under rules adopted under Section 531.02417(e).

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.01(a), eff. September 28, 2011.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 1648, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM. (a) Not later than March 31, 2018, the commission shall conduct a review of the electronic visit verification system in use under this section on August 31, 2017. Notwithstanding any other provision of this section, the commission is required to implement a change in law made to this section by S.B. 894, Acts of the 85th Legislature, Regular Session, 2017, only if the commission determines the implementation is appropriate based on the findings of the review. The commission may combine the review required by this subsection with any similar review required to be conducted by the commission.

(b) Subject to Subsection (g), the commission shall, in accordance with federal law, implement an electronic visit verification system to electronically verify through a telephone, global positioning, or computer-based system that personal care services, attendant care services, or other services identified by the commission that are provided to recipients under Medicaid, including personal care services or attendant care services provided under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) or any other Medicaid waiver program, are provided to recipients in accordance with a prior authorization or plan of care. The electronic visit verification system implemented under this subsection must allow for verification of only the following information relating to the delivery of Medicaid services:

(1) the type of service provided;

(2) the name of the recipient to whom the service is provided;

(3) the date and times the provider began and ended the service delivery visit;

(4) the location, including the address, at which the service was provided;

(5) the name of the individual who provided the service; and

(6) other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims.

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

(d) In implementing the electronic visit verification system:

(1) subject to Subsection (e), the executive commissioner shall adopt compliance standards for health care providers; and

(2) the commission shall ensure that:

(A) the information required to be reported by health care providers is standardized across managed care organizations that contract with the commission to provide health care services to Medicaid recipients and across commission programs;

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

(C) standardized processes are established for addressing the failure of a managed care organization to provide a timely authorization for delivering services necessary to ensure continuity of care.

(e) In establishing compliance standards for health care providers under Subsection (d), the executive commissioner shall consider:

(1) the administrative burdens placed on health care providers required to comply with the standards; and

(2) the benefits of using emerging technologies for ensuring compliance, including Internet-based, mobile telephone-based, and global positioning-based technologies.

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

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

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

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

(4) ensure that the commission or the managed care organization with which a claim for reimbursement for a service is filed may review electronic visit verification system documentation related to the claim or obtain a copy of that

documentation at no charge to the commission or the organization; and

(5) at any time, allow the commission or a managed care organization with which a health care provider contracts to provide health care services to recipients enrolled in the organization's managed care plan to have direct, on-site access to the electronic visit verification system in use by the health care provider.

(g) The commission may recognize a health care provider's proprietary electronic visit verification system, whether purchased or developed by the provider, as complying with this section and allow the health care provider to use that system for a period determined by the commission if the commission determines that the system:

(1) complies with all necessary data submission, exchange, and reporting requirements established under this section; and

(2) meets all other standards and requirements established under this section.

(g-1) If feasible, the executive commissioner shall ensure a health care provider that uses the provider's proprietary electronic visit verification system recognized under Subsection (g) is reimbursed for the use of that system.

(g-2) For purposes of facilitating the use of proprietary electronic visit verification systems by health care providers under Subsection (g) and in consultation with industry stakeholders and the work group established under Subsection (h), the commission or the executive commissioner, as appropriate, shall:

(1) develop an open model system that mitigates the administrative burdens identified by providers required to use electronic visit verification;

(2) allow providers to use emerging technologies, including Internet-based, mobile telephone-based, and global positioning-based technologies, in the providers' proprietary electronic visit verification systems; and

(3) adopt rules governing data submission and provider reimbursement.

(h) The commission shall create a stakeholder work group

comprised of representatives of affected health care providers, managed care organizations, and Medicaid recipients and periodically solicit from that work group input regarding the ongoing operation of the electronic visit verification system under this section.

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

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.01(a), eff. September 28, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 2, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 667 (S.B. 1991), Sec. 1, eff. September 1, 2019.

Sec. 531.02418. MEDICAID AND CHILD HEALTH PLAN PROGRAM ELIGIBILITY DETERMINATIONS FOR CERTAIN INDIVIDUALS. (a) The commission shall enter into a memorandum of understanding with the Texas Juvenile Justice Department to ensure that each individual who is committed, placed, or detained under Title 3, Family Code, is assessed by the commission for eligibility for Medicaid and the child health plan program before that individual's release from commitment, placement, or detention. Local juvenile probation departments are subject to the requirements of the memorandum.

(c) The memorandum of understanding entered into as required by this section must specify:

(1) the information that must be provided to the commission;

(2) the process by which and time frame within which the information must be provided; and

(3) the roles and responsibilities of all parties to the memorandum, which must include a requirement that the commission pursue the actions needed to complete eligibility applications as necessary.

(d) The memorandum of understanding required by Subsection (a) must be tailored to achieve the goal of ensuring that an individual described by Subsection (a) who is determined eligible

by the commission for coverage under Medicaid or the child health plan program is enrolled in the program for which the individual is eligible and may begin receiving services through the program as soon as possible after the eligibility determination is made and, if possible, to achieve the goal of ensuring that the individual may begin receiving those services on the date of the individual's release from placement, detention, or commitment.

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1279 (H.B. 1630), Sec. 1, eff. June 19, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.056, eff. April 2, 2015.

Sec. 531.024181. VERIFICATION OF IMMIGRATION STATUS OF APPLICANTS FOR CERTAIN BENEFITS WHO ARE QUALIFIED ALIENS. (a) This section applies only with respect to the following benefits programs:

(1) the child health plan program under Chapter 62, Health and Safety Code;

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

(3) Medicaid; and

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.

(b) If, at the time of application for benefits under a program to which this section applies, a person states that the person is a qualified alien, as that term is defined by 8 U.S.C. Section 1641(b), the commission shall, to the extent allowed by federal law, verify information regarding the immigration status of the person using an automated system or systems where available.

(c) The executive commissioner shall adopt rules necessary to implement this section.

(d) Nothing in this section adds to or changes the eligibility requirements for any of the benefits programs to which this section applies.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.17, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.057, eff. April 2, 2015.

Sec. 531.024182. VERIFICATION OF SPONSORSHIP INFORMATION FOR CERTAIN BENEFITS RECIPIENTS; REIMBURSEMENT. (a) In this section, "sponsored alien" means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

(b) If, at the time of application for benefits, a person stated that the person is a sponsored alien, the commission may, to the extent allowed by federal law, verify information relating to the sponsorship, using an automated system or systems where available, after the person is determined eligible for and begins receiving benefits under any of the following benefits programs:

(1) the child health plan program under Chapter 62, Health and Safety Code;

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

(3) Medicaid; or

(4) the supplemental nutrition assistance program under Chapter 33, Human Resources Code.

(c) If the commission verifies that a person who receives benefits under a program listed in Subsection (b) is a sponsored alien, the commission may seek reimbursement from the person's sponsor for benefits provided to the person under those programs to the extent allowed by federal law, provided the commission determines that seeking reimbursement is cost-effective.

(d) If, at the time a person applies for benefits under a program listed in Subsection (b), the person states that the person is a sponsored alien, the commission shall make a reasonable effort to notify the person that the commission may seek reimbursement from the person's sponsor for any benefits the person receives

under those programs.

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules that specify the most cost-effective procedures by which the commission may seek reimbursement under Subsection (c).

(f) Nothing in this section adds to or changes the eligibility requirements for any of the benefits programs listed in Subsection (b).

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.17, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.058, eff. April 2, 2015.

Sec. 531.0242. USE OF AGENCY STAFF. To the extent requested by the commission, a health and human services agency shall assign existing staff to perform a function imposed under this chapter.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.07(a), eff. Sept. 1, 1997.

Sec. 531.0244. ENSURING APPROPRIATE CARE SETTING FOR PERSONS WITH DISABILITIES. (a) The commission and appropriate health and human services agencies shall implement a comprehensive, effectively working plan that provides a system of services and support that fosters independence and productivity and provides meaningful opportunities for a person with a disability to live in the most appropriate care setting, considering:

(1) the person's physical, medical, and behavioral needs;

(2) the least restrictive care setting in which the person can reside;

(3) the person's choice of care settings in which to reside;

(4) the availability of state resources; and

(5) the availability of state programs for which the person qualifies that can assist the person.

(b) The comprehensive, effectively working plan required by

Subsection (a) must require appropriate health and human services agencies to:

(1) provide to a person with a disability living in an institution and to any other person as required by Sections 531.042 and 531.02442 information regarding care and support options available to the person with a disability, including community-based services appropriate to the needs of that person;

(2) recognize that certain persons with disabilities are represented by legally authorized representatives as defined by Section 241.151, Health and Safety Code, whom the agencies must include in any decision-making process facilitated by the plan's implementation;

(3) facilitate a timely and appropriate transfer of a person with a disability from an institution to an appropriate setting in the community if:

(A) the person chooses to live in the community;

(B) the person's treating professionals determine the transfer is appropriate; and

(C) the transfer can be reasonably accommodated, considering the state's available resources and the needs of other persons with disabilities; and

(4) develop strategies to prevent the unnecessary placement in an institution of a person with a disability who is living in the community but is in imminent risk of requiring placement in an institution because of a lack of community services.

(c) For purposes of developing the strategies required by Subsection (b)(4), a person with a mental illness who is admitted to a facility of the Department of State Health Services for inpatient mental health services three or more times during a 180-day period is presumed to be in imminent risk of requiring placement in an institution. The strategies must be developed in a manner that presumes the person's eligibility for and the appropriateness of intensive community-based services and support.

(c-1) For purposes of determining the appropriateness of transfers under Subsection (b)(3) and developing the strategies required by Subsection (b)(4), a health and human services agency

shall presume the eligibility of a child residing in a general residential operation, as defined by Section 42.002, Human Resources Code, for transfer to an appropriate community-based setting.

(d) In implementing the plan required by Subsection (a), a health and human services agency may not deny an eligible person with a disability access to an institution or remove an eligible person with a disability from an institution if the person prefers the type and degree of care provided in the institution and that care is appropriate for the person. A health and human services agency may deny the person access to an institution or remove the person from an institution to protect the person's health or safety.

(e) Each appropriate health and human services agency shall implement the strategies and recommendations under the plan required by Subsection (a) subject to the availability of funds.

(f) This section does not create a cause of action.

(g) Not later than December 1 of each even-numbered year, the executive commissioner shall submit to the governor and the legislature a report on the status of the implementation of the plan required by Subsection (a). The report must include recommendations on any statutory or other action necessary to implement the plan.

Added by Acts 2001, 77th Leg., ch. 1239, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 728 (S.B. 49), Sec. 1, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.059, eff. April 2, 2015.

Sec. 531.02442. COMMUNITY LIVING OPTIONS INFORMATION PROCESS FOR CERTAIN PERSONS WITH AN INTELLECTUAL DISABILITY. (a) In this section:

(1) "Department" means the Department of Aging and Disability Services.

(1-a) "Institution" means:

(A) a residential care facility operated or

maintained by the department to provide 24-hour services, including residential services, to persons with an intellectual disability; or

(B) an ICF-IID, as defined by Section 531.002, Health and Safety Code.

(2) "Legally authorized representative" has the meaning assigned by Section 241.151, Health and Safety Code.

(3) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(b) In addition to providing information regarding care and support options as required by Section 531.042, the department shall implement a community living options information process in each institution to inform persons with an intellectual disability who reside in the institution and their legally authorized representatives of alternative community living options.

(c) The department shall provide the information required by Subsection (b) through the community living options information process at least annually. The department shall also provide the information at any other time on request by a person with an intellectual disability who resides in an institution or the person's legally authorized representative.

(d) If a person with an intellectual disability residing in an institution or the person's legally authorized representative indicates a desire to pursue an alternative community living option after receiving the information provided under this section, the department shall refer the person or the person's legally authorized representative to the local intellectual and developmental disability authority. The local intellectual and developmental disability authority shall place the person in an alternative community living option, subject to the availability of funds, or on a waiting list for those options if the options are not available to the person for any reason on or before the 30th day after the date the person or the person's legally authorized representative is referred to the local intellectual and developmental disability authority.

(e) The department shall document in the records of each

person with an intellectual disability who resides in an institution the information provided to the person or the person's legally authorized representative through the community living options information process and the results of that process.

Added by Acts 2001, 77th Leg., ch. 1239, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.061, eff. April 2, 2015.

Sec. 531.02443. IMPLEMENTATION OF COMMUNITY LIVING OPTIONS INFORMATION PROCESS AT STATE INSTITUTIONS FOR CERTAIN ADULT RESIDENTS. (a) In this section:

(1) "Adult resident" means a person with an intellectual disability who:

(A) is at least 22 years of age; and

(B) resides in a state supported living center.

(2) "Department" means the Department of Aging and Disability Services.

(3) "Legally authorized representative" has the meaning assigned by Section 241.151, Health and Safety Code.

(4) "Local intellectual and developmental disability authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(5) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

(b) This section applies only to the community living options information process for an adult resident.

(c) The department shall contract with local intellectual and developmental disability authorities to implement the community living options information process required by Section 531.02442 for an adult resident.

(d) The contract with the local intellectual and developmental disability authority must:

(1) delegate to the local intellectual and developmental disability authority the department's duties under Section 531.02442 with regard to the implementation of the community living options information process at a state supported

living center;

(2) include performance measures designed to assist the department in evaluating the effectiveness of a local intellectual and developmental disability authority in implementing the community living options information process; and

(3) ensure that the local intellectual and developmental disability authority provides service coordination and relocation services to an adult resident who chooses, is eligible for, and is recommended by the interdisciplinary team for a community living option to facilitate a timely, appropriate, and successful transition from the state supported living center to the community living option.

(e) The department, with the advice and assistance of the interagency task force on ensuring appropriate care settings for persons with disabilities and representatives of family members or legally authorized representatives of adult residents, persons with an intellectual disability, state supported living centers, and local intellectual and developmental disability authorities, shall:

(1) develop an effective community living options information process;

(2) create uniform procedures for the implementation of the community living options information process; and

(3) minimize any potential conflict of interest regarding the community living options information process between a state supported living center and an adult resident, an adult resident's legally authorized representative, or a local intellectual and developmental disability authority.

(f) A state supported living center shall:

(1) allow a local intellectual and developmental disability authority to participate in the interdisciplinary planning process involving the consideration of community living options for an adult resident;

(2) to the extent not otherwise prohibited by state or federal confidentiality laws, provide a local intellectual and developmental disability authority with access to an adult resident and an adult resident's records to assist the authority in

implementing the community living options information process; and

(3) provide the adult resident or the adult resident's legally authorized representative with accurate information regarding the risks of moving the adult resident to a community living option.

Added by Acts 2007, 80th Leg., R.S., Ch. 970 (S.B. 27), Sec. 1, eff. June 15, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.062, eff. April 2, 2015.

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

(1) a Medicaid buy-in program for persons with disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (Pub. L. No. 105-33); and

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

(b) The executive commissioner shall adopt rules in accordance with federal law that provide for:

(1) eligibility requirements for each program described by Subsection (a); and

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

(c) Rules adopted by the executive commissioner under Subsection (b) with respect to the program for children with disabilities described by Subsection (a)(2) must require a participant to pay monthly premiums according to a sliding scale that is based on family income, subject to the requirements of 42 U.S.C. Sections 1396o(i)(2) and (3).

Added by Acts 2005, 79th Leg., Ch. 30 (S.B. 566), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 34 (S.B. 187), Sec. 1, eff. September 1, 2009.

Reenacted and amended by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.063, eff. April 2, 2015.

Sec. 531.02445. TRANSITION SERVICES FOR YOUTH WITH DISABILITIES. (a) The executive commissioner shall monitor programs and services offered through health and human services agencies designed to assist youth with disabilities to transition from school-oriented living to post-schooling activities, services for adults, or community living.

(b) In monitoring the programs and services, the executive commissioner shall:

(1) consider whether the programs or services result in positive outcomes in the employment, community integration, health, and quality of life of individuals with disabilities; and

(2) collect information regarding the outcomes of the transition process as necessary to assess the programs and services.

Added by Acts 2007, 80th Leg., R.S., Ch. 465 (H.B. 1230), Sec. 1, eff. September 1, 2007.

Sec. 531.02447. EMPLOYMENT-FIRST POLICY. (a) It is the policy of the state that earning a living wage through competitive employment in the general workforce is the priority and preferred outcome for working-age individuals with disabilities who receive public benefits.

(b) The commission, the Texas Education Agency, and the Texas Workforce Commission shall jointly adopt and implement an employment-first policy in accordance with the state's policy under Subsection (a). The policy must:

(1) affirm that an individual with a disability is able to meet the same employment standards as an individual who does not have a disability;

(2) ensure that all working-age individuals with disabilities, including young adults, are offered factual

information regarding employment as an individual with a disability, including the relationship between an individual's earned income and the individual's public benefits;

(3) ensure that individuals with disabilities are given the opportunity to understand and explore options for education or training, including postsecondary, graduate, and postgraduate education, vocational or technical training, or other training, as pathways to employment;

(4) promote the availability and accessibility of individualized training designed to prepare an individual with a disability for the individual's preferred employment;

(5) promote partnerships with employers to overcome barriers to meeting workforce needs with the creative use of technology and innovation;

(6) ensure that the staff of public schools, vocational service programs, and community providers are trained and supported to assist in achieving the goal of competitive employment for all individuals with disabilities; and

(7) ensure that competitive employment, while being the priority and preferred outcome, is not required of an individual with a disability to secure or maintain public benefits for which the individual is otherwise eligible.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1199 (S.B. 1226), Sec. 1, eff. June 14, 2013.

Sec. 531.0245. PERMANENCY PLANNING FOR CERTAIN CHILDREN. (a) The commission and each appropriate health and human services agency shall develop procedures to ensure that permanency planning is provided for each child residing in an institution in this state on a temporary or long-term basis or for whom institutional care is sought.

(b) In this section:

(1) "Institution" has the meaning assigned by Section 242.002, Health and Safety Code.

(2) "Permanency planning" has the meaning assigned by Section 531.151.

Added by Acts 1997, 75th Leg., ch. 913, Sec. 2, eff. Sept. 1, 1997.

Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 9.011, eff. Sept. 1, 2003.

Sec. 531.0246. REGIONAL MANAGEMENT OF HEALTH AND HUMAN SERVICES AGENCIES. (a) The commission may require a health and human services agency, under the direction of the commission, to:

(1) ensure that the agency's location is accessible to employees with disabilities and agency clients with disabilities; and

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

(b) The executive commissioner may require a health and human services agency, under the direction of the executive commissioner, to locate all or a portion of the agency's employees and programs in the same building as another health and human services agency or at a location near or adjacent to the location of another health and human services agency.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.02, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.064, eff. April 2, 2015.

Sec. 531.0247. ANNUAL BUSINESS PLAN. The commission shall develop and implement an annual business services plan for each health and human services region that establishes performance objectives for all health and human services agencies providing services in the region and measures agency effectiveness and efficiency in achieving those objectives.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.02, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.065, eff. April 2, 2015.

Sec. 531.0248. COMMUNITY-BASED SUPPORT SYSTEMS. (a) Subject to Section 531.0055(d), the commission shall assist communities in this state in developing comprehensive, community-based support systems for health and human services. At the request of a community, the commission shall provide resources and assistance to the community to enable the community to:

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

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

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

(c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval. The commission shall review the initiative to ensure that the initiative is consistent with other similar programs offered in communities and does not duplicate other services provided in the community.

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

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.02, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.066, eff. April 2, 2015.

Sec. 531.02481. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEMS FOR LONG-TERM CARE SERVICES. (a) The commission and the Department of Aging and Disability Services shall assist communities in this state in developing comprehensive,

community-based support and service delivery systems for long-term care services. At the request of a community-based organization or combination of community-based organizations, the commission may provide a grant to the organization or combination of organizations in accordance with Subsection (g). At the request of a community, the commission shall provide resources and assistance to the community to enable the community to:

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

(2) develop a system of blended funds, consistent with the requirements of federal law and the General Appropriations Act, to allow the community to customize services to fit individual community needs; and

(3) develop a local system of access and assistance to aid clients in accessing the full range of long-term care services.

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

(c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval. The commission shall review the initiative to ensure that the initiative is consistent with other similar programs offered in communities and does not duplicate other services provided in the community.

(d) In implementing this section, the commission shall consider models used in other service delivery systems.

(e) The executive commissioner shall assure the maintenance of no fewer than 28 area agencies on aging in order to assure the continuation of a local system of access and assistance that is sensitive to the aging population.

(f) A community-based organization or a combination of organizations may make a proposal under this section. A community-based organization includes:

(1) an area agency on aging;

(2) an independent living center;

(3) a municipality, county, or other local government;

(4) a nonprofit or for-profit organization; or

(5) a community mental health and intellectual disability center.

(g) In making a grant to a community-based organization, the commission shall evaluate the organization's proposal based on demonstrated need and the merit of the proposal. If a combination of community-based organizations makes a proposal, the combination must designate a single organization to receive and administer the grant. The commission may adopt guidelines for proposals under this subsection. The commission shall give priority to proposals that will use the Internet and related information technologies to provide to clients referral services, other information regarding local long-term care services, and needs assessment. To receive a grant under this section, a community-based organization must at least partially match the state grant with money or other resources obtained from a nongovernmental entity, from a local government, or if the community-based organization is a local government, from fees or taxes collected by the local government. The community-based organization may then combine the money or resources the organization obtains from a variety of state, local, federal, or private sources to accomplish the purpose of the proposal. If a community-based organization receives a grant on behalf of a combination of community-based organizations or if the community-based organization's proposal involved coordinating with other entities to accomplish the purpose of the proposal, the commission may condition receipt of the grant on the organization's making a good faith effort to coordinate with other entities in the manner indicated in the proposal.

Added by Acts 1999, 76th Leg., ch. 1505, Sec. 1.01, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 1442, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.067, eff. April 2, 2015.

Sec. 531.02482. FAITH- AND COMMUNITY-BASED ORGANIZATION SUPPORT FOR CERTAIN PERSONS RECEIVING PUBLIC ASSISTANCE. (a) In this section, "community-based organization" and "faith-based organization" have the meanings assigned by Section 535.001.

(b) The commission shall establish a program under which faith- and community-based organizations may, on the request of the applicant, contact and offer supplemental assistance to an applicant for benefits under:

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

(2) the medical assistance program under Chapter 32, Human Resources Code;

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

(4) the child health plan program under Chapter 62, Health and Safety Code.

(c) At the time of application for benefits described by Subsection (b), an applicant must:

(1) be informed about and given the opportunity to enroll in the program; and

(2) be informed that enrolling in the program will not affect the person's eligibility for benefits.

(d) The commission shall develop a procedure under which faith- and community-based organizations may apply to participate in the program.

(e) The executive commissioner shall adopt rules to implement the program established under this section, including rules that:

(1) describe the types of faith- and community-based organizations that may apply to participate in the program and the qualifications and standards of service required of a participating organization;

(2) facilitate contact between a person who enrolls in the program and a faith- and community-based organization participating in the program that provides supplemental services that may be of assistance to the person;

(3) establish processes for the suspension, revocation, and periodic renewal of an organization's participation in the program, as appropriate;

(4) establish methods to ensure the confidentiality and appropriate use of applicant information shared with a participating organization; and

(5) permit a person enrolled in the program to terminate the person's enrollment in the program.

(f) In establishing the program, the commission may solicit expertise and assistance from interested persons, including faith- and community-based organizations, and may establish a temporary work group to provide input and assistance. This subsection expires, and any work group established under this subsection is abolished, September 1, 2017.

Added by Acts 2015, 84th Leg., R.S., Ch. 1091 (H.B. 2718), Sec. 1, eff. September 1, 2016.

Sec. 531.02491. JOINT TRAINING FOR CERTAIN CASEWORKERS. (a) The executive commissioner shall provide for joint training for health and human services caseworkers whose clients are children, including caseworkers employed by:

(1) the commission;

(2) the Department of Aging and Disability Services;

(3) the Department of State Health Services;

(4) a local mental health authority; and

(5) a local intellectual and developmental disability authority.

(b) Training provided under this section must be designed to increase a caseworker's knowledge and awareness of the services available to children at each health and human services agency or local mental health or intellectual and developmental disability authority, including long-term care programs and services available under a Section 1915(c) waiver program.

Added by Acts 2001, 77th Leg., ch. 156, Sec. 1, eff. Sept. 1, 2001. Renumbered from Government Code Sec. 531.0244 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(66), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.068, eff. April 2, 2015.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 800, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.02492. DELIVERY OF HEALTH AND HUMAN SERVICES TO YOUNG TEXANS.

(b) The commission shall electronically publish on the commission's Internet website a biennial report and, on or before the date the report is due, shall notify the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, the Legislative Budget Board, and the appropriate legislative committees that the report is available on the commission's Internet website. The report must address the efforts of the health and human services agencies to provide health and human services to children younger than six years of age. The report may contain recommendations by the commission to better coordinate state agency programs relating to the delivery of health and human services to children younger than six years of age and may propose joint agency collaborative programs.

Added by Acts 2001, 77th Leg., ch. 156, Sec. 1, eff. Sept. 1, 2001.

Renumbered from Government Code Sec. 531.0244 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(67), eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 34, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.069, eff. April 2, 2015.

Sec. 531.025. STATEWIDE NEEDS APPRAISAL PROJECT. (a) The commission may implement the Statewide Needs Appraisal Project to obtain county-specific demographic data concerning health and human services needs in this state. Any collected data shall be made available for use in planning and budgeting for health and human services programs by state agencies.

(b) The commission shall coordinate its activities with the appropriate health and human services agencies.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.027. APPROPRIATIONS REQUEST BY AGENCIES. (a) Each health and human services agency shall submit to the commission a biennial agency legislative appropriations request on a date to be determined by commission rule.

(b) A health and human services agency may not submit to the legislature or the governor its legislative appropriations request until the commission reviews and comments on the legislative appropriations request.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.08(a), eff. Sept. 1, 1997.

Sec. 531.0271. HEALTH AND HUMAN SERVICES AGENCIES OPERATING BUDGETS. The commission may, within the limits established by and subject to the General Appropriations Act, transfer amounts appropriated to health and human services agencies among the agencies to:

(1) enhance the receipt of federal money under the federal money management system established under Section 531.028;

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

(3) perform the functions assigned to the executive commissioner under Section 531.0055.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.09(a), eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 3.03, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.070, eff. April 2, 2015.

Sec. 531.0273. INFORMATION RESOURCES PLANNING AND MANAGEMENT. (a) The commission is responsible for strategic

planning for information resources at each health and human services agency and shall direct the management of information resources at each health and human services agency. The commission shall:

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

(A) covers a five-year period;

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

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

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

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

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

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

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

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

(b) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(53), eff. June 17, 2011.

(c) A health and human services agency may not submit its plans to the Department of Information Resources or the Legislative Budget Board under Subchapter E, Chapter 2054, until those plans are approved by the commission.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.09(a), eff. Sept. 1,

1997. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 3.03, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 188, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 691 (H.B. 1788), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 21(2), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(53), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.071, eff. April 2, 2015.

Sec. 531.02731. REPORT OF INFORMATION RESOURCES MANAGER TO COMMISSION. Notwithstanding Section 2054.075(b), the information resources manager of a health and human services agency shall report directly to the executive commissioner or a deputy executive commissioner designated by the executive commissioner.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.13, eff. September 1, 2015.

Sec. 531.0274. COORDINATION AND APPROVAL OF CASELOAD ESTIMATES. (a) The commission shall coordinate and approve caseload estimates made for programs administered by health and human services agencies.

(b) To implement this section, the commission shall:

(1) adopt uniform guidelines to be used by health and human services agencies in estimating their caseloads, with allowances given for those agencies for which exceptions from the guidelines may be necessary;

(2) assemble a single set of economic and demographic data and provide that data to each health and human services agency to be used in estimating its caseloads; and

(3) seek advice from health and human services agencies, the Legislative Budget Board, the governor's budget office, the comptroller, and other relevant agencies as needed to coordinate the caseload estimating process.

(c) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(54), eff. June 17, 2011.

(d) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(54), eff. June 17, 2011.

(e) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(54), eff. June 17, 2011.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.09(a), eff. Sept. 1, 1997.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 2, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 21(3), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 10, eff. June 17, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(54), eff. June 17, 2011.

Sec. 531.028. MONITORING AND EFFECTIVE MANAGEMENT OF FUNDS. (a) The commission, within the limits established by and subject to the General Appropriations Act, shall be responsible for planning for, and managing the use of, all federal funds in a manner that maximizes the federal funding available to the state while promoting the delivery of services.

(b) The executive commissioner shall establish a federal money management system to coordinate and monitor the use of federal money that is received by health and human services agencies to ensure that the money is spent in the most efficient manner and shall:

(1) establish priorities for use of federal money by all health and human services agencies, in coordination with the coordinated strategic plan established under Section 531.022;

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

(3) review and approve all federal funding plans for

health and human services in this state;

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

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

(6) transfer appropriated amounts as described by Section 531.0271; and

(7) ensure that each governmental entity identified under Section 531.022(e) has access to complete and timely information about all sources of federal money for health and human services programs and that technical assistance is available to governmental entities seeking grants of federal money to provide health and human services.

(c) The commission shall prepare an annual report with respect to the results of the implementation of this section. The report must identify strategies to maximize the receipt and use of federal funds and to improve federal funds management. The commission shall file the report with the governor, the lieutenant governor, and the speaker of the house of representatives not later than December 15 of each year.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.10(a), eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1460, Sec. 3.04, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.072, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 1.06, eff. September 1, 2019.

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

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.073, eff. April 2, 2015.

Sec. 531.0312. TEXAS INFORMATION AND REFERRAL NETWORK. (a) The Texas Information and Referral Network at the commission is the program responsible for the development, coordination, and implementation of a statewide information and referral network that integrates existing community-based structures with state and local agencies. The network must:

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

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

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

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

(b) The commission shall cooperate with the Records Management Interagency Coordinating Council and the comptroller to establish a single method of categorizing information about health and human services to be used by the Records Management Interagency Coordinating Council and the Texas Information and Referral Network. The network, in cooperation with the council and the comptroller, shall ensure that:

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

(2) the single method of categorizing information

about health and human services is used in a residential telephone directory described by Subdivision (1).

(c) A health and human services agency or a public or private entity receiving state-appropriated funds to provide health and human services shall provide the Texas Information and Referral Network and the Records Management Interagency Coordinating Council with information about the health and human services provided by the agency or entity for inclusion in the statewide information and referral network, residential telephone directories described by Subsection (b), and any other materials produced under the direction of the network or the council. The agency or entity shall provide the information in the format required by the Texas Information and Referral Network or the Records Management Interagency Coordinating Council and shall update the information at least quarterly or as required by the network or the council.

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

(e) Each local workforce development board, the Texas Head Start State Collaboration Office, and each school district shall provide the Texas Information and Referral Network with information regarding eligibility for and availability of child-care and education services for inclusion in the statewide information and referral network. The local workforce development boards, Texas Head Start State Collaboration Office, and school districts shall provide the information in a form determined by the executive commissioner. In this subsection, "child-care and education services" has the meaning assigned by Section 531.03131.

Added by Acts 1997, 75th Leg., ch. 652, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 50, Sec. 1, eff. May 10, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 3.05, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1367, Sec. 1.31, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 1260 (H.B. 2048), Sec. 23(a), eff. June 18, 2005.

Acts 2007, 80th Leg., R.S., Ch. 937 (H.B. 3560), Sec. 1.60, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.074(a), eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.074(b), eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.074(c), eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 1116 (H.B. 2325), Sec. 4, eff. September 1, 2019.

Sec. 531.0313. ELECTRONIC ACCESS TO HEALTH AND HUMAN SERVICES REFERRAL INFORMATION. (a) The Texas Information and Referral Network may develop an Internet site to provide information to the public regarding the health and human services provided by public or private entities throughout the state.

(b) The material in the Texas Information and Referral Network Internet site must be geographically indexed and designed to inform an individual about the health and human services provided in the area where the individual lives. The material must be further indexed by type of service provided within each geographic area.

(c) The Internet site may contain links to the Internet sites of any local provider of health and human services and may contain:

(1) the name, address, and phone number of organizations providing health and human services in a county;

(2) a description of the type of services provided by those organizations; and

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

(d) The Texas Information and Referral Network shall coordinate with the Department of Information Resources to maintain the Internet site through the state electronic Internet portal

project established by the Department of Information Resources.

(e) In this section, "Internet" means the largest nonproprietary, nonprofit cooperative public computer network, popularly known as the Internet.

Added by Acts 1997, 75th Leg., ch. 652, Sec. 1, eff. Sept. 1, 1997.

Amended by Acts 2001, 77th Leg., ch. 357, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 973 (H.B. 1504), Sec. 8, eff. June 17, 2011.

Sec. 531.03131. ELECTRONIC ACCESS TO CHILD-CARE AND EDUCATION SERVICES REFERRAL INFORMATION. (a) In this section, "child-care and education services" means:

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

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

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

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

(b) In addition to providing health and human services information, the Texas Information and Referral Network Internet site established under Section 531.0313 shall provide information to the public regarding child-care and education services provided by public or private entities throughout the state. The Internet site will serve as a single point of access through which a person may be directed on how or where to apply for all child-care and education services available in the person's community.

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

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

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

(3) be designed in a manner that allows staff of the Texas Information and Referral Network to:

(A) provide an applicant with the telephone number, physical address, and electronic mail address of the nearest Head Start or Early Head Start office or center and local workforce development center and the appropriate school district; and

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

(d) On receipt of an electronic mail message from the Texas Information and Referral Network under Subsection (c)(3)(B), each entity shall contact the applicant to verify information regarding the applicant's eligibility for available child-care and education services and, on certifying eligibility, shall match the applicant with entities providing those services in the applicant's community, including local workforce development boards, local child-care providers, or a Head Start or Early Head Start program provider.

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

(f) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec.

2.08(b)(2), eff. September 1, 2015.

(g) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec. 2.08(b)(2), eff. September 1, 2015.

Added by Acts 2005, 79th Leg., Ch. 1260 (H.B. 2048), Sec. 23(b), eff. June 18, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 35, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.08(b)(2), eff. September 1, 2015.

Sec. 531.03132. ELECTRONIC ACCESS TO REFERRAL INFORMATION ABOUT HOUSING OPTIONS FOR PERSONS WITH MENTAL ILLNESS. (a) The commission shall make available through the Texas Information and Referral Network Internet site established under Section 531.0313 information regarding housing options for persons with mental illness provided by public or private entities throughout the state. The Internet site will serve as a single point of access through which a person may be directed on how or where to apply for housing for persons with mental illness in the person's community. In this subsection, "private entity" includes any provider of housing specifically for persons with mental illness other than a state agency, municipality, county, or other political subdivision of this state, regardless of whether the provider accepts payment for providing housing for persons with mental illness.

(b) To the extent resources are available, the Internet site must be geographically indexed and designed to inform a person about the housing options for persons with mental illness provided in the area where the person lives.

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

(1) state hospitals;

(2) step-down units in state hospitals;

(3) community hospitals;

(4) private psychiatric hospitals;

(5) a provider of inpatient treatment services in the network of service providers assembled by a local mental health authority under Section 533.035(e), Health and Safety Code;

(6) assisted living facilities;

(7) continuing care facilities;

(8) boarding homes;

(9) emergency shelters for homeless persons;

(10) transitional housing intended to move homeless persons to permanent housing;

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

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

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

(d) For each housing facility named in the listing of available housing options for persons with mental illness, the Internet site must indicate whether the provider that operates the housing facility is licensed by the state.

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

(f) Each entity providing housing specifically for persons with mental illness in this state, including the Department of State Health Services, municipalities, counties, other political subdivisions of this state, and private entities, shall cooperate with the Texas Information and Referral Network as necessary in the administration of this section.

Added by Acts 2013, 83rd Leg., R.S., Ch. 288 (H.B. 1191), Sec. 1, eff. June 14, 2013.

Sec. 531.0315. IMPLEMENTING NATIONAL ELECTRONIC DATA INTERCHANGE STANDARDS FOR HEALTH CARE INFORMATION. (a) Each health and human services agency and every other state agency that acts as a health care provider or a claims payer for the provision of health care shall:

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

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

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

(B) to not comply with one or more of the standards.

(b) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1126, Sec. 21, eff. September 1, 2012.

Added by Acts 1999, 76th Leg., ch. 494, Sec. 1, eff. June 18, 1999.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1126 (H.B. 300), Sec. 21, eff. September 1, 2012.

Sec. 531.0317. HEALTH AND HUMAN SERVICES INFORMATION MADE AVAILABLE THROUGH THE INTERNET. (a) In this section, "Internet" means the largest nonproprietary, nonprofit cooperative public computer network, popularly known as the Internet.

(b) The commission, in cooperation with the Department of Information Resources, shall establish and maintain through the state electronic Internet portal project established by the Department of Information Resources a generally accessible and interactive Internet site that contains information for the public regarding the services and programs provided or administered by

each of the health and human services agencies throughout the state. The commission shall establish the site in such a manner that it can be located easily through electronic means.

(c) The Internet site must:

(1) contain information that is:

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

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

(2) contain eligibility criteria for each agency program;

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

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

(B) Medicaid; and

(C) nutritional assistance under Chapter 33, Human Resources Code;

(4) to avoid duplication of functions and efforts, provide a link that provides access to a site maintained by the Texas Information and Referral Network under Section 531.0313;

(5) contain the telephone number and, to the extent available, the electronic mail address for each health and human services agency and local provider of health and human services;

(6) be designed in a manner that allows a member of the public to send questions about each agency's programs or services electronically and receive responses to the questions from the agency electronically; and

(7) be updated at least quarterly.

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

(e) The commission shall ensure that:

(1) the Internet site does not contain any confidential information, including any confidential information

regarding a client of a human services provider; and

(2) the Internet site's design and applications comply with generally acceptable standards for Internet accessibility for persons with disabilities and contain appropriate controls for information security.

(f) A health and human services agency, the Texas Information and Referral Network, and the Department of Information Resources shall cooperate with the commission to the extent necessary to enable the commission to perform its duties under this section.

Added by Acts 2001, 77th Leg., ch. 357, Sec. 2, eff. Sept. 1, 2001.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 973 (H.B. 1504), Sec. 9, eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.075, eff. April 2, 2015.

Sec. 531.0318. LONG-TERM CARE CONSUMER INFORMATION MADE AVAILABLE THROUGH THE INTERNET. (a) The Internet site maintained under Section 531.0317 must include information for consumers concerning long-term care services that complies with this section. The Internet site maintained by the Department of Aging and Disability Services must also include, or provide a link to, the information required by this section.

(b) The information for consumers required by this section must:

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

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

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

(B) for the Star + Plus Medicaid managed care

program, information that allows a consumer to evaluate the performance of each participating plan issuer, including for each issuer, in an accessible format such as a table:

(i) the enrollment in each county;

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

(iii) a summary of the financial statistical report required under Subchapter A, Chapter 533;

(iv) complaint information;

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

(vi) information concerning consumer satisfaction; and

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

(c) In addition to providing the information required by this section through the Internet, the commission or the Department of Aging and Disability Services shall, on request by a consumer without Internet access, provide the consumer with a printed copy of the information from the website. The commission or department may charge a reasonable fee for printing the information. The executive commissioner shall establish the fee by rule.

Added by Acts 2009, 81st Leg., R.S., Ch. 759 (S.B. 705), Sec. 3, eff. June 19, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.076, eff. April 2, 2015.

Sec. 531.032. APPLICATION OF OTHER LAWS. The commission is subject to Chapters 2001 and 2002.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.033. RULES. The executive commissioner shall

adopt rules necessary to carry out the commission's duties under this chapter.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.077, eff. April 2, 2015.

Sec. 531.0335. PROHIBITION ON PUNITIVE ACTION FOR FAILURE TO IMMUNIZE. (a) In this section:

(1) "Person responsible for a child's care, custody, or welfare" has the meaning assigned by Section 261.001, Family Code.

(2) "Punitive action" includes the initiation of an investigation of a person responsible for a child's care, custody, or welfare for alleged or suspected abuse or neglect of a child.

(b) The executive commissioner by rule shall prohibit a health and human services agency from taking a punitive action against a person responsible for a child's care, custody, or welfare for failure of the person to ensure that the child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

(c) This section does not affect a law, including Chapter 31, Human Resources Code, that specifically provides a punitive action for failure to ensure that a child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.04, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.078, eff. April 2, 2015.

Sec. 531.035. DISPUTE ARBITRATION. The executive commissioner shall arbitrate and render the final decision on interagency disputes.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.10(c), eff.

Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.079, eff. April 2, 2015.

Sec. 531.036. PUBLIC HEARINGS. (a) The commission biennially shall conduct a series of public hearings in diverse locations throughout the state to give citizens of the state an opportunity to comment on health and human services issues.

(b) A hearing held under this section is subject to Chapter 551.

(c) In conducting a public hearing under this section, the commission shall, to the greatest extent possible, encourage participation in the hearings process by diverse groups of citizens in this state. Hearings shall be of a sufficient number to allow reasonable access to citizens in both rural and urban areas, with an emphasis on geographic diversity.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.037. NOTICE OF PUBLIC HEARINGS. (a) In addition to the notice required by Chapter 551, the commission shall:

(1) provide written notification to public officials in the affected area; and

(2) publish notice of a public hearing under Section 531.036 in a newspaper of general circulation in the county in which the hearing is to be held.

(b) If the county in which the hearing is to be held does not have a newspaper of general circulation, the commission shall publish notice in a newspaper of general circulation in an adjacent county or in the nearest county in which a newspaper of general circulation is published.

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

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1,

1995.

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

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.0381. CERTAIN GIFTS AND GRANTS TO HEALTH AND HUMAN SERVICES AGENCIES. (a) Subject to this section, a health and human services agency may accept a gift or grant of money, drugs, equipment, or any other item of value from a pharmaceutical manufacturer, distributor, provider, or another entity engaged in a pharmaceutical-related business.

(b) Acceptance of a gift or grant under this section is subject to the written approval of the executive commissioner. Chapter 575 does not apply to a gift or grant under this section.

(c) The executive commissioner may adopt rules and procedures to implement this section. The rules must ensure that acceptance of a gift or grant under this section is consistent with any applicable federal law or regulation and does not adversely affect federal financial participation in any state program, including Medicaid.

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

Added by Acts 2003, 78th Leg., ch. 722, Sec. 1, eff. June 20, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.080, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.081, eff. April 2, 2015.

Sec. 531.039. CONTRACTS. The commission may enter into

contracts as necessary to perform any of the commission's powers or duties.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.0391. SUBROGATION AND THIRD-PARTY REIMBURSEMENT COLLECTION CONTRACT. (a) The commission shall enter into a contract under which the contractor is authorized on behalf of the commission or a health and human services agency to recover money under a subrogation or third-party reimbursement right held by the commission or a health and human services agency arising from payment of medical expenses. The contract must provide that:

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

(2) with the approval of the attorney required by other law to represent the commission or agency in court, the contractor may represent the commission or agency in a court proceeding to recover money under a subrogation or third-party reimbursement right if the representation is cost-effective and specifically authorized by the commission.

(b) The commission shall develop a process for identifying claims for the recovery of money under a subrogation or third-party reimbursement right described by this section and referring the claims to the contractor. A health and human services agency shall cooperate with the contractor on a claim of the agency referred to the contractor for collection.

(c) The commission is not required to enter into a contract under Subsection (a) if the commission cannot identify a contractor who is willing to contract with the commission on reasonable terms. If the commission cannot identify such a contractor, the commission shall develop and implement alternative policies to ensure the collection of money under a subrogation or third-party reimbursement right.

(d) The commission may allow a state agency other than a health and human services agency to be a party to the contract required under Subsection (a). In that case, the commission shall

modify the contract as necessary to reflect the services to be provided by the contractor to the additional state agency.

Added by Acts 1997, 75th Leg., ch. 1030, Sec. 1, eff. June 19, 1997.

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

(b) The commission shall obtain Medicaid reimbursement from each fiscal intermediary who makes a payment to a service provider on behalf of the Medicare program, including a reimbursement for a payment made to a home health services provider or nursing facility for services rendered to a dually eligible individual.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.05, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.082, eff. April 2, 2015.

Sec. 531.040. REFERENCE GUIDE; DICTIONARY. (a) The commission shall publish a biennial reference guide describing available public health and human services in this state and shall make the guide available to all interested parties and agencies.

(b) The reference guide must include a dictionary of uniform terms and services.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Sec. 531.041. GENERAL POWERS AND DUTIES. The executive commissioner and the commission have all the powers and duties necessary to administer this chapter.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.083, eff. April 2, 2015.

Sec. 531.0411. RULES REGARDING REFUGEE RESETTLEMENT. (a) In this section, "local resettlement agency" and "national voluntary agency" have the meanings assigned by 45 C.F.R. Section 400.2.

(b) The executive commissioner shall adopt rules to ensure that local governmental and community input is included in any refugee placement report required under a federal refugee resettlement program and that governmental entities and officials are provided with related information. In adopting rules under this section, the executive commissioner shall, to the extent permitted under federal law, ensure that:

(1) meetings are convened, at least quarterly, in the communities proposed for refugee placement at which representatives of local resettlement agencies have an opportunity to consult with and obtain feedback from local governmental entities and officials, including municipal and county officials, local school district officials, and representatives of local law enforcement agencies, and from other community stakeholders, including major providers under the local health care system and major employers of refugees, regarding proposed refugee placement;

(2) a local resettlement agency:

(A) considers all feedback obtained in meetings conducted under Subdivision (1) before preparing a proposed annual report on the placement of refugees for purposes of 8 U.S.C. Section 1522(b)(7)(E);

(B) informs the state and local governmental entities and officials and community stakeholders described under Subdivision (1) of the proposed annual report; and

(C) develops a final annual report for the national voluntary agencies and the commission that includes a summary regarding how stakeholder input contributed to the report; and

(3) the commission:

(A) obtains from local resettlement agencies the preliminary number of refugees the local resettlement agencies recommended to the national voluntary agencies for placement in communities throughout this state and provides that information to

local governmental entities and officials in those communities; and

(B) obtains from the United States Department of State or other appropriate federal agency the number of refugees apportioned to this state and provides that information and information regarding the number of refugees intended to be placed in each community in this state to local governmental entities and officials in those communities.

Added by Acts 2015, 84th Leg., R.S., Ch. 1227 (S.B. 1928), Sec. 1, eff. June 19, 2015.

Sec. 531.042. INFORMATION AND ASSISTANCE REGARDING CARE AND SUPPORT OPTIONS. (a) The executive commissioner by rule shall require each health and human services agency to provide to each patient or client of the agency and to at least one family member of the patient or client, if possible, information regarding all care and support options available to the patient or client, including community-based services appropriate to the needs of the patient or client, before the agency allows the patient or client to be placed in a care setting, including a nursing facility, intermediate care facility for individuals with an intellectual disability, or general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services, to receive care or services provided by the agency or by a person under an agreement with the agency.

(b) The rules must require each health and human services agency to provide information about all long-term care options and long-term support options available to the patient or client, including community-based options and options available through another agency or a private provider. The information must be provided in a manner designed to maximize the patient's or client's understanding of all available options. If the patient or client has a legally authorized representative, as defined by Section 241.151, Health and Safety Code, the information must also be provided to that representative. If the patient or client is in the conservatorship of a health and human services agency, the information must be provided to the patient's or client's agency caseworker and foster parents, if applicable.

(c) A health and human services agency that provides a patient, client, or other person as required by this section with information regarding care and support options available to the patient or client shall assist the patient, client, or other person in taking advantage of an option selected by the patient, client, or other person, subject to the availability of funds. If the selected option is not immediately available for any reason, the agency shall provide assistance in placing the patient or client on a waiting list for that option.

(d) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 1312, Sec. 99(16), eff. September 1, 2013.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.11(a), eff. Sept. 1, 1997. Amended by Acts 2001, 77th Leg., ch. 1239, Sec. 2, eff. Sept. 1, 2001.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 36, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 99(16), eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.084, eff. April 2, 2015.

Sec. 531.043. LONG-TERM CARE VISION. (a) In conjunction with the appropriate state agencies, the executive commissioner shall develop a plan for access to individualized long-term care services for persons with functional limitations or medical needs and their families that assists those persons in achieving and maintaining the greatest possible independence, autonomy, and quality of life.

(b) The guiding principles and goals of the plan focusing on the individual and the individual's family must:

(1) recognize that it is the policy of this state that children should grow up in families and that persons with disabilities and elderly persons should live in the setting of their choice; and

(2) ensure that persons needing assistance and their families will have:

(A) the maximum possible control over their services;

(B) a choice of a broad, comprehensive array of services designed to meet individual needs; and

(C) the easiest possible access to appropriate care and support, regardless of the area of the state in which they live.

(c) The guiding principles and goals of the long-term care plan focusing on services and delivery of those services by the state must:

(1) emphasize the development of home-based and community-based services and housing alternatives to complement the long-term care services already in existence;

(2) ensure that services will be of the highest possible quality, with a minimum amount of regulation, structure, and complexity at the service level;

(3) recognize that maximum independence and autonomy represent major goals, and with those comes a certain degree of risk;

(4) maximize resources to the greatest extent possible, with the consumer receiving only the services that the consumer prefers and that are indicated by a functional assessment of need; and

(5) structure the service delivery system to support these goals, ensuring that any necessary complexity of the system is at the administrative level rather than at the client level.

(d) The commission shall coordinate state services to ensure that:

(1) the roles and responsibilities of the agencies providing long-term care are clarified; and

(2) duplication of services and resources is minimized.

(e) In this section, "long-term care" means the provision of health care, personal care, and assistance related to health and social services over a sustained period to people of all ages and their families, regardless of the setting in which the care is given.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.12(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.085, eff. April 2, 2015.

Sec. 531.044. FINANCIAL ASSISTANCE RECIPIENTS ELIGIBLE FOR FEDERAL PROGRAMS. The commission shall assist recipients of financial assistance under Chapter 31, Human Resources Code, who are eligible for assistance under federal programs to apply for benefits under those federal programs. The commission may delegate this responsibility to a health and human services agency, contract with a unit of local government, or use any other cost-effective method to assist financial assistance recipients who are eligible for federal programs.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.13(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.086, eff. April 2, 2015.

Sec. 531.047. SUBSTITUTE CARE PROVIDER OUTCOME STANDARDS. (a) The executive commissioner, after consulting with representatives from the Department of Family and Protective Services, the Texas Juvenile Justice Department, the Department of Aging and Disability Services, and the Department of State Health Services, shall by rule adopt result-oriented standards that a provider of substitute care services for children under the care of the state must achieve.

(b) A health and human services agency that purchases substitute care services must include the result-oriented standards as requirements in each substitute care service provider contract.

(c) A health and human services agency may provide information about a substitute care provider, including rates, contracts, outcomes, and client information, to another agency that purchases substitute care services.

Added by Acts 1997, 75th Leg., ch. 1022, Sec. 98, eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.088, eff. April 2, 2015.

Sec. 531.048. CASELOAD STANDARDS. (a) The executive commissioner may establish caseload standards and other standards relating to caseloads for each category of caseworker employed by the Department of Family and Protective Services.

(b) In establishing standards under this section, the executive commissioner shall:

(1) ensure the standards are based on the actual duties of the caseworker;

(2) ensure the caseload standards are reasonable and achievable;

(3) ensure the standards are consistent with existing professional caseload standards;

(4) consider standards developed by other states for caseworkers in similar positions of employment; and

(5) ensure the standards are consistent with existing caseload standards of other state agencies.

(c) Subject to the availability of funds appropriated by the legislature, the commissioner of the Department of Family and Protective Services shall use the standards established by the executive commissioner under this section to determine the number of personnel to assign as caseworkers for the department.

(d) Subject to the availability of funds appropriated by the legislature, the Department of Family and Protective Services shall use the standards established by the executive commissioner to assign caseloads to individual caseworkers employed by the department.

(f) Nothing in this section may be construed to create a cause of action.

Added by Acts 1997, 75th Leg., ch. 1022, Sec. 99, eff. Sept. 1, 1997.

Amended by:

Acts 2005, 79th Leg., Ch. 268 (S.B. 6), Sec. 2.18(a), eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.089, eff. April 2, 2015.

Sec. 531.050. MINIMUM COLLECTION GOAL. (a) Before August 31 of each year, the executive commissioner by rule shall set a minimum goal for the commission that specifies the percentage of the amount of benefits granted by the commission in error under the supplemental nutrition assistance program or the program of financial assistance under Chapter 31, Human Resources Code, that the commission should recover. The executive commissioner shall set the percentage based on comparable recovery rates reported by other states or other appropriate factors identified by the executive commissioner.

(b) If the commission fails to meet the goal set under Subsection (a) for the fiscal year, the executive commissioner shall notify the comptroller, and the comptroller shall reduce the commission's general revenue appropriation by an amount equal to the difference between the amount of state funds the commission would have collected had the commission met the goal and the amount of state funds the commission actually collected.

(c) The executive commissioner, the governor, and the Legislative Budget Board shall monitor the commission's performance in meeting the goal set under this section. The commission shall cooperate by providing to the governor and the Legislative Budget Board, on request, information concerning the commission's collection efforts.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.05(a), eff. June 20, 1997. Renumbered from Sec. 531.047 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(47), eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.090, eff. April 2, 2015.

Sec. 531.051. CONSUMER DIRECTION OF CERTAIN SERVICES FOR PERSONS WITH DISABILITIES AND ELDERLY PERSONS. (a) In this

section:

(1) "Consumer" means a person who receives services through a consumer direction model established by the commission under this section.

(2) "Consumer direction" or "consumer direction model" means a service delivery model under which a consumer or the consumer's legally authorized representative exercises control over the development and implementation of the consumer's individual service plan or over the persons delivering the services directly to the consumer. The term includes the consumer-directed service option, the service responsibility option, and other types of service delivery models developed by the commission under this section.

(3) "Consumer-directed service option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative, as the employer, exercises control over:

(i) the recruitment, hiring, management, or dismissal of persons providing services directly to the consumer; or

(ii) the retention of contractors or vendors for other authorized program services; and

(B) the consumer-directed services agency serves as fiscal agent and performs employer-related administrative functions for the consumer or the consumer's legally authorized representative, including payroll and the filing of tax and related reports.

(4) "Designated representative" means an adult volunteer appointed by a consumer or the consumer's legally authorized representative, as an employer, to perform all or part of the consumer's or the representative's duties as employer as approved by the consumer or the representative.

(5) "Legally authorized representative":

(A) means:

(i) a parent or legal guardian if the person is a minor;

(ii) a legal guardian if the person has been adjudicated as incapacitated to manage the person's personal affairs; or

(iii) any other person authorized or required by law to act on behalf of the person with regard to the person's care; and

(B) does not include a designated representative.

(6) "Service responsibility option" means a type of consumer direction model in which:

(A) a consumer or the consumer's legally authorized representative participates in the selection of, trains, and manages persons providing services directly to the consumer; and

(B) the provider agency, as the employer, performs employer-related administrative functions for the consumer or the consumer's legally authorized representative, including the hiring and dismissal of persons providing services directly to the consumer.

(b) The commission shall develop and oversee the implementation of consumer direction models under which a person with a disability or an elderly person who is receiving certain state-funded or Medicaid-funded services, or the person's legally authorized representative, exercises control over the development and implementation of the person's individual service plan or over the persons who directly deliver the services.

(c) In adopting rules for the consumer direction models, the executive commissioner shall:

(1) determine which services are appropriate and suitable for delivery through consumer direction;

(2) ensure that each consumer direction model is designed to comply with applicable federal and state laws;

(3) maintain procedures to ensure that a potential consumer or the consumer's legally authorized representative has adequate and appropriate information, including the responsibilities of a consumer or representative under each service delivery option, to make an informed choice among the types of

consumer direction models;

(4) require each consumer or the consumer's legally authorized representative to sign a statement acknowledging receipt of the information required by Subdivision (3);

(5) maintain procedures to monitor delivery of services through consumer direction to ensure:

(A) adherence to existing applicable program standards;

(B) appropriate use of funds; and

(C) consumer satisfaction with the delivery of services;

(6) ensure that authorized program services that are not being delivered to a consumer through consumer direction are provided by a provider agency chosen by the consumer or the consumer's legally authorized representative; and

(7) set a timetable to complete the implementation of the consumer direction models.

(d) The consumer direction models established under this section may be implemented in appropriate and suitable programs of the commission or a health and human services agency.

(e) Section 301.251(a), Occupations Code, does not apply to delivery of a service for which payment is provided under the consumer-directed service option developed under this section if:

(1) the person who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter 301, Occupations Code, that is revoked or suspended; and

(C) performs a service that is not expressly prohibited from delegation by the Texas Board of Nursing; and

(2) the consumer who receives the service:

(A) has a disability and the service would have been performed by the consumer or the consumer's legally authorized representative except for that disability; and

(B) if:

(i) the consumer is capable of training the person in the proper performance of the service, the consumer

directs the person to deliver the service; or

(ii) the consumer is not capable of training the person in the proper performance of the service, the consumer's legally authorized representative is capable of training the person in the proper performance of the service and directs the person to deliver the service.

(f) If the person delivers the service under Subsection (e)(2)(B)(ii), the legally authorized representative must be present when the service is performed or be immediately accessible to the person who delivers the service. If the person will perform the service when the representative is not present, the representative must observe the person performing the service at least once to assure the representative that the person performing the service can competently perform that service.

(g) Repealed by Acts 2007, 80th Leg., R.S., Ch. 576, Sec. 5, eff. September 1, 2007.

(h) Repealed by Acts 2007, 80th Leg., R.S., Ch. 576, Sec. 5, eff. September 1, 2007.

Added by Acts 1999, 76th Leg., ch. 1288, Sec. 1, eff. June 18, 1999. Amended by Acts 2001, 77th Leg., ch. 1508, Sec. 1, eff. June 17, 2001; Acts 2003, 78th Leg., ch. 553, Sec. 2.006, eff. Feb. 1, 2004.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 576 (S.B. 1766), Sec. 1, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 576 (S.B. 1766), Sec. 2, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 576 (S.B. 1766), Sec. 5, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 229 (S.B. 1484), Sec. 1, eff. May 27, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.091, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.06, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.06, eff. January 1, 2016.

Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER PROGRAM: CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections 531.051(c)(1) and (d), a consumer direction model implemented under Section 531.051, including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program must allow for the delivery of all services and supports available under that program through consumer direction.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 2, eff. September 1, 2019.

Sec. 531.0515. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER PROGRAMS. (a) In this section, "legally authorized representative" has the meaning assigned by Section 531.051.

(b) The commission shall consider developing risk management criteria under home and community-based services waiver programs designed to allow individuals eligible to receive services under the programs to assume greater choice and responsibility over the services and supports the individuals receive.

(c) The commission shall ensure that any risk management criteria developed under this section include:

(1) a requirement that if an individual to whom services and supports are to be provided has a legally authorized representative, the representative be involved in determining which services and supports the individual will receive; and

(2) a requirement that if services or supports are declined, the decision to decline is clearly documented.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1057 (S.B. 222), Sec. 1, eff. September 1, 2011.

Sec. 531.053. LEASES AND SUBLEASES OF CERTAIN OFFICE SPACE. (a) A health and human services agency, with the approval of the commission, or the Texas Workforce Commission or any other state agency that administers employment services programs may sublease office space to a private service entity or lease office space from a private service entity that provides publicly funded health, human, or workforce services to enable agency eligibility and

enrollment personnel to work with the entity if:

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

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

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

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

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

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

Acts 1999, 76th Leg. ch. 1013, Sec. 1, eff. Sept. 1, 1999. Renumbered from Sec. 531.051 by Acts 2001, 77th Leg., ch. 1420, Sec. 21.001(46), eff. Sept. 1, 2001.

Sec. 531.054. ASSUMPTION OF LEASES FOR IMPLEMENTATIONS OF INTEGRATED ENROLLMENT SERVICES INITIATIVE. (a) A health and human services agency, with the approval of the commission, or the Texas Workforce Commission or any other state agency that administers employment services programs may assume a lease from an integrated enrollment services initiative contractor or subcontractor for the purpose of implementing the initiative at one development center, one mail center, or 10 or more call or change centers.

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

Added by Acts 1999, 76th Leg., ch. 1013, Sec. 1, eff. Sept. 1, 1999. Renumbered from Sec. 531.052 by Acts 2001, 77th Leg., ch. 1420, Sec. 21.001(47), eff. Sept. 1, 2001.

Sec. 531.055. MEMORANDUM OF UNDERSTANDING ON SERVICES FOR PERSONS NEEDING MULTIAGENCY SERVICES. (a) The Health and Human Services Commission, the Department of Family and Protective Services, the Department of State Health Services, the Texas Education Agency, the Texas Correctional Office on Offenders with Medical or Mental Impairments, the Texas Department of Criminal Justice, the Texas Department of Housing and Community Affairs, the Texas Workforce Commission, and the Texas Juvenile Justice Department shall enter into a joint memorandum of understanding to promote a system of local-level interagency staffing groups to identify and coordinate services for persons needing multiagency services to be provided in the least restrictive setting appropriate, using residential, institutional, or congregate care settings only as a last resort. The division within the Health and Human Services Commission that coordinates the policy and delivery of mental health services shall oversee the development and implementation of the joint memorandum of understanding.

(b) The memorandum must:

(1) clarify the statutory responsibilities of each agency in relation to persons needing multiagency services, including subcategories for different services such as:

(A) family preservation and strengthening;

(B) physical and behavioral health care;

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

(i) child abuse;

(ii) neglect; or

(iii) delinquency, truancy, or school dropout;

(D) diversion from juvenile or criminal justice involvement;

(E) housing;

(F) aging in place;

(G) emergency shelter;

(H) residential care;

(I) after-care;

(J) information and referral; and

(K) investigation services;

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

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

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

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

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

(A) a local representative of each agency;

(B) representatives of local private sector agencies; and

(C) family members or caregivers of persons needing multiagency services or other current or previous consumers of multiagency services acting as general consumer advocates;

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

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

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

(10) provide that an agency representative may be excused from attending a meeting if the staffing group determines that the age or needs of the person to be considered are clearly not within the agency's service responsibilities, provided that each agency representative is encouraged to attend all meetings to

contribute to the collective ability of the staffing group to solve a person's need for multiagency services;

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

(12) provide that records that are used or developed by a local-level interagency staffing group or its members that relate to a particular person are confidential and may not be released to any other person or agency except as provided by this section or by other law; and

(13) provide a procedure that permits the agencies to share confidential information while preserving the confidential nature of the information.

(c) The agencies that participate in the formulation of the memorandum of understanding shall consult with and solicit input from advocacy and consumer groups.

(d) Each agency shall adopt the memorandum of understanding and all revisions to the memorandum. The agencies shall develop revisions as necessary to reflect major agency reorganizations or statutory changes affecting the agencies.

(e) The agencies shall ensure that a state-level interagency staffing group provides:

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

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

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

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

(A) the number of persons served through the local-level interagency staffing groups and the outcomes of the services provided;

(B) a description of any barriers identified to the state's ability to provide effective services to persons

needing multiagency services; and

(C) any other information relevant to improving the delivery of services to persons needing multiagency services.

(f) In this section, "least restrictive setting" means a service setting for a person that, in comparison to other available service settings:

(1) is most able to meet the identified needs of the person;

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

(3) engages the strengths of the family.

Added by Acts 2001, 77th Leg., ch. 114, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.092, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1203 (S.B. 1455), Sec. 9, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 507 (H.B. 2904), Sec. 1, eff. September 1, 2017.

Sec. 531.056. REVIEW OF SURVEY PROCESS IN CERTAIN INSTITUTIONS AND FACILITIES. (a) The commission shall adopt procedures to review:

(1) citations or penalties assessed for a violation of a rule or law against an institution or facility licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, considering:

(A) the number of violations by geographic region;

(B) the patterns of violations in each region; and

(C) the outcomes following the assessment of a penalty or citation; and

(2) the performance of duties by employees and agents of a state agency responsible for licensing, inspecting, surveying, or investigating institutions and facilities licensed under

Chapter 242, 247, or 252, Health and Safety Code, or certified to participate in Medicaid administered in accordance with Chapter 32, Human Resources Code, related to:

(A) complaints received by the commission; or

(B) any standards or rules violated by an employee or agent of a state agency.

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 7.02, eff. June 15, 2001.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 21(6), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(57), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.093, eff. April 2, 2015.

Sec. 531.057. VOLUNTEER ADVOCATE PROGRAM FOR THE ELDERLY. (a) In this section:

(1) "Designated caregiver" means:

(A) a person designated as a caregiver by an elderly individual receiving services from or under the direction of the commission or a health and human services agency; or

(B) a court-appointed guardian of an elderly individual receiving services from or under the direction of the commission or a health and human services agency.

(2) "Elderly" means individuals who are at least 60 years of age.

(3) "Program" means the volunteer advocate program created under this section for the elderly receiving services from or under the direction of the commission or a health and human services agency.

(4) "Volunteer advocate" means a person who successfully completes the volunteer advocate curriculum described by Subsection (c)(2).

(c) The program shall adhere to the following principles:

(1) the intent of the program is to evaluate, through operation of pilot projects, whether providing the services of a

trained volunteer advocate selected by an elderly individual or the individual's designated caregiver is effective in achieving the following goals:

(A) extend the time the elderly individual can remain in an appropriate home setting;

(B) maximize the efficiency of services delivered to the elderly individual by focusing on services needed to sustain family caregiving;

(C) protect the elderly individual by providing a knowledgeable third party to review the quality of care and services delivered to the individual and the care options available to the individual and the individual's family; and

(D) facilitate communication between the elderly individual or the individual's designated caregiver and providers of health care and other services;

(2) a volunteer advocate curriculum must be maintained that incorporates best practices as determined and recognized by a professional organization recognized in the elder health care field;

(3) the use of pro bono assistance from qualified professionals must be maximized in modifying the volunteer advocate curriculum and the program;

(4) trainers must be certified on the ability to deliver training;

(5) training shall be offered through multiple community-based organizations; and

(6) participation in the program is voluntary and must be initiated by the elderly individual or the individual's designated caregiver.

(d) The executive commissioner may enter into agreements with appropriate nonprofit organizations for the provision of services under the program. A nonprofit organization is eligible to provide services under the program if the organization:

(1) has significant experience in providing services to elderly individuals;

(2) has the capacity to provide training and supervision for individuals interested in serving as volunteer

advocates; and

(3) meets any other criteria prescribed by the executive commissioner.

(e) The commission shall fund the program, including the design and evaluation of pilot projects, modification of the volunteer advocate curriculum, and training of volunteers, through existing appropriations to the commission.

(f) Notwithstanding Subsection (e), the commission may accept gifts, grants, or donations for the program from any public or private source to:

(1) carry out the design of the program;

(2) develop criteria for evaluation of any proposed pilot projects operated under the program;

(3) modify a volunteer advocate training curriculum;

(4) conduct training for volunteer advocates; and

(5) develop a request for offers to conduct any proposed pilot projects under the program.

(g) The executive commissioner may adopt rules as necessary to implement the program.

Added by Acts 2009, 81st Leg., R.S., Ch. 1014 (H.B. 4154), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.094, eff. April 2, 2015.

Sec. 531.058. INFORMAL DISPUTE RESOLUTION FOR CERTAIN LONG-TERM CARE FACILITIES.

Text of subsection as amended by Acts 2017, 85th Leg., R.S., Ch. 590 (S.B. 924), Sec. 2

(a) The executive commissioner by rule shall establish an informal dispute resolution process in accordance with this section. The process must provide for adjudication by an appropriate disinterested person of disputes relating to a proposed enforcement action or related proceeding of the commission under Section 32.021(d), Human Resources Code, or under Chapter 242, 247,

or 252, Health and Safety Code. The informal dispute resolution process must require:

(1) an institution or facility to request informal dispute resolution not later than the 10th calendar day after notification by the commission of the violation of a standard or standards; and

(2) the completion of the process not later than:

(A) the 30th calendar day after receipt of a request from an institution or facility, other than an assisted living facility, for informal dispute resolution; or

(B) the 90th calendar day after receipt of a request from an assisted living facility for informal dispute resolution.

Text of subsection as amended by Acts 2017, 85th Leg., R.S., Ch. 836 (H.B. 2025), Sec. 1

(a) The executive commissioner by rule shall establish an informal dispute resolution process in accordance with this section. The process must provide for adjudication by an appropriate disinterested person of disputes relating to a proposed enforcement action or related proceeding of the commission under Section 32.021(d), Human Resources Code, or the Department of Aging and Disability Services or its successor agency under Chapter 242, 247, or 252, Health and Safety Code. The informal dispute resolution process must require:

(1) an institution or facility to request informal dispute resolution not later than the 10th calendar day after notification by the commission or department, as applicable, of the violation of a standard or standards; and

(2) the commission to complete the process not later than:

(A) the 30th calendar day after receipt of a request from an institution or facility, other than an assisted living facility, for informal dispute resolution; or

(B) the 90th calendar day after receipt of a request from an assisted living facility for informal dispute

resolution.

(a-1) As part of the informal dispute resolution process established under this section, the commission shall contract with an appropriate disinterested person to adjudicate disputes between an institution or facility licensed under Chapter 242, Health and Safety Code, or a facility licensed under Chapter 247, Health and Safety Code, and the commission concerning a statement of violations prepared by the commission in connection with a survey conducted by the commission of the institution or facility. Section 2009.053 does not apply to the selection of an appropriate disinterested person under this subsection. The person with whom the commission contracts shall adjudicate all disputes described by this subsection. The informal dispute resolution process for the statement of violations must require:

(1) the surveyor who conducted the survey for which the statement was prepared to be available to clarify or answer questions related to the facility or the statement that are asked by the person reviewing the dispute or by the facility; and

(2) the commission's review of the institution's or facility's informal dispute resolution request to be conducted by a registered nurse with long-term care experience for a standard of care violation.

(b) The executive commissioner shall adopt rules to adjudicate claims in contested cases.

(c) The commission may not delegate its responsibility to administer the informal dispute resolution process established by this section to another state agency.

(d) The rules adopted by the executive commissioner under Subsection (a) that relate to a dispute described by Section 247.051(a), Health and Safety Code, must incorporate the requirements of Section 247.051, Health and Safety Code.

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 7.02, eff. June 15, 2001.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 218 (H.B. 33), Sec. 3, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.096, eff.

April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1142 (S.B. 304), Sec. 5, eff. June 19, 2015.

Acts 2017, 85th Leg., R.S., Ch. 590 (S.B. 924), Sec. 2, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 836 (H.B. 2025), Sec. 1, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 637 (S.B. 1519), Sec. 1, eff. June 10, 2019.

Acts 2019, 86th Leg., R.S., Ch. 805 (H.B. 2205), Sec. 1, eff. June 10, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 3720, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.0581. LONG-TERM CARE FACILITIES COUNCIL. (a) In this section:

(1) "Council" means the Long-Term Care Facilities Council.

(2) "Long-term care facility" means a facility subject to regulation under Section 32.021(d), Human Resources Code, or Chapter 242, 247, or 252, Health and Safety Code.

(b) The executive commissioner shall establish a Long-Term Care Facilities Council as a permanent advisory committee to the commission. The council is composed of the following members appointed by the executive commissioner:

(1) at least one member who is a for-profit nursing facility provider;

(2) at least one member who is a nonprofit nursing facility provider;

(3) at least one member who is an assisted living services provider;

(4) at least one member responsible for survey enforcement within the state survey and certification agency;

(5) at least one member responsible for survey inspection within the state survey and certification agency;

(6) at least one member of the state agency responsible for informal dispute resolution;

(7) at least one member with expertise in Medicaid quality-based payment systems for long-term care facilities;

(8) at least one member who is a practicing medical director of a long-term care facility; and

(9) at least one member who is a physician with expertise in infectious disease or public health.

(c) The executive commissioner shall designate a member of the council to serve as presiding officer. The members of the council shall elect any other necessary officers.

(d) A member of the council serves at the will of the executive commissioner.

(e) The council shall meet at the call of the executive commissioner.

(f) A member of the council is not entitled to reimbursement of expenses or to compensation for service on the council.

(g) The council shall study and make recommendations regarding a consistent survey and informal dispute resolution process for long-term care facilities, Medicaid quality-based payment systems for those facilities, and the allocation of Medicaid beds in those facilities. The council shall:

(1) study and make recommendations regarding best practices and protocols to make survey, inspection, and informal dispute resolution processes more efficient and less burdensome on long-term care facilities;

(2) recommend uniform standards for those processes;

(3) study and make recommendations regarding Medicaid quality-based payment systems and a rate-setting methodology for long-term care facilities; and

(4) study and make recommendations relating to the allocation of and need for Medicaid beds in long-term care facilities, including studying and making recommendations relating to:

(A) the effectiveness of rules adopted by the executive commissioner relating to the procedures for certifying and decertifying Medicaid beds in long-term care facilities; and

(B) the need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds in long-term care facilities.

(h) Not later than January 1 of each odd-numbered year, the council shall submit a report on the council's findings and recommendations to the executive commissioner, the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate legislative committees.

(i) Chapter 2110 does not apply to the council.

Added by Acts 2019, 86th Leg., R.S., Ch. 637 (S.B. 1519), Sec. 2, eff. June 10, 2019.

Sec. 531.0585. ISSUANCE OF MATERIALS TO CERTAIN LONG-TERM CARE FACILITIES. The executive commissioner shall review the commission's methods for issuing informational letters, policy updates, policy clarifications, and other related materials to an entity licensed under Chapter 103, Human Resources Code, or Chapter 242, 247, 248A, or 252, Health and Safety Code, and develop and implement more efficient methods to issue those materials as appropriate.

Added by Acts 2017, 85th Leg., R.S., Ch. 836 (H.B. 2025), Sec. 2, eff. September 1, 2017.

Sec. 531.059. VOUCHER PROGRAM FOR TRANSITIONAL LIVING ASSISTANCE FOR PERSONS WITH DISABILITIES. (a) In this section:

(1) "Institutional housing" means:

(A) an ICF-IID, as defined by Section 531.002, Health and Safety Code;

(B) a nursing facility;

(C) a state hospital, state supported living center, or state center maintained and managed by the Department of State Health Services or the Department of Aging and Disability Services;

(D) a general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services; or

(E) a general residential operation, as defined

by Section 42.002, Human Resources Code.

(2) "Integrated housing" means housing in which a person with a disability resides or may reside that is found in the community but that is not exclusively occupied by persons with disabilities and their care providers.

(b) Subject to the availability of funds, the commission shall coordinate with the Texas Department of Housing and Community Affairs, the Department of State Health Services, and the Department of Aging and Disability Services to develop a housing assistance program to assist persons with disabilities in moving from institutional housing to integrated housing. In developing the program, the agencies shall address:

(1) eligibility requirements for assistance;

(2) the period during which a person with a disability may receive assistance;

(3) the types of housing expenses to be covered under the program; and

(4) the locations at which the program will be operated.

(c) Subject to the availability of funds, the Department of Aging and Disability Services shall administer the housing assistance program under this section. The department shall coordinate with the Texas Department of Housing and Community Affairs in administering the program, determining the availability of funding from the United States Department of Housing and Urban Development, and obtaining those funds.

(d) The Texas Department of Housing and Community Affairs and the Department of Aging and Disability Services shall provide information to the commission as necessary to facilitate the administration of the housing assistance program.

Added by Acts 2001, 77th Leg., ch. 1239, Sec. 3, eff. Sept. 1, 2001. Renumbered from Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(68), eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 728 (S.B. 49), Sec. 2, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.097, eff.

April 2, 2015.

Sec. 531.060. FAMILY-BASED ALTERNATIVES FOR CHILDREN. (a) The purpose of the system of family-based alternatives required by this section is to further the state's policy of providing for a child's basic needs for safety, security, and stability through ensuring that a child becomes a part of a successful permanent family as soon as possible.

(b) In achieving the purpose described by Subsection (a), the system is intended to be operated in a manner that recognizes that parents are a valued and integral part of the process established under the system. The system shall encourage parents to participate in all decisions affecting their children and shall respect the authority of parents, other than parents whose parental rights have been terminated, to make decisions regarding their children.

(c) In this section:

(1) "Child" means a person younger than 22 years of age who has a physical or developmental disability or who is medically fragile.

(2) "Family-based alternative" means a family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(3) "Institution" means any congregate care facility, including:

(A) a nursing facility;

(B) an ICF-IID, as defined by Section 531.002, Health and Safety Code;

(C) a group home operated by the Department of Aging and Disability Services; and

(D) a general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services.

(4) "Waiver services" means services provided under:

(A) the Medically Dependent Children Program (MDCP);

(B) the Community Living Assistance and Support Services (CLASS) waiver program;

(C) the Home and Community-based Services (HCS) waiver program;

(D) the Deaf Blind with Multiple Disabilities (DBMD) waiver program; and

(E) any other Section 1915(c) waiver program that provides long-term care services for children.

(d) The commission shall contract with a community organization, including a faith-based community organization, or a nonprofit organization for the development and implementation of a system under which a child who cannot reside with the child's birth family may receive necessary services in a family-based alternative instead of an institution. To be eligible for the contract under this subsection, an organization must possess knowledge regarding the support needs of children with disabilities and their families. For purposes of this subsection, a community organization, including a faith-based community organization, or a nonprofit organization does not include:

(1) any governmental entity; or

(2) any quasi-governmental entity to which a state agency delegates its authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

(e) The contractor may subcontract for one or more components of implementation of the system with:

(1) community organizations, including faith-based community organizations;

(2) nonprofit organizations;

(3) governmental entities; or

(4) quasi-governmental entities to which state agencies delegate authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

(f) The commission shall begin implementation of the system in areas of this state with high numbers of children who reside in institutions.

(g) Each affected health and human services agency shall cooperate with the contractor and any subcontractors and take all action necessary to implement the system and comply with the requirements of this section. The commission has final authority to make any decisions and resolve any disputes regarding the system.

(h) The system may be administered in cooperation with public and private entities.

(i) The system must provide for:

(1) recruiting and training alternative families to provide services for children;

(2) comprehensively assessing each child in need of services and each alternative family available to provide services, as necessary to identify the most appropriate alternative family for placement of the child;

(3) providing to a child's parents or guardian information regarding the availability of a family-based alternative;

(4) identifying each child residing in an institution and offering support services, including waiver services, that would enable the child to return to the child's birth family or be placed in a family-based alternative; and

(5) determining through a child's permanency plan other circumstances in which the child must be offered waiver services, including circumstances in which changes in an institution's status affect the child's placement or the quality of services received by the child.

(j) In complying with the requirement imposed by Subsection (i)(3), the commission shall ensure that the procedures for providing information to parents or a guardian permit and encourage the participation of an individual who is not affiliated with the institution in which the child resides or with an institution in which the child could be placed.

(k) In placing a child in a family-based alternative, the system may use a variety of placement options, including an arrangement in which shared parenting occurs between the alternative family and the child's birth family. Regardless of the

option used, a family-based alternative placement must be designed to be a long-term arrangement, except in cases in which the child's birth family chooses to return the child to their home. In cases in which the birth family's parental rights have been terminated, adoption of the child by the child's alternative family is an available option.

(l) The commission or the contractor may solicit and accept gifts, grants, and donations to support the system's functions under this section.

(m) In designing the system, the commission shall consider and, when appropriate, incorporate current research and recommendations developed by other public and private entities involved in analyzing public policy relating to children residing in institutions.

(n) As necessary to implement this section, the commission shall:

(1) ensure that an appropriate number of openings for waiver services that become available as a result of funding for the purpose of transferring persons with disabilities into community-based services are made available to both children and adults;

(2) ensure that service definitions applicable to waiver services are modified as necessary to permit the provision of waiver services through family-based alternatives;

(3) ensure that procedures are implemented for making a level of care determination for each child and identifying the most appropriate waiver service for the child, including procedures under which the director of long-term care for the commission, after considering any preference of the child's birth family or alternative family, resolves disputes among agencies about the most appropriate waiver service; and

(4) require that the health and human services agency responsible for providing a specific waiver service to a child also assume responsibility for identifying any necessary transition activities or services.

(o) Not later than January 1 of each year, the commission shall report to the legislature on the implementation of the

system. The report must include a statement of:

(1) the number of children currently receiving care in an institution;

(2) the number of children placed in a family-based alternative under the system during the preceding year;

(3) the number of children who left an institution during the preceding year under an arrangement other than a family-based alternative under the system or for another reason unrelated to the availability of a family-based alternative under the system;

(4) the number of children waiting for an available placement in a family-based alternative under the system; and

(5) the number of alternative families trained and available to accept placement of a child under the system.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 2, eff. Sept. 1, 2001.
Renumbered from Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(69), eff. Sept. 1, 2003.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.098, eff. April 2, 2015.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 1648, 87th Legislature, Regular Session, for amendments affecting the following section.

For expiration of this section, see Subsection (f).

Sec. 531.0601. LONG-TERM CARE SERVICES WAIVER PROGRAM INTEREST LISTS. (a) This section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) A legally authorized representative of a child who is notified by the commission that the child is no longer eligible for the medically dependent children (MDCP) waiver program following a

Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, may request that the commission:

(1) return the child to the interest list for the program unless the child is ineligible due to the child's age; or

(2) place the child on the interest list for another Section 1915(c) waiver program.

(c) At the time a child's legally authorized representative makes a request under Subsection (b), the commission shall:

(1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection (a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date the child was initially placed on the interest list for the other waiver program.

(d) Notwithstanding Subsection (c)(1)(B) or (c)(2), a child may be placed on an interest list for a Section 1915(c) waiver program in the position described by those subsections only if the

child has previously been placed on the interest list for that waiver program.

(e) At the time the commission provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, the commission shall inform the representative in writing about:

(1) the options under this section for placing the child on an interest list; and

(2) the process for applying for the Medicaid buy-in program for children with disabilities implemented under Section 531.02444.

(f) This section expires December 1, 2021.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM ASSESSMENTS AND REASSESSMENTS. (a) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides the results of the initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver program for review. The commission shall ensure the provision of the results does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services.

(b) The commission shall require the parent's or representative's signature to verify the parent or representative received the results of the initial assessment or reassessment from the care coordinator under Subsection (a). A Medicaid managed care organization may not delay the delivery of care pending the signature.

(c) The commission shall provide a parent or representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with

the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.

(d) This section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal process, the Medicaid fair hearing process, or the external medical review process.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM QUALITY MONITORING; REPORT. (a) The commission, based on the state's external quality review organization's initial report on the STAR Kids managed care program, shall determine whether the findings of the report necessitate additional data and research to improve the program. If the commission determines additional data and research are needed, the commission, through the external quality review organization, may:

(1) conduct annual surveys of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;

(2) conduct annual focus groups with recipients described by Subdivision (1) or their representatives on issues identified through:

(A) the Consumer Assessment of Healthcare Providers and Systems;

(B) other external quality review organization activities; or

(C) stakeholders, including the STAR Kids Managed Care Advisory Committee described by Section 533.00254; and

(3) in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254 and as frequently as feasible, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as the collaborative innovation improvement network.

(b) Not later than the 30th day after the last day of each

state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program:

(1) enrollment in the Medicaid buy-in for children program implemented under Section 531.02444;

(2) requests relating to interest list placements under Section 531.0601;

(3) use of the Medicaid escalation help line established under Section 533.00253, if the help line was operational during the applicable state fiscal quarter;

(4) use of, requests for, and outcomes of the external medical review procedure established under Section 531.024164; and

(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

Sec. 531.0603. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM. (a) Notwithstanding any other law and to the extent allowed by federal law, in determining eligibility of a child for the medically dependent children (MDCP) waiver program, the deaf-blind with multiple disabilities (DBMD) waiver program, or a "Money Follows the Person" demonstration project, the commission shall consider whether the child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or

(2) receives Medicaid hospice or palliative care services.

(b) If the commission determines a child is eligible for a waiver program under Subsection (a), the child's enrollment in the

applicable program is contingent on the availability of a slot in the program. If a slot is not immediately available, the commission shall place the child in the first position on the interest list for the medically dependent children (MDCP) waiver program or deaf-blind with multiple disabilities (DBMD) waiver program, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

Sec. 531.0604. MEDICALLY DEPENDENT CHILDREN PROGRAM ELIGIBILITY REQUIREMENTS; NURSING FACILITY LEVEL OF CARE. To the extent allowed by federal law, the commission may not require that a child reside in a nursing facility for an extended period of time to meet the nursing facility level of care required for the child to be determined eligible for the medically dependent children (MDCP) waiver program.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 3(b), eff. September 1, 2019.

Sec. 531.061. PARTICIPATION BY FATHERS. (a) The commission and each health and human services agency shall periodically examine commission or agency policies and procedures to determine if the policies and procedures deter or encourage participation of fathers in commission or agency programs and services relating to children.

(b) Based on the examination required under Subsection (a), the commission and each health and human services agency shall modify policies and procedures as necessary to permit full participation of fathers in commission or agency programs and services relating to children in all appropriate circumstances.

Added by Acts 2001, 77th Leg., ch. 256, Sec. 2, eff. Sept. 1, 2001. Renumbered from Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(70), eff. Sept. 1, 2003.

Sec. 531.062. PILOT PROJECTS RELATING TO TECHNOLOGY APPLICATIONS. (a) Notwithstanding any other law, the commission may establish one or more pilot projects through which

reimbursement under Medicaid is made to demonstrate the applications of technology in providing services under that program.

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

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

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

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

Added by Acts 2001, 77th Leg., ch. 959, Sec. 1, eff. June 14, 2001. Renumbered from Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(71), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.099, eff. April 2, 2015.

Sec. 531.063. CALL CENTERS. (a) The executive commissioner by rule shall establish at least one but not more than four call centers for purposes of determining and certifying or recertifying a person's eligibility and need for services related to the programs listed under Section 531.008(c), if cost-effective.

(b) The commission shall contract with at least one but not more than four private entities for the operation of call centers required by this section unless the commission determines that contracting would not be cost-effective.

(c) Each call center required by this section must be located in this state. This subsection does not prohibit a call center located in this state from processing overflow calls through a center located in another state.

(d) Each call center required by this section shall provide

translation services as required by federal law for clients unable to speak, hear, or comprehend the English language.

(e) The commission shall develop consumer service and performance standards for the operation of each call center required by this section. The standards shall address a call center's:

(1) ability to serve its consumers in a timely manner, including consideration of the consumers' ability to access the call center, whether the call center has toll-free telephone access, the average amount of time a consumer spends on hold, the frequency of call transfers, whether a consumer is able to communicate with a live person at the call center, and whether the call center makes mail correspondence available;

(2) staff, including employee courtesy, friendliness, training, and knowledge about the programs listed under Section 531.008(c); and

(3) complaint handling procedures, including the level of difficulty involved in filing a complaint and whether the call center's complaint responses are timely.

(f) The commission shall make available to the public the standards developed under Subsection (e).

(g) The commission shall develop:

(1) mechanisms for measuring consumer service satisfaction; and

(2) performance measures to evaluate whether each call center meets the standards developed under Subsection (e).

(h) The commission may inspect each call center and analyze its consumer service performance through use of a consumer service evaluator who poses as a consumer of the call center.

(i) Notwithstanding Subsection (a), the executive commissioner shall develop and implement policies that provide an applicant for services related to the programs listed under Section 531.008(c) with an opportunity to appear in person to establish initial eligibility or to comply with periodic eligibility recertification requirements if the applicant requests a personal interview. In implementing the policies, the commission shall maintain offices to serve applicants who request a personal

interview. This subsection does not affect a law or rule that requires an applicant to appear in person to establish initial eligibility or to comply with periodic eligibility recertification requirements.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.06, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.100, eff. April 2, 2015.

Sec. 531.064. VACCINES FOR CHILDREN PROGRAM PROVIDER ENROLLMENT AND REIMBURSEMENT. (a) In this section, "vaccines for children program" means the program operated by the Department of State Health Services under authority of 42 U.S.C. Section 1396s, as amended.

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

(c) The commission shall allow providers to report vaccines administered under the vaccines for children program to the immunization registry established under Section 161.007, Health and Safety Code, and to use the immunization registry, including individually identifiable information in accordance with state and federal law, to determine whether a child has received an immunization.

Added by Acts 2003, 78th Leg., ch. 613, Sec. 2, eff. Sept. 1, 2003.

Renumbered from Government Code, Section 531.063 by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(33), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.101, eff. April 2, 2015.

Sec. 531.066. PARTICIPATION OF DIAGNOSTIC LABORATORY SERVICE PROVIDERS IN CERTAIN PROGRAMS. Notwithstanding any other law, a diagnostic laboratory may participate as an in-state provider under any program administered by a health and human services agency or the commission that involves diagnostic

laboratory services, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:

(1) the laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains diagnostic laboratory operations in this state;

(2) the laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and

(3) the laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefits programs administered by a health and human services agency or the commission based on conduct that constitutes fraud, waste, or abuse.

Added by Acts 2013, 83rd Leg., R.S., Ch. 789 (S.B. 1401), Sec. 1, eff. June 14, 2013.

Sec. 531.067. PROGRAM TO IMPROVE AND MONITOR CERTAIN OUTCOMES OF RECIPIENTS UNDER CHILD HEALTH PLAN PROGRAM AND MEDICAID. The commission may design and implement a program to improve and monitor clinical and functional outcomes of a recipient of services under Medicaid or the state child health plan program. The program may use financial, clinical, and other criteria based on pharmacy, medical services, and other claims data related to Medicaid or the child health plan program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.08, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.102, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.07, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.07, eff. January 1, 2016.

Sec. 531.069. PERIODIC REVIEW OF VENDOR DRUG PROGRAM. (a) The commission shall periodically review all purchases made under the vendor drug program to determine the cost-effectiveness of including a component for prescription drug benefits in any capitation rate paid by the state under a Medicaid managed care program or the child health plan program.

(b) In making the determination required by Subsection (a), the commission shall consider the value of any prescription drug rebates received by the state.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.10, eff. Sept. 1, 2003.

Sec. 531.0693. PRESCRIPTION DRUG USE AND EXPENDITURE PATTERNS. (a) The commission shall monitor and analyze prescription drug use and expenditure patterns in Medicaid. The commission shall identify the therapeutic prescription drug classes and individual prescription drugs that are most often prescribed to patients or that represent the greatest expenditures.

(b) The commission shall post the data determined by the commission under Subsection (a) on the commission's website and update the information on a quarterly basis.

Added by Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.105, eff. April 2, 2015.

Sec. 531.0694. PERIOD OF VALIDITY FOR PRESCRIPTION. In the rules and standards governing the vendor drug program, the executive commissioner, to the extent allowed by federal law and laws regulating the writing and dispensing of prescription medications, shall ensure that a prescription written by an authorized health care provider under Medicaid is valid for the lesser of the period for which the prescription is written or one year. This section does not apply to a prescription for a controlled substance, as defined by Chapter 481, Health and Safety Code.

Added by Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.106, eff. April 2, 2015.

Sec. 531.0696. CONSIDERATIONS IN AWARDING CERTAIN CONTRACTS. The commission may not contract with a managed care organization, including a health maintenance organization, or a pharmacy benefit manager if, in the preceding three years, the organization or pharmacy benefit manager, in connection with a bid, proposal, or contract with the commission, was subject to a final judgment by a court of competent jurisdiction resulting in a conviction for a criminal offense under state or federal law:

(1) related to the delivery of an item or service;

(2) related to neglect or abuse of patients in connection with the delivery of an item or service;

(3) consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; or

(4) resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.15, eff. September 28, 2011.

Sec. 531.0697. PRIOR APPROVAL AND PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS. (a) This section applies to:

(1) the vendor drug program for Medicaid and the child health plan program;

(2) the kidney health care program;

(3) the children with special health care needs program; and

(4) any other state program administered by the commission that provides prescription drug benefits.

(b) A managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that

administers claims for prescription drug benefits under a program to which this section applies shall, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients collectively under a program:

(1) submit a copy of the communication to the commission for approval; and

(2) if applicable, allow the pharmacy providers of recipients who are to receive the communication access to the communication.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.15, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.107, eff. April 2, 2015.

Sec. 531.070. SUPPLEMENTAL REBATES. (a) In this section:

(1) "Labeler" means a person that:

(A) has a labeler code from the United States Food and Drug Administration under 21 C.F.R. Section 207.20; and

(B) receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

(2) "Manufacturer" means a manufacturer of prescription drugs as defined by 42 U.S.C. Section 1396r-8(k)(5) and its subsequent amendments, including a subsidiary or affiliate of a manufacturer.

(3) "Wholesaler" means a person licensed under Subchapter I, Chapter 431, Health and Safety Code.

(b) For purposes of this section, the term "supplemental rebates" means cash rebates paid by a manufacturer to the state on the basis of appropriate quarterly health and human services program utilization data relating to the manufacturer's products, pursuant to a state supplemental rebate agreement negotiated with the manufacturer and, if necessary, approved by the federal government under Section 1927 of the federal Social Security Act (42 U.S.C. Section 1396r-8).

(c) The commission may enter into a written agreement with a

manufacturer to accept certain program benefits in lieu of supplemental rebates, as defined by this section, only if:

(1) the program benefit yields savings that are at least equal to the amount the manufacturer would have provided under a state supplemental rebate agreement during the current biennium as determined by the written agreement;

(2) the manufacturer posts a performance bond guaranteeing savings to the state, and agrees that if the savings are not achieved in accordance with the written agreement, the manufacturer will forfeit the bond to the state less any savings that were achieved; and

(3) the program benefit is in addition to other program benefits currently offered by the manufacturer to recipients of Medicaid or related programs.

(d) For purposes of this section, a program benefit may mean disease management programs authorized under this title, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to a program operated by a health and human services agency.

(e) Other than as required to satisfy the provisions of this section, the program benefits shall be deemed an alternative to, and not the equivalent of, supplemental rebates and shall be treated in the state's submissions to the federal government (including, as appropriate, waiver requests and quarterly Medicaid claims) so as to maximize the availability of federal matching payments.

(f) Agreements by the commission to accept program benefits as defined by this section:

(1) may not prohibit the commission from entering into similar agreements related to different drug classes with other entities;

(2) shall be limited to a time period expressly determined by the commission; and

(3) may only cover products that have received approval by the Federal Drug Administration at the time of the

agreement, and new products approved after the agreement may be incorporated only under an amendment to the agreement.

(g) For purposes of this section, the commission may consider a monetary contribution or donation to the arrangements described in Subsection (c) for the purpose of offsetting expenditures to other state health care programs, but which funding may not be used to offset expenditures for covered outpatient drugs as defined by 42 U.S.C. Section 1396r-8(k)(2) under the vendor drug program. An arrangement under this subsection may not yield less than the amount the state would have benefited under a supplemental rebate. The commission may consider an arrangement under this section as satisfying the requirements related to Section 531.072(b).

(h) Subject to Subsection (i), the commission shall negotiate with manufacturers and labelers, including generic manufacturers and labelers, to obtain supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including community mental health centers and state mental health hospitals.

(i) The commission may by contract authorize a private entity to negotiate with manufacturers and labelers on behalf of the commission.

(j) A manufacturer or labeler that sells prescription drugs in this state may voluntarily negotiate with the commission and enter into an agreement to provide supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including

community mental health centers and state mental health hospitals.

(k) In negotiating terms for a supplemental rebate amount, the commission shall consider:

(1) rebates calculated under the Medicaid rebate program in accordance with 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) any other available information on prescription drug prices or rebates; and

(3) other program benefits as specified in Subsection (c).

(l) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(58), eff. June 17, 2011.

(m) In negotiating terms for a supplemental rebate, the commission shall use the average manufacturer price (AMP), as defined in 42 U.S.C. Section 1396r-8(k)(1), as the cost basis for the product.

(n) Prior to or during supplemental rebate agreement negotiations for drugs being considered for the preferred drug list, the commission shall disclose to pharmaceutical manufacturers any clinical edits or clinical protocols that may be imposed on drugs within a particular drug category that are placed on the preferred list during the contract period. Clinical edits will not be imposed for a preferred drug during the contract period unless the above disclosure is made.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.11(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 16(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 21(7), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(58), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.108, eff. April 2, 2015.

Sec. 531.0701. VALUE-BASED ARRANGEMENTS. (a) In this

section, "manufacturer" has the meaning assigned by Section 531.070.

(b) Subject to Section 531.071, the commission may enter into a value-based arrangement for the Medicaid vendor drug program by written agreement with a manufacturer based on outcome data or other metrics to which this state and the manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus, or any other thing of value.

Added by Acts 2019, 86th Leg., R.S., Ch. 272 (S.B. 1780), Sec. 1, eff. September 1, 2019.

Sec. 531.071. CONFIDENTIALITY OF INFORMATION REGARDING DRUG REBATES, PRICING, AND NEGOTIATIONS. (a) Notwithstanding any other state law, information obtained or maintained by the commission regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure under Chapter 552.

(b) Information that is confidential under Subsection (a) includes information described by Subsection (a) that is obtained or maintained by the commission in connection with the Medicaid vendor drug program, the child health plan program, the kidney health care program, the children with special health care needs program, or another state program administered by the commission or a health and human services agency.

(c) General information about the aggregate costs of different classes of drugs is not confidential under Subsection (a), except that a drug name or information that could reveal a drug name is confidential.

(d) Information about whether the commission and a manufacturer or labeler reached or did not reach a supplemental rebate agreement under Section 531.070 for a particular drug is not confidential under Subsection (a).

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.12, eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 2, eff. September 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.109, eff. April 2, 2015.

Sec. 531.072. PREFERRED DRUG LISTS. (a) In a manner that complies with applicable state and federal law, the commission shall adopt preferred drug lists for the Medicaid vendor drug program and for prescription drugs purchased through the child health plan program. The commission may adopt preferred drug lists for community mental health centers, state mental health hospitals, and any other state program administered by the commission or a state health and human services agency.

(b) The preferred drug lists may contain only drugs provided by a manufacturer or labeler that reaches an agreement with the commission on supplemental rebates under Section 531.070.

(b-1) Notwithstanding Subsection (b), the preferred drug lists may contain:

(1) a drug provided by a manufacturer or labeler that has not reached a supplemental rebate agreement with the commission if the commission determines that inclusion of the drug on the preferred drug lists will have no negative cost impact to the state; or

(2) a drug provided by a manufacturer or labeler that has reached an agreement with the commission to provide program benefits in lieu of supplemental rebates, as described by Section 531.070.

(b-2) Consideration must be given to including all strengths and dosage forms of a drug on the preferred drug lists.

(c) In making a decision regarding the placement of a drug on each of the preferred drug lists, the commission shall consider:

(1) the recommendations of the Drug Utilization Review Board under Section 531.0736;

(2) the clinical efficacy of the drug;

(3) the price of competing drugs after deducting any federal and state rebate amounts; and

(4) program benefit offerings solely or in conjunction with rebates and other pricing information.

(c-1) In addition to the considerations listed under Subsection (c), the commission shall consider the inclusion of multiple methods of delivery within each drug class, including liquid, tablet, capsule, and orally disintegrating tablets.

(d) The commission shall provide for the distribution of current copies of the preferred drug lists by posting the list on the Internet. In addition, the commission shall mail copies of the lists to any health care provider on request of that provider.

(e) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 531.070. The commission shall ensure that:

(1) a manufacturer or labeler may submit written evidence supporting the inclusion of a drug on the preferred drug lists before a supplemental agreement is reached with the commission; and

(2) any drug that has been approved or has had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the Drug Utilization Review Board at the next regularly scheduled meeting of the board. On receiving notice from a manufacturer or labeler of the availability of a new product, the commission, to the extent possible, shall schedule a review for the product at the next regularly scheduled meeting of the board.

(f) A recipient of drug benefits under the Medicaid vendor drug program may appeal a denial of prior authorization under Section 531.073 of a covered drug or covered dosage through the Medicaid fair hearing process.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.13(a), eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 3, eff. September 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.08(d),

eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.08(d), eff. January 1, 2016.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 2822, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.073. PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTION DRUGS. (a) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program and the child health plan program, shall require prior authorization for the reimbursement of a drug that is not included in the appropriate preferred drug list adopted under Section 531.072, except for any drug exempted from prior authorization requirements by federal law and except as provided by Subsection (j). The executive commissioner may require prior authorization for the reimbursement of a drug provided through any other state program administered by the commission or a state health and human services agency, including a community mental health center and a state mental health hospital if the commission adopts preferred drug lists under Section 531.072 that apply to those facilities and the drug is not included in the appropriate list. The executive commissioner shall require that the prior authorization be obtained by the prescribing physician or prescribing practitioner.

(a-1) Until the commission has completed a study evaluating the impact of a requirement of prior authorization on recipients of certain drugs, the executive commissioner shall delay requiring prior authorization for drugs that are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies.

(a-2) Not later than the 30th day before the date on which prior authorization requirements are implemented, the commission shall post on the Internet for consumers and providers:

(1) a notification of the implementation date; and

(2) a detailed description of the procedures to be used in obtaining prior authorization.

(b) The commission shall establish procedures for the prior authorization requirement under the Medicaid vendor drug program to ensure that the requirements of 42 U.S.C. Section 1396r-8(d)(5) and its subsequent amendments are met. Specifically, the procedures must ensure that:

(1) a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Drug Utilization Review Board under Section 531.0736;

(2) there will be a response to a request for prior authorization by telephone or other telecommunications device within 24 hours after receipt of a request for prior authorization; and

(3) a 72-hour supply of the drug prescribed will be provided in an emergency or if the commission does not provide a response within the time required by Subdivision (2).

(c) The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency or for a person who becomes eligible under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency is not subject to any requirement for prior authorization under this section unless the recipient has exhausted all the prescription, including any authorized refills, or a period prescribed by the commission has expired, whichever occurs first.

(d) The commission shall implement procedures to ensure that a recipient under the child health plan program, Medicaid, or another state program administered by the commission or a person who becomes eligible under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency receives continuity of care in relation to certain prescriptions identified by the commission.

(e) The commission may by contract authorize a private

entity to administer the prior authorization requirements imposed by this section on behalf of the commission.

(f) The commission shall ensure that the prior authorization requirements are implemented in a manner that minimizes the cost to the state and any administrative burden placed on providers.

(g) The commission shall ensure that requests for prior authorization may be submitted by telephone, facsimile, or electronic communications through the Internet.

(h) The commission shall provide an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request.

(i) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 1312, Sec. 99(17), eff. September 1, 2013.

(j) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program, may not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse. In this subsection, "antiretroviral drug" means a drug that treats human immunodeficiency virus infection or prevents acquired immune deficiency syndrome. The term includes:

(1) protease inhibitors;

(2) non-nucleoside reverse transcriptase inhibitors;

(3) nucleoside reverse transcriptase inhibitors;

(4) integrase inhibitors;

(5) fusion inhibitors;

(6) attachment inhibitors;

(7) CD4 post-attachment inhibitors;

(8) CCR5 receptor antagonists; and

(9) other antiretroviral drugs used to treat human immunodeficiency virus infection or prevent acquired immune deficiency syndrome.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.14, eff. Sept. 1,

2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 4, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 99(17), eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.110, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.08(e), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.08(e), eff. January 1, 2016.

Acts 2019, 86th Leg., R.S., Ch. 1343 (S.B. 1283), Sec. 1, eff. September 1, 2019.

Sec. 531.0735. MEDICAID DRUG UTILIZATION REVIEW PROGRAM: DRUG USE REVIEWS AND ANNUAL REPORT. (a) In this section:

(1) "Medicaid Drug Utilization Review Program" means the program operated by the vendor drug program to improve the quality of pharmaceutical care under Medicaid.

(2) "Prospective drug use review" means the review of a patient's drug therapy and prescription drug order or medication order before dispensing or distributing a drug to the patient.

(3) "Retrospective drug use review" means the review of prescription drug claims data to identify patterns of prescribing.

(b) The commission shall provide for an increase in the number and types of retrospective drug use reviews performed each year under the Medicaid Drug Utilization Review Program, in comparison to the number and types of reviews performed in the state fiscal year ending August 31, 2009.

(c) In determining the number and types of drug use reviews to be performed, the commission shall:

(1) allow for the repeat of retrospective drug use reviews that address ongoing drug therapy problems and that, in previous years, improved client outcomes and reduced Medicaid

spending;

(2) consider implementing disease-specific retrospective drug use reviews that address ongoing drug therapy problems in this state and that reduced Medicaid prescription drug use expenditures in other states; and

(3) regularly examine Medicaid prescription drug claims data to identify occurrences of potential drug therapy problems that may be addressed by repeating successful retrospective drug use reviews performed in this state and other states.

(d) In addition to any other information required by federal law, the commission shall include the following information in the annual report regarding the Medicaid Drug Utilization Review Program:

(1) a detailed description of the program's activities; and

(2) estimates of cost savings anticipated to result from the program's performance of prospective and retrospective drug use reviews.

(e) The cost-saving estimates for prospective drug use reviews under Subsection (d) must include savings attributed to drug use reviews performed through the vendor drug program's electronic claims processing system and clinical edits screened through the prior authorization system implemented under Section 531.073.

(f) The commission shall post the annual report regarding the Medicaid Drug Utilization Review Program on the commission's website.

Added by Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.104, eff. April 2, 2015.

Redesignated from Government Code, Section 531.0691 by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.08(a), eff. January 1, 2016.

Redesignated from Government Code, Section 531.0691 by Acts 2015,

84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.08(a), eff. January 1, 2016.

Sec. 531.0736. DRUG UTILIZATION REVIEW BOARD. (a) In this section, "board" means the Drug Utilization Review Board.

(b) In addition to performing any other duties required by federal law, the board shall:

(1) develop and submit to the commission recommendations for preferred drug lists adopted by the commission under Section 531.072;

(2) suggest to the commission restrictions or clinical edits on prescription drugs;

(3) recommend to the commission educational interventions for Medicaid providers;

(4) review drug utilization across Medicaid; and

(5) perform other duties that may be specified by law and otherwise make recommendations to the commission.

(c) The executive commissioner shall determine the composition of the board, which must:

(1) comply with applicable federal law, including 42 C.F.R. Section 456.716;

(2) include two representatives of managed care organizations as nonvoting members, one of whom must be a physician and one of whom must be a pharmacist;

(3) include at least 17 physicians and pharmacists who:

(A) provide services across the entire population of Medicaid recipients and represent different specialties, including at least one of each of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist; and

(v) an adult psychiatrist; and

(B) have experience in either developing or

practicing under a preferred drug list; and

(4) include a consumer advocate who represents Medicaid recipients.

(c-1) The executive commissioner by rule shall develop and implement a process by which a person may apply to become a member of the board and shall post the application and information regarding the application process on the commission's Internet website.

(d) Members appointed under Subsection (c)(2) may attend quarterly and other regularly scheduled meetings, but may not:

(1) attend executive sessions; or

(2) access confidential drug pricing information.

(e) Members of the board serve staggered four-year terms.

(f) The voting members of the board shall elect from among the voting members a presiding officer. The presiding officer must be a physician.

(g) The board shall hold a public meeting quarterly at the call of the presiding officer and shall permit public comment before voting on any changes in the preferred drug lists, the adoption of or changes to drug use criteria, or the adoption of prior authorization or drug utilization review proposals. The location of the quarterly public meeting may rotate among different geographic areas across this state, or allow for public input through teleconferencing centers in various geographic areas across this state. The board shall hold public meetings at other times at the call of the presiding officer. Minutes of each meeting shall be made available to the public not later than the 10th business day after the date the minutes are approved. The board may meet in executive session to discuss confidential information as described by Subsection (i).

(h) In developing its recommendations for the preferred drug lists, the board shall consider the clinical efficacy, safety, and cost-effectiveness of and any program benefit associated with a product.

(i) The executive commissioner shall adopt rules governing the operation of the board, including rules governing the procedures used by the board for providing notice of a meeting and

rules prohibiting the board from discussing confidential information described by Section 531.071 in a public meeting. The board shall comply with the rules adopted under this subsection and Subsection (j).

(j) In addition to the rules under Subsection (i), the executive commissioner by rule shall require the board or the board's designee to present a summary of any clinical efficacy and safety information or analyses regarding a drug under consideration for a preferred drug list that is provided to the board by a private entity that has contracted with the commission to provide the information. The board or the board's designee shall provide the summary in electronic form before the public meeting at which consideration of the drug occurs. Confidential information described by Section 531.071 must be omitted from the summary. The summary must be posted on the commission's Internet website.

(k) To the extent feasible, the board shall review all drug classes included in the preferred drug lists adopted under Section 531.072 at least once every 12 months and may recommend inclusions to and exclusions from the lists to ensure that the lists provide for a range of clinically effective, safe, cost-effective, and medically appropriate drug therapies for the diverse segments of the Medicaid population, children receiving health benefits coverage under the child health plan program, and any other affected individuals.

(l) The commission shall provide administrative support and resources as necessary for the board to perform its duties.

(m) Chapter 2110 does not apply to the board.

(n) The commission or the commission's agent shall publicly disclose, immediately after the board's deliberations conclude, each specific drug recommended for or against preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The disclosure must be posted on the commission's Internet website not later than the 10th business day after the date of conclusion of board deliberations that result in recommendations made to the executive commissioner regarding the placement of drugs on the preferred drug list. The public disclosure must include:

(1) the general basis for the recommendation for each drug class; and

(2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Section 531.070.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.08(b), eff. January 1, 2016.

Added by Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.08(b), eff. January 1, 2016.

Sec. 531.0737. DRUG UTILIZATION REVIEW BOARD: CONFLICTS OF INTEREST. (a) A voting member of the Drug Utilization Review Board may not have a contractual relationship, ownership interest, or other conflict of interest with a pharmaceutical manufacturer or labeler or with an entity engaged by the commission to assist in the development of the preferred drug lists or in the administration of the Medicaid Drug Utilization Review Program.

(b) The executive commissioner may implement this section by adopting rules that identify prohibited relationships and conflicts or requiring the board to develop a conflict-of-interest policy that applies to the board.

Added by Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 1, eff. September 1, 2009.

Redesignated and amended from Government Code, Section 531.0692 by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.08(c), and Ch. 946 (S.B. 277), Sec. 2.08(c), eff. January 1, 2016.

For expiration of this section, see Subsection (b).

Sec. 531.0738. APPLICATION FOR FUNDING TO IMPLEMENT MODEL OF CARE FOR CERTAIN MEDICAID RECIPIENTS. (a) The commission shall apply to the Centers for Medicare and Medicaid Services to receive any federal money available to implement a model of care that improves the quality and accessibility of care for:

(1) pregnant women with opioid use disorder enrolled in Medicaid during the prenatal and postpartum periods; and

(2) their children after birth.

(b) This section expires September 1, 2021.

Added by Acts 2019, 86th Leg., R.S., Ch. 601 (S.B. 750), Sec. 1, eff. June 10, 2019.

Sec. 531.0741. PUBLICATION OF INFORMATION REGARDING COMMISSION DECISIONS ON PREFERRED DRUG LIST PLACEMENT. The commission shall publish on the commission's Internet website any decisions on preferred drug list placement, including:

(1) a list of drugs reviewed and the commission's decision for or against placement on a preferred drug list of each drug reviewed;

(2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Section 531.070; and

(3) the rationale for any departure from a recommendation of the Drug Utilization Review Board under Section 531.0736.

Added by Acts 2009, 81st Leg., R.S., Ch. 1286 (H.B. 2030), Sec. 6, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.08(f), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.08(f), eff. January 1, 2016.

Sec. 531.075. PRIOR AUTHORIZATION FOR HIGH-COST MEDICAL SERVICES. The commission may evaluate and implement, as appropriate, procedures, policies, and methodologies to require prior authorization for high-cost medical services and procedures and may contract with qualified service providers or organizations to perform those functions. Any such program shall recognize any prohibitions in state or federal law on limits in the amount, duration, or scope of medically necessary services for children on Medicaid.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.16, eff. Sept. 1, 2003.

Sec. 531.076. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION

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

(b) The commission shall monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 4, eff. September 1, 2013.

Sec. 531.077. RECOVERY OF CERTAIN ASSISTANCE. (a) The executive commissioner shall ensure that Medicaid implements 42 U.S.C. Section 1396p(b)(1).

(b) The Medicaid account is an account in the general revenue fund. Any funds recovered by implementing 42 U.S.C. Section 1396p(b)(1) shall be deposited in the Medicaid account. Money in the account may be appropriated only to fund long-term care, including community-based care and facility-based care.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.17, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.112, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.113, eff. April 2, 2015.

Sec. 531.078. QUALITY ASSURANCE FEES ON CERTAIN WAIVER PROGRAM SERVICES. (a) In this section, "gross receipts" means money received as compensation for services under an intermediate care facility for individuals with an intellectual disability

waiver program such as a home and community services waiver or a community living assistance and support services waiver. The term does not include a charitable contribution, revenues received for services or goods other than waivers, or any money received from consumers or their families as reimbursement for services or goods not normally covered by the waivers.

(b) The executive commissioner by rule shall modify the quality assurance fee program under Subchapter H, Chapter 252, Health and Safety Code, by providing for a quality assurance fee program that imposes a quality assurance fee on persons providing services under a home and community services waiver or a community living assistance and support services waiver.

(c) The executive commissioner shall establish the fee at an amount that will produce annual revenues of not more than six percent of the total annual gross receipts in this state.

(d) The executive commissioner shall adopt rules governing:

(1) the reporting required to compute and collect the fee and the manner and times of collecting the fee; and

(2) the administration of the fee, including the imposition of penalties for a violation of the rules.

(e) Fees collected under this section shall be deposited in the waiver program quality assurance fee account.

Added by Acts 2005, 79th Leg., Ch. 896 (S.B. 1830), Sec. 1, eff. June 17, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.114, eff. April 2, 2015.

Sec. 531.079. WAIVER PROGRAM QUALITY ASSURANCE FEE ACCOUNT. (a) The waiver program quality assurance fee account is a dedicated account in the general revenue fund. The account is exempt from the application of Section 403.095.

(b) The account consists of fees collected under Section 531.078.

(c) Subject to legislative appropriation and state and federal law, money in the account may be appropriated only to the Department of Aging and Disability Services to increase

reimbursement rates paid under the home and community services waiver program or the community living assistance and support services waiver program or to offset allowable expenses under Medicaid.

Added by Acts 2005, 79th Leg., Ch. 896 (S.B. 1830), Sec. 1, eff. June 17, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.115, eff. April 2, 2015.

Sec. 531.080. REIMBURSEMENT OF WAIVER PROGRAMS. Subject to legislative appropriation and state and federal law, the Department of Aging and Disability Services shall use money from the waiver program quality assurance fee account, together with any federal money available to match money from the account, to increase reimbursement rates paid under the home and community services waiver program or the community living assistance and support services waiver program.

Added by Acts 2005, 79th Leg., Ch. 896 (S.B. 1830), Sec. 1, eff. June 17, 2005.

Sec. 531.081. INVALIDITY; FEDERAL FUNDS. If any portion of Sections 531.078-531.080 is held invalid by a final order of a court that is not subject to appeal, or if the commission determines that the imposition of the quality assurance fee and the expenditure of the money collected as provided by those sections will not entitle this state to receive additional federal money under Medicaid, the commission shall:

(1) stop collection of the quality assurance fee; and

(2) not later than the 30th day after the date the collection of the quality assurance fee is stopped, return any money collected under Section 531.078, but not spent under Section 531.080, to the persons who paid the fees in proportion to the total amount paid by those persons.

Added by Acts 2005, 79th Leg., Ch. 896 (S.B. 1830), Sec. 1, eff. June 17, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.116, eff. April 2, 2015.

Sec. 531.082. EXPIRATION OF QUALITY ASSURANCE FEE ON WAIVER PROGRAMS. If Subchapter H, Chapter 252, Health and Safety Code, expires, this section and Sections 531.078-531.081 expire on the same date.

Added by Acts 2005, 79th Leg., Ch. 896 (S.B. 1830), Sec. 1, eff. June 17, 2005.

Sec. 531.083. MEDICAID LONG-TERM CARE SYSTEM. The commission shall ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds. The commission shall also make every effort to improve the quality of care for recipients of Medicaid long-term care services by:

(1) evaluating the need for expanding the provider base for consumer-directed services and, if the commission identifies a demand for that expansion, encouraging area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with the Department of Aging and Disability Services;

(2) ensuring that all recipients who reside in a nursing facility are provided information about end-of-life care options and the importance of planning for end-of-life care; and

(3) developing policies to encourage a recipient who resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an appropriate continuum of care.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 5(a), eff. September 1, 2005.

Sec. 531.084. MEDICAID LONG-TERM CARE COST CONTAINMENT STRATEGIES. (a) The commission shall make every effort to achieve cost efficiencies within the Medicaid long-term care program. To achieve those efficiencies, the commission shall:

(1) establish a fee schedule for reimbursable incurred medical expenses for dental services controlled in long-term care facilities;

(2) implement a fee schedule for reimbursable incurred medical expenses for durable medical equipment in nursing facilities and ICF-IID facilities;

(3) implement a durable medical equipment fee schedule action plan;

(4) establish a system for private contractors to secure and coordinate the collection of Medicare funds for recipients who are dually eligible for Medicare and Medicaid;

(5) create additional partnerships with pharmaceutical companies to obtain discounted prescription drugs for Medicaid recipients; and

(6) develop and implement a system for auditing the Medicaid hospice care system that provides services in long-term care facilities to ensure correct billing for pharmaceuticals.

(b) The executive commissioner and the commissioner of aging and disability services shall jointly appoint persons to serve on a work group to assist the commission in developing the fee schedule required by Subsection (a)(1). The work group must consist of providers of long-term care services, including dentists and long-term care advocates.

(c) In developing the fee schedule required by Subsection (a)(1), the commission shall consider:

(1) the need to ensure access to dental services for residents of long-term care facilities who are unable to travel to a dental office to obtain care;

(2) the most recent Comprehensive Fee Report published by the National Dental Advisory Service;

(3) the difficulty of providing dental services in long-term care facilities;

(4) the complexity of treating medically compromised patients; and

(5) time-related and travel-related costs incurred by dentists providing dental services in long-term care facilities.

(d) The commission shall annually update the fee schedule

required by Subsection (a)(1).

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 5(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.117, eff. April 2, 2015.

Sec. 531.0841. LONG-TERM CARE INSURANCE AWARENESS AND EDUCATION CAMPAIGN. (a) The commission, in consultation with the Department of Aging and Disability Services and the Texas Department of Insurance, shall develop and implement a public awareness and education campaign designed to:

(1) educate the public on the cost of long-term care, including the limits of Medicaid eligibility and the limits of Medicare benefits;

(2) educate the public on the value and availability of long-term care insurance; and

(3) encourage individuals to obtain long-term care insurance.

(b) The Department of Aging and Disability Services and the Texas Department of Insurance shall cooperate with and assist the commission in implementing the campaign under this section.

(c) The commission may coordinate the implementation of the campaign under this section with any other state outreach campaign or activity relating to long-term care issues.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 4, eff. March 1, 2008.

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

(1) "Complex rehabilitation technology equipment" means equipment that is classified as durable medical equipment under the Medicare program on January 1, 2013, configured specifically for an individual to meet the individual's unique medical, physical, and functional needs and capabilities for basic and instrumental daily living activities, and medically necessary to prevent the individual's hospitalization or

institutionalization. The term includes a complex rehabilitation power wheelchair, highly configurable manual wheelchair, adaptive seating and positioning system, standing frame, and gait trainer.

(2) "Durable medical equipment" means equipment, including repair and replacement parts for the equipment, but excluding complex rehabilitation technology equipment, that:

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to a person in the absence of illness or injury; and

(D) is appropriate and safe for use in the home.

(b) If the commission determines that it is cost-effective, the executive commissioner by rule shall establish a program to facilitate the reuse of durable medical equipment provided to recipients under the Medicaid program.

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

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

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

(d) The program does not:

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

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

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 609 (S.B. 1175), Sec. 1, eff. June 14, 2013.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 1136, 87th Legislature, Regular Session, for amendments affecting the

following section.

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

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

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

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

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

(3) payment of a nominal referral fee to hospital emergency rooms that perform an initial medical evaluation of a recipient and subsequently refer the recipient, if medically stable, to an appropriate level of health care, such as care provided by a primary care physician, advanced practice registered nurse, or local clinic;

(4) a program under which the commission or a managed care organization that enters into a contract with the commission under Chapter 533 contacts, by telephone or mail, a recipient who accesses a hospital emergency room three times during a six-month period and provides the recipient with information on ways the recipient may secure a medical home to avoid unnecessary treatment at hospital emergency rooms;

(5) a health care literacy program under which the commission develops partnerships with other state agencies and private entities to:

(A) assist the commission in developing materials that:

(i) contain basic health care information for parents of young children who are recipients under Medicaid and

who are participating in public or private child-care or prekindergarten programs, including federal Head Start programs; and

(ii) are written in a language understandable to those parents and specifically tailored to be applicable to the needs of those parents;

(B) distribute the materials developed under Paragraph (A) to those parents; and

(C) otherwise teach those parents about the health care needs of their children and ways to address those needs; and

(6) other initiatives developed and implemented in other states that have shown success in reducing the incidence of unnecessary treatment in hospital emergency rooms.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 12(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.118, eff. April 2, 2015.

Sec. 531.0861. PHYSICIAN INCENTIVE PROGRAM TO REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) If cost-effective, the executive commissioner by rule shall establish a physician incentive program designed to reduce the use of hospital emergency room services for non-emergent conditions by recipients under Medicaid.

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

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

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.09(a), eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.119, eff. April 2, 2015.

Sec. 531.087. DISTRIBUTION OF EARNED INCOME TAX CREDIT INFORMATION. (a) The commission shall ensure that educational materials relating to the federal earned income tax credit are provided in accordance with this section to each person receiving assistance or benefits under:

(1) the child health plan program;

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

(3) Medicaid;

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

(5) another appropriate health and human services program.

(b) In accordance with Section 531.0317, the commission shall, by mail or through the Internet, provide a person described by Subsection (a) with access to:

(1) Internal Revenue Service publications relating to the federal earned income tax credit or information prepared by the comptroller under Section 403.025 relating to that credit;

(2) federal income tax forms necessary to claim the federal earned income tax credit; and

(3) where feasible, the location of at least one program in close geographic proximity to the person that provides free federal income tax preparation services to low-income and other eligible persons.

(c) In January of each year, the commission or a representative of the commission shall mail to each person described by Subsection (a) information about the federal earned income tax credit that provides the person with referrals to the resources described by Subsection (b).

Added by Acts 2005, 79th Leg., Ch. 925 (H.B. 401), Sec. 2, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.120, eff. April 2, 2015.

Sec. 531.088. POOLED FUNDING FOR FOSTER CARE PREVENTIVE SERVICES. (a) The commission and the Department of Family and Protective Services shall develop and implement a plan to combine, to the extent and in the manner allowed by Section 51, Article III, Texas Constitution, and other applicable law, funds of those agencies with funds of other appropriate state agencies and local governmental entities to provide services designed to prevent children from being placed in foster care. The preventive services may include:

(1) child and family counseling;

(2) instruction in parenting and homemaking skills;

(3) parental support services;

(4) temporary respite care; and

(5) crisis services.

(b) The plan must provide for:

(1) state funding to be distributed to other state agencies, local governmental entities, or private entities only as specifically directed by the terms of a grant or contract to provide preventive services;

(2) procedures to ensure that funds received by the commission by gift, grant, or interagency or interlocal contract from another state agency, a local governmental entity, the federal government, or any other public or private source for purposes of this section are disbursed in accordance with the terms under which the commission received the funds; and

(3) a reporting mechanism to ensure appropriate use of funds.

(c) For the purposes of this section, the commission may request and accept gifts and grants under the terms of a gift, grant, or contract from a local governmental entity, a private entity, or any other public or private source for use in providing services designed to prevent children from being placed in foster care. If required by the terms of a gift, grant, or contract or by applicable law, the commission shall use the amounts received:

(1) from a local governmental entity to provide the services in the geographic area of this state in which the entity is located; and

(2) from the federal government or a private entity to provide the services statewide or in a particular geographic area of this state.

Added by Acts 2005, 79th Leg., Ch. 268 (S.B. 6), Sec. 1.70(a), eff. September 1, 2005.

Renumbered from Government Code, Section 531.078 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(32), eff. September 1, 2007.

Sec. 531.089. CERTAIN MEDICATION FOR SEX OFFENDERS PROHIBITED. (a) To the maximum extent allowable under federal law, the commission may not provide sexual performance enhancing medication under the Medicaid vendor drug program or any other health and human services program to a person required to register as a sex offender under Chapter 62, Code of Criminal Procedure.

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

Added by Acts 2005, 79th Leg., Ch. 1008 (H.B. 867), Sec. 3.01, eff. September 1, 2005.

Renumbered from Government Code, Section 531.078 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(33), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.121, eff. April 2, 2015.

Sec. 531.090. JOINT PURCHASING OF PRESCRIPTION DRUGS AND OTHER MEDICATIONS. (a) Subject to Subsection (b), the commission and each health and human services agency authorized by the executive commissioner may enter into an agreement with one or more other states for the joint bulk purchasing of prescription drugs and other medications to be used in Medicaid, the state child health plan, or another program under the authority of the commission.

(b) An agreement under this section may not be entered into

until:

(1) the commission determines that entering into the agreement would be feasible and cost-effective; and

(2) if appropriated money would be spent under the proposed agreement, the governor and the Legislative Budget Board grant prior approval to expend appropriated money under the proposed agreement.

(c) If an agreement is entered into, the commission shall adopt procedures applicable to an agreement and joint purchase required by this section. The procedures must ensure that this state receives:

(1) all prescription drugs and other medications purchased with money provided by this state; and

(2) an equitable share of any price benefits resulting from the joint bulk purchase.

(d) In determining the feasibility and cost-effectiveness of entering into an agreement under this section, the commission shall identify:

(1) the most cost-effective existing joint bulk purchasing agreement; and

(2) any potential groups of states with which this state could enter into a new cost-effective joint bulk purchasing agreement.

Added by Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 6.01, eff. August 29, 2005.

Renumbered from Government Code, Section 531.080 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(34), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.122, eff. April 2, 2015.

Sec. 531.091. INTEGRATED BENEFITS ISSUANCE. (a) The commission may develop and implement a method to consolidate, to the extent possible, recipient identification and benefits issuance for the commission and health and human services agencies if the commission determines that the implementation would be

feasible and cost-effective.

(b) The method may:

(1) provide for the use of a single integrated benefits issuance card or multiple cards capable of integrating benefits issuance or other program functions;

(2) incorporate a fingerprint image identifier to enable personal identity verification at a point of service and reduce fraud;

(3) enable immediate electronic verification of recipient eligibility; and

(4) replace multiple forms, cards, or other methods used for fraud reduction or provision of health and human services benefits, including:

(A) electronic benefits transfer cards; and

(B) smart cards used in Medicaid.

(c) In developing and implementing the method, the commission shall:

(1) to the extent possible, use industry-standard communication, messaging, and electronic benefits transfer protocols;

(2) ensure that all identifying and descriptive information of recipients of each health and human services program included in the method can only be accessed by providers or other entities participating in the particular program;

(3) ensure that a provider or other entity participating in a health and human services program included in the method cannot identify whether a recipient of the program is receiving benefits under another program included in the method; and

(4) ensure that the storage and communication of all identifying and descriptive information included in the method complies with existing federal and state privacy laws governing individually identifiable information for recipients of public benefits programs.

Added by Acts 2005, 79th Leg., Ch. 666 (S.B. 46), Sec. 1, eff. June 17, 2005.

Renumbered from Government Code, Section 531.080 by Acts 2007, 80th

Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(35), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.123, eff. April 2, 2015.

Sec. 531.092. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES. (a) The commission shall quantify the amount of money appropriated by the legislature that would have been spent during the remainder of a state fiscal biennium to care for a person who lives in a nursing facility but who is leaving that facility before the end of the biennium to live in the community with the assistance of community-based services.

(b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the executive commissioner shall direct, as appropriate:

(1) the comptroller, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection among the health and human services agencies and the commission as necessary to comply with this section; or

(2) the commission or a health and human services agency, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection within the agency's budget as necessary to comply with this section.

(c) The commission shall ensure that the amount transferred under this section is redirected by the commission or health and human services agency, as applicable, to one or more community-based programs in the amount necessary to provide community-based services to the person after the person leaves the nursing facility.

Added by Acts 2005, 79th Leg., Ch. 985 (H.B. 1867), Sec. 1, eff. September 1, 2005.

Renumbered from Government Code, Section 531.082 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(36), eff. September 1, 2007.

For expiration of this section, see Subsection (e).

Sec. 531.0925. VETERAN SUICIDE PREVENTION ACTION PLAN. (a) The commission, in collaboration with the Texas Coordinating Council for Veterans Services, the United States Department of Veterans Affairs, the Service Members, Veterans, and Their Families Technical Assistance Center Implementation Academy of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, veteran advocacy groups, medical providers, and any other organization or interested party the commission considers appropriate, shall develop a comprehensive action plan to increase access to and availability of professional veteran health services to prevent veteran suicides.

(b) The action plan must:

(1) identify opportunities for raising awareness of and providing resources for veteran suicide prevention;

(2) identify opportunities to increase access to veteran mental health services;

(3) identify funding resources to provide accessible, affordable veteran mental health services;

(4) provide measures to expand public-private partnerships to ensure access to quality, timely mental health services;

(5) provide for proactive outreach measures to reach veterans needing care;

(6) provide for peer-to-peer service coordination, including training, certification, recertification, and continuing education for peer coordinators; and

(7) address suicide prevention awareness, measures, and training regarding veterans involved in the justice system.

(c) The commission shall make specific short-term and long-term statutory, administrative, and budget-related recommendations to the legislature and the governor regarding the policy initiatives and reforms necessary to implement the action plan developed under this section. The short-term recommendations must include a plan for state implementation beginning not later

than September 1, 2019. The initiatives and reforms in the short-term plan must be fully implemented by September 1, 2021. The long-term recommendations must include a plan for state implementation beginning not later than September 1, 2021. The initiatives and reforms in the long-term plan must be fully implemented by September 1, 2027.

(d) The commission shall include in its strategic plan under Chapter 2056 the plans for implementation of the short-term and long-term recommendations under Subsection (c).

(e) This section expires September 1, 2027.

Added by Acts 2017, 85th Leg., R.S., Ch. 561 (S.B. 578), Sec. 1, eff. June 9, 2017.

Redesignated from Government Code, Section 531.0999 by Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 21.001(24), eff. September 1, 2019.

Sec. 531.093. SERVICES FOR MILITARY PERSONNEL. (a) In this section, "servicemember" has the meaning assigned by Section 161.551, Health and Safety Code.

(b) The executive commissioner shall ensure that each health and human services agency adopts policies and procedures that require the agency to:

(1) identify servicemembers who are seeking services from the agency during the agency's intake and eligibility determination process; and

(2) direct servicemembers seeking services to appropriate service providers, including the United States Veterans Health Administration, National Guard Bureau facilities, and other federal, state, and local service providers.

(c) The executive commissioner shall make the directory of resources established under Section 161.552, Health and Safety Code, accessible to each health and human services agency.

Added by Acts 2007, 80th Leg., R.S., Ch. 1381 (S.B. 1058), Sec. 5, eff. September 1, 2007.

Sec. 531.0931. INTEREST LIST OR OTHER WAITING LIST RULES FOR CERTAIN MILITARY MEMBERS AND THEIR DEPENDENTS. (a) In this

section, "military member" means a member of the United States military serving in the army, navy, air force, marine corps, or coast guard on active duty.

(b) This section applies only to:

(1) a military member who has declared and maintains this state as the member's state of legal residence in the manner provided by the applicable military branch, or a spouse or dependent child of the member; or

(2) the spouse or dependent child of a former military member who had declared and maintained this state as the member's state of legal residence in the manner provided by the applicable military branch and who:

(A) was killed in action; or

(B) died while in service.

(c) The executive commissioner by rule shall require the commission or another health and human services agency to:

(1) maintain the position of a person subject to this section in the queue of an interest list or other waiting list for any assistance program, including a Section 1915(c) waiver program, provided by the commission or other health and human services agency, if the person cannot receive benefits under the assistance program because the person temporarily resides out of state as the result of military service; and

(2) subject to Subsection (e), offer benefits to the person according to the person's position on the interest list or other waiting list that was attained while the person resided out of state if the person returns to reside in this state.

(d) If a person subject to this section reaches a position on an interest list or other waiting list that would allow the person to receive benefits under an assistance program but the person cannot receive the benefits because the person temporarily resides out of state as the result of military service, the commission or agency providing the benefits shall maintain the person's position on the list relative to other persons on the list but continue to offer benefits to other persons on the interest list or other waiting list in accordance with those persons' respective positions on the list.

(e) In adopting rules under Subsection (c), the executive commissioner must limit the amount of time a person may maintain the person's position on an interest list or other waiting list under Subsection (c) to not more than one year after the date on which, as applicable:

(1) the member's active duty ends;

(2) the member was killed if the member was killed in action; or

(3) the member died if the member died while in service.

Added by Acts 2015, 84th Leg., R.S., Ch. 466 (S.B. 169), Sec. 1, eff. June 15, 2015.

Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a) If the commission determines that it is cost-effective and feasible, the commission shall develop and implement a Medicaid health savings account pilot program that is consistent with federal law to:

(1) encourage health care cost awareness and sensitivity by adult recipients; and

(2) promote appropriate utilization of Medicaid services by adult recipients.

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

(c) If the commission implements the pilot program, the commission shall ensure that:

(1) participation in the pilot program is voluntary; and

(2) a recipient who participates in the pilot program may, at the recipient's option and subject to Subsection (d), discontinue participation in the program and resume receiving benefits and services under the traditional Medicaid delivery model.

(d) A recipient who chooses to discontinue participation in the pilot program and resume receiving benefits and services under the traditional Medicaid delivery model before completion of the

health savings account enrollment period forfeits any funds remaining in the recipient's health savings account.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 4(a), eff. September 1, 2007.

Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to develop and, subject to Subsection (c), implement tailored benefit packages designed to:

(1) provide Medicaid benefits that are customized to meet the health care needs of recipients within defined categories of the Medicaid population through a defined system of care;

(2) improve health outcomes for those recipients;

(3) improve those recipients' access to services;

(4) achieve cost containment and efficiency; and

(5) reduce the administrative complexity of delivering Medicaid benefits.

(b) The commission:

(1) shall develop a tailored benefit package that is customized to meet the health care needs of Medicaid recipients who are children with special health care needs, subject to approval of the waiver described by Subsection (a); and

(2) may develop tailored benefit packages that are customized to meet the health care needs of other categories of Medicaid recipients.

(c) If the commission develops tailored benefit packages under Subsection (b)(2), the commission shall submit a report to the standing committees of the senate and house of representatives having primary jurisdiction over Medicaid that specifies, in detail, the categories of Medicaid recipients to which each of those packages will apply and the services available under each package.

(d) Except as otherwise provided by this section and subject to the terms of the waiver authorized by this section, the commission has broad discretion to develop the tailored benefit

packages under this section and determine the respective categories of Medicaid recipients to which the packages apply in a manner that preserves recipients' access to necessary services and is consistent with federal requirements.

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

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

(2) to the extent applicable to the category of Medicaid recipients to which the package applies:

(A) a set of benefits customized to meet the health care needs of recipients in that category; and

(B) services to integrate the management of a recipient's acute and long-term care needs, to the extent feasible.

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

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

(g-1) A tailored benefit package developed under this section must increase the state's flexibility with respect to the state's use of Medicaid funding and may not reduce the benefits available under the Medicaid state plan to any Medicaid recipient population.

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

(i) The executive commissioner, by rule, shall define each category of recipients to which a tailored benefit package applies and a mechanism for appropriately placing recipients in specific categories. Recipient categories must include children with special health care needs and may include:

(1) persons with disabilities or special health needs;

(2) elderly persons;

(3) children without special health care needs; and

(4) working-age parents and caretaker relatives.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 4(a), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.124, eff. April 2, 2015.

Sec. 531.0971. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) The commission shall 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) If the commission determines that it is feasible and to the extent permitted by federal and state law, the commission shall:

(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.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 4(a), eff. September 1, 2007.

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

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 5, eff.

September 1, 2007.

Sec. 531.0973. DEAF-BLIND WITH MULTIPLE DISABILITIES WAIVER PROGRAM: CAREER LADDER FOR INTERVENERS. (a) In this section, "deaf-blind-related course work" means educational courses designed to improve a student's:

(1) knowledge of deaf-blindness and its effect on learning;

(2) knowledge of the role of intervention and ability to facilitate the intervention process;

(3) knowledge of areas of communication relevant to deaf-blindness, including methods, adaptations, and use of assistive technology, and ability to facilitate a deaf-blind person's development and use of communication skills;

(4) knowledge of the effect that deaf-blindness has on a person's psychological, social, and emotional development and ability to facilitate the emotional well-being of a deaf-blind person;

(5) knowledge of and issues related to sensory systems and ability to facilitate the use of the senses;

(6) knowledge of motor skills, movement, orientation, and mobility strategies and ability to facilitate orientation and mobility skills;

(7) knowledge of the effect that additional disabilities have on a deaf-blind person and ability to provide appropriate support; or

(8) professionalism and knowledge of ethical issues relevant to the role of an intervener.

(b) The executive commissioner by rule shall adopt a career ladder for persons who provide intervener services under the deaf-blind with multiple disabilities waiver program. The rules must provide a system under which each person may be classified based on the person's level of training, education, and experience, as one of the following:

(1) Intervener;

(2) Intervener I;

(3) Intervener II; or

(4) Intervener III.

(c) The rules adopted by the executive commissioner under Subsection (b) must, at a minimum, require that:

(1) an Intervener:

(A) complete any orientation or training course that is required to be completed by any person who provides direct care services to recipients of services under the deaf-blind with multiple disabilities waiver program;

(B) hold a high school diploma or a high school equivalency certificate;

(C) have at least two years of experience working with individuals with developmental disabilities;

(D) have the ability to proficiently communicate in the functional language of the deaf-blind person; and

(E) meet all direct-care worker qualifications as determined by the deaf-blind with multiple disabilities waiver program;

(2) an Intervener I:

(A) meet the requirements of an Intervener under Subdivision (1);

(B) have at least six months of experience working with deaf-blind persons; and

(C) have completed at least eight semester credit hours, plus a one-hour practicum in deaf-blind-related course work, at an accredited college or university;

(3) an Intervener II:

(A) meet the requirements of an Intervener I;

(B) have at least nine months of experience working with deaf-blind persons; and

(C) have completed an additional 10 semester credit hours in deaf-blind-related course work at an accredited college or university; and

(4) an Intervener III:

(A) meet the requirements of an Intervener II;

(B) have at least one year of experience working with deaf-blind persons; and

(C) hold an associate's or bachelor's degree from

an accredited college or university in a course of study with a focus on deaf-blind-related course work.

(d) Notwithstanding Subsections (b) and (c), the executive commissioner may adopt a career ladder under this section based on credentialing standards for interveners developed by the Academy for Certification of Vision Rehabilitation and Education Professionals or any other private credentialing entity that the executive commissioner determines is appropriate.

(e) The compensation that an intervener receives for providing services under the deaf-blind with multiple disabilities waiver program must be based on and commensurate with the intervener's career ladder classification.

Added by Acts 2009, 81st Leg., R.S., Ch. 160 (S.B. 63), Sec. 1, eff. September 1, 2009.

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 6.04, eff. September 1, 2013.

Sec. 531.099. ALIGNMENT OF MEDICAID DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES WITH MEDICARE DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES. (a) The commission shall review forms and requirements under Medicaid regarding written orders for diabetic equipment and supplies to identify variations between permissible ordering procedures under that program and ordering procedures available to providers under the Medicare program.

(b) To the extent practicable, and in conformity with Chapter 157, Occupations Code, and Chapter 483, Health and Safety Code, after conducting a review under Subsection (a) the commission or executive commissioner, as appropriate, shall modify only forms,

rules, and procedures applicable to orders for diabetic equipment and supplies under Medicaid to provide for an ordering system that is comparable to the ordering system for diabetic equipment and supplies under the Medicare program. The ordering system must permit a diabetic equipment or supplies supplier to complete the forms by hand or to enter by electronic format medical information or supply orders into any form as necessary to provide the information required to dispense diabetic equipment or supplies.

(c) A provider of diabetic equipment and supplies may bill and collect payment for the provider's services if the provider has a copy of the form that meets the requirements of Subsection (b) and that is signed by a medical practitioner licensed in this state to treat diabetic patients. Additional documentation may not be required.

Added by Acts 2009, 81st Leg., R.S., Ch. 380 (H.B. 1487), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.125, eff. April 2, 2015.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 3088, 87th Legislature, Regular Session, for amendments affecting the following section.

See note following this section.

Sec. 531.0991. GRANT PROGRAM FOR MENTAL HEALTH SERVICES. (a) To the extent money is appropriated to the commission for that purpose, the commission shall establish a matching grant program for the purpose of supporting community mental health programs providing services and treatment to individuals experiencing mental illness.

(b) The commission shall ensure that each grant recipient obtains or secures contributions to match awarded grants in amounts of money or other consideration as required by Subsection (h). The money or other consideration obtained or secured by the recipient, as determined by the executive commissioner, may include cash or in-kind contributions from any person but may not include money

from state or federal funds.

(c) Money appropriated to or obtained by the commission for the matching grant program must be disbursed directly to grant recipients by the commission, as authorized by the executive commissioner.

(d) A grant awarded under the matching grant program and matching amounts must be used for the sole purpose of supporting community programs that provide mental health care services and treatment to individuals with a mental illness and that coordinate mental health care services for individuals with a mental illness with other transition support services.

(e) The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and governmental entities. The executive commissioner shall develop criteria for the evaluation of those applications or proposals and the selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address whether the services proposed in the application or proposal would duplicate services already available in the applicant's service area;

(3) address the possibility of and method for making multiple awards; and

(4) include other factors that the executive commissioner considers relevant.

(f) A nonprofit or governmental entity that applies for a grant under this section must notify each local mental health authority with a local service area that is covered wholly or partly by the entity's proposed community mental health program and must provide in the entity's application a letter of support from each local mental health authority with a local service area that is covered wholly or partly by the entity's proposed community mental health program. The commission shall consider a local mental

health authority's written input before awarding a grant under this section and may take any recommendations made by the authority.

(g) The commission shall condition each grant awarded to a recipient under the program on the recipient obtaining or securing matching funds from non-state sources in amounts of money or other consideration as required by Subsection (h).

(h) A community that receives a grant under this section is required to leverage funds in an amount:

(1) equal to 50 percent of the grant amount if the community mental health program is located in a county with a population of less than 250,000;

(2) equal to 100 percent of the grant amount if the community mental health program is located in a county with a population of at least 250,000; and

(3) equal to the percentage of the grant amount otherwise required by this subsection for the largest county in which a community mental health program is located if the community mental health program is located in more than one county.

(i) Except as provided by Subsection (j), from money appropriated to the commission for each fiscal year to implement this section, the commission shall reserve 50 percent of that total to be awarded only as grants to a community mental health program located in a county with a population not greater than 250,000.

(j) To the extent money appropriated to the commission to implement this section for a fiscal year remains available to the commission after the commission selects grant recipients for the fiscal year, the commission shall make grants available using the money remaining for the fiscal year through a competitive request for proposal process, without regard to the limitation provided by Subsection (i).

(k) Not later than December 1 of each calendar year, the executive commissioner shall submit to the governor, the lieutenant governor, and each member of the legislature a report evaluating the success of the matching grant program created by this section.

(l) The executive commissioner shall adopt any rules necessary to implement the matching grant program under this section.

(m) The commission shall implement a process to better coordinate all behavioral health grants administered by the commission in a manner that streamlines the administrative processes at the commission and decreases the administrative burden on applicants applying for multiple grants. This may include the development of a standard application for multiple behavioral health grants.

Text of section effective on June 14, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 770 (H.B. 13), Sec. 2, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2017, 85th Leg., R.S., Ch. 770 (H.B. 13), Sec. 1, eff. June 14, 2017.

Redesignated from Government Code, Section 531.0999 by Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 21.001(25), eff. September 1, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 3088, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.0992. GRANT PROGRAM FOR MENTAL HEALTH SERVICES FOR VETERANS AND THEIR FAMILIES. (a) To the extent funds are appropriated to the commission for that purpose, the commission shall establish a grant program for the purpose of supporting community mental health programs providing services and treatment to veterans and their families.

(b) Repealed by Acts 2019, 86th Leg., R.S., Ch. 336 (S.B. 822), Sec. 2, eff. May 31, 2019.

(c) The commission shall ensure that each grant recipient obtains or secures contributions to match awarded grants in amounts of money or other consideration as required by Subsection (d-1) or (d-2). The money or other consideration obtained or secured by the commission may, as determined by the executive commissioner, include cash or in-kind contributions from private contributors or

local governments but may not include state or federal funds.

(d) Money appropriated to, or obtained by, the commission for the grant program must be disbursed directly to grant recipients by the commission, as authorized by the executive commissioner.

(d-1) For services and treatment provided in a single county, the commission shall condition each grant provided under this section on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 50 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of less than 250,000; or

(2) 100 percent of the grant amount if the community mental health program to be supported by the grant provides services and treatment in a county with a population of 250,000 or more.

(d-2) For a community mental health program that provides services and treatment in more than one county, the commission shall condition each grant provided under this section on a potential grant recipient providing funds from non-state sources in a total amount at least equal to:

(1) 50 percent of the grant amount if the largest county in which the community mental health program to be supported by the grant provides services and treatment has a population of less than 250,000; or

(2) 100 percent of the grant amount if the largest county in which the community mental health program to be supported by the grant provides services and treatment has a population of 250,000 or more.

(e) All grants awarded under the grant program must be used for the sole purpose of supporting community programs that provide mental health care services and treatment to veterans and their families and that coordinate mental health care services for veterans and their families with other transition support services.

(f) The commission shall select grant recipients based on the submission of applications or proposals by nonprofit and

governmental entities. The executive commissioner shall develop criteria for the evaluation of those applications or proposals and the selection of grant recipients. The selection criteria must:

(1) evaluate and score:

(A) fiscal controls for the project;

(B) project effectiveness;

(C) project cost; and

(D) an applicant's previous experience with grants and contracts;

(2) address the possibility of and method for making multiple awards; and

(3) include other factors that the executive commissioner considers relevant.

(g) Repealed by Acts 2019, 86th Leg., R.S., Ch. 336 (S.B. 822), Sec. 2, eff. May 31, 2019.

(h) The executive commissioner shall adopt any rules necessary to implement the grant program under this section.

Added by Acts 2015, 84th Leg., R.S., Ch. 327 (S.B. 55), Sec. 1, eff. June 4, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 336 (S.B. 822), Sec. 1, eff. May 31, 2019.

Acts 2019, 86th Leg., R.S., Ch. 336 (S.B. 822), Sec. 2, eff. May 31, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 3088, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.0993. GRANT PROGRAM TO REDUCE RECIDIVISM, ARREST, AND INCARCERATION AMONG INDIVIDUALS WITH MENTAL ILLNESS AND TO REDUCE WAIT TIME FOR FORENSIC COMMITMENT. (a) The commission shall establish a program to provide grants to county-based community collaboratives for the purposes of reducing:

(1) recidivism by, the frequency of arrests of, and incarceration of persons with mental illness; and

(2) the total waiting time for forensic commitment of

persons with mental illness to a state hospital.

(b) A community collaborative may petition the commission for a grant under the program only if the collaborative includes a county, a local mental health authority that operates in the county, and each hospital district, if any, located in the county. A community collaborative may include other local entities designated by the collaborative's members.

(c) The commission shall condition each grant provided to a community collaborative under this section on the collaborative providing funds from non-state sources in a total amount at least equal to:

(1) 50 percent of the grant amount if the collaborative includes a county with a population of less than 250,000;

(2) 100 percent of the grant amount if the collaborative includes a county with a population of 250,000 or more; and

(3) the percentage of the grant amount otherwise required by this subsection for the largest county included in the collaborative, if the collaborative includes more than one county.

(c-1) To raise the required non-state sourced funds, a collaborative may seek and receive gifts, grants, or donations from any person.

(c-2) Beginning on or after September 1, 2018, from money appropriated to the commission for each fiscal year to implement this section, the commission shall reserve at least 20 percent of that total to be awarded only as grants to a community collaborative that includes a county with a population of less than 250,000.

(d) For each state fiscal year for which a community collaborative seeks a grant, the collaborative must submit a petition to the commission not later than the 30th day of that fiscal year. The community collaborative must include with a petition:

(1) a statement indicating the amount of funds from non-state sources the collaborative is able to provide; and

(2) a plan that:

(A) is endorsed by each of the collaborative's

member entities;

(B) identifies a target population;

(C) describes how the grant money and funds from non-state sources will be used;

(D) includes outcome measures to evaluate the success of the plan; and

(E) describes how the success of the plan in accordance with the outcome measures would further the state's interest in the grant program's purposes.

(e) The commission must review plans submitted with a petition under Subsection (d) before the commission provides a grant under this section. The commission must fulfill the commission's requirements under this subsection not later than the 60th day of each fiscal year.

(f) Acceptable uses for the grant money and matching funds include:

(1) the continuation of a mental health jail diversion program;

(2) the establishment or expansion of a mental health jail diversion program;

(3) the establishment of alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) the provision of assertive community treatment or forensic assertive community treatment with an outreach component;

(5) the provision of intensive mental health services and substance abuse treatment not readily available in the county;

(6) the provision of continuity of care services for an individual being released from a state hospital;

(7) the establishment of interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) the provision of local community hospital, crisis, respite, or residential beds.

(f-1) Beginning on or after September 1, 2018, to the extent money appropriated to the commission for a fiscal year to implement

this section remains available to the commission after the commission selects grant recipients for the fiscal year, the commission shall make grants available using the money remaining for the fiscal year through a competitive request for proposal process, without regard to the limitation provided by Subsection (c-2).

(g) Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this section, each community collaborative that receives a grant shall prepare and submit a report describing the effect of the grant money and matching funds in achieving the standard defined by the outcome measures in the plan submitted under Subsection (d).

(h) The commission may make inspections of the operation and provision of mental health services provided by a community collaborative to ensure state money appropriated for the grant program is used effectively.

(i) The commission may not award a grant under this section for a fiscal year to a community collaborative that includes a county with a population greater than four million if the legislature appropriates money for a mental health jail diversion program in the county for that fiscal year.

Added by Acts 2017, 85th Leg., R.S., Ch. 528 (S.B. 292), Sec. 1, eff. September 1, 2017.

Sec. 531.09935. GRANT PROGRAM TO REDUCE RECIDIVISM, ARREST, AND INCARCERATION AMONG INDIVIDUALS WITH MENTAL ILLNESS AND TO REDUCE WAIT TIME FOR FORENSIC COMMITMENT IN MOST POPULOUS COUNTY. (a) The commission shall establish a program to provide a grant to a county-based community collaborative in the most populous county in this state for the purposes of reducing:

(1) recidivism by, the frequency of arrests of, and incarceration of persons with mental illness; and

(2) the total waiting time for forensic commitment of persons with mental illness to a state hospital.

(b) The community collaborative may receive a grant under the program only if the collaborative includes the county, a local mental health authority that operates in the county, and each

hospital district located in the county. A community collaborative may include other local entities designated by the collaborative's members.

(c) Not later than the 30th day of each fiscal year, the commission shall make available to the community collaborative established in the county described by Subsection (a) a grant in an amount equal to the lesser of:

(1) the amount appropriated to the commission for that fiscal year for a mental health jail diversion pilot program in that county; or

(2) the collaborative's available matching funds.

(d) The commission shall condition a grant provided to the community collaborative under this section on the collaborative providing funds from non-state sources in a total amount at least equal to the grant amount.

(e) To raise the required non-state sourced funds, the collaborative may seek and receive gifts, grants, or donations from any person.

(f) Acceptable uses for the grant money and matching funds include:

(1) the continuation of a mental health jail diversion program;

(2) the establishment or expansion of a mental health jail diversion program;

(3) the establishment of alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) the provision of assertive community treatment or forensic assertive community treatment with an outreach component;

(5) the provision of intensive mental health services and substance abuse treatment not readily available in the county;

(6) the provision of continuity of care services for an individual being released from a state hospital;

(7) the establishment of interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) the provision of local community hospital, crisis, respite, or residential beds.

(g) Not later than the 90th day after the last day of the state fiscal year for which the commission distributes a grant under this section, the community collaborative shall prepare and submit a report describing the effect of the grant money and matching funds in fulfilling the purpose described by Subsection (a).

(h) The commission may make inspections of the operation and provision of mental health services provided by the community collaborative to ensure state money appropriated for the grant program is used effectively.

Added by Acts 2017, 85th Leg., R.S., Ch. 528 (S.B. 292), Sec. 2, eff. September 1, 2017.

Sec. 531.0994. STUDY; ANNUAL REPORT. (a) The commission, in consultation with the Department of State Health Services, the Texas Medical Board, and the Texas Department of Insurance, shall explore and evaluate new developments in safeguarding protected health information.

(b) Not later than December 1 each year, the commission shall report to the legislature on new developments in safeguarding protected health information and recommendations for the implementation of safeguards within the commission.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1126 (H.B. 300), Sec. 17, eff. September 1, 2012.

Sec. 531.0995. INFORMATION FOR CERTAIN ENROLLEES IN THE HEALTHY TEXAS WOMEN PROGRAM. (a) In this section, "Healthy Texas Women program" means a program operated by the commission that is substantially similar to the demonstration project operated under former Section 32.0248, Human Resources Code, and that is intended to expand access to preventive health and family planning services for women in this state.

(b) This section applies to a woman who is automatically enrolled in the Healthy Texas Women program following a pregnancy for which the woman received Medicaid, but who is no longer eligible

to participate in Medicaid.

(c) After a woman described by Subsection (b) is enrolled in the Healthy Texas Women program, the commission shall provide to the woman:

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

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

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

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

(2) the manner by which the information should be provided, including the information about health care providers described by Subsection (c)(2).

Added by Acts 2019, 86th Leg., R.S., Ch. 89 (S.B. 2132), Sec. 1, eff. May 20, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 3607, 87th Legislature, Regular Session, for amendments affecting the following section.

For expiration of this section, see Subsection (h).

Sec. 531.0996. PREGNANCY MEDICAL HOME PILOT PROGRAM. (a) The commission shall develop a pilot program to establish pregnancy medical homes that provide coordinated evidence-based maternity care management to women who reside in a pilot program area and are recipients of Medicaid through a Medicaid managed care model or arrangement under Chapter 533. The commission shall implement the pilot program in:

(1) at least two counties with populations of more than two million;

(2) at least one county with a population of more than 100,000 and less than 500,000; and

(3) at least one rural county with high rates of

maternal mortality and morbidity as determined by the commission in consultation with the Maternal Mortality and Morbidity Task Force established under Chapter 34, Health and Safety Code.

(b) In implementing the pilot program, the commission shall ensure each pregnancy medical home provides a maternity management team that:

(1) consists of health care providers, including obstetricians, gynecologists, family physicians, physician assistants, certified nurse midwives, nurse practitioners, and social workers, who provide health care services at the same location;

(2) conducts a risk assessment of each pilot program participant on her entry into the program to determine the risk classification for her pregnancy;

(3) based on the assessment conducted under Subdivision (2), establishes an individual pregnancy care plan for each participant; and

(4) follows each participant throughout her pregnancy to reduce poor birth outcomes.

(c) The commission may incorporate as a component of the pilot program financial incentives for health care providers who participate in a maternity management team.

(d) The commission may waive a requirement of this section for a pregnancy medical home located in a rural county.

(e) Notwithstanding Section 531.02176, the commission may:

(1) provide home telemonitoring services and necessary durable medical equipment to pilot program participants who are at risk of experiencing pregnancy-related complications, as determined by a physician, to the extent the commission anticipates the services and equipment will reduce unnecessary emergency room visits or hospitalizations; and

(2) reimburse providers under Medicaid for the provision of home telemonitoring services and durable medical equipment under the pilot program.

(f) Not later than January 1, 2021, the commission shall submit to the legislature a report on the pilot program. The report must include:

(1) an evaluation of the pilot program's success in reducing poor birth outcomes; and

(2) a recommendation on whether the pilot program should continue, be expanded, or be terminated.

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

(h) This section expires September 1, 2023.

Added by Acts 2019, 86th Leg., R.S., Ch. 973 (S.B. 748), Sec. 8, eff. September 1, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 800, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.0998. MEMORANDUM OF UNDERSTANDING REGARDING PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM; MAXIMIZATION OF BENEFITS. (a) In this section, "system" means the Public Assistance Reporting Information System (PARIS) operated by the Administration for Children and Families of the United States Department of Health and Human Services.

(b) The commission, the Texas Veterans Commission, the Veterans' Land Board, and the Department of Aging and Disability Services shall enter into a memorandum of understanding for the purposes of:

(1) coordinating and collecting information about the use and analysis among state agencies of data received from the system; and

(2) developing new strategies for state agencies to use system data in ways that:

(A) generate fiscal savings for the state; and

(B) maximize the availability of and access to benefits for veterans.

(c) The commission, the Texas Veterans Commission, and the Department of Aging and Disability Services shall coordinate to assist veterans in maximizing the benefits available to each veteran by using the system.

(d) The commission and the Texas Veterans Commission

together may determine the geographic scope of the efforts described by Subsection (c).

(e) Not later than October 1 of each year, the commission, the Texas Veterans Commission, the Veterans' Land Board, and the Department of Aging and Disability Services collectively shall submit to the legislature, the governor, and the Legislative Budget Board a report describing:

(1) interagency progress in identifying and obtaining United States Department of Veterans Affairs benefits for veterans receiving Medicaid and other public benefit programs;

(2) the number of veterans benefits claims awarded, the total dollar amount of veterans benefits claims awarded, and the costs to the state that were avoided as a result of state agencies' use of the system;

(3) efforts to expand the use of the system and improve the effectiveness of shifting veterans from Medicaid and other public benefits to United States Department of Veterans Affairs benefits, including any barriers and how state agencies have addressed those barriers; and

(4) the extent to which the Texas Veterans Commission has targeted specific populations of veterans, including populations in rural counties and in specific age and service-connected disability categories, in order to maximize benefits for veterans and savings to the state.

(f) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 1016, Sec. 2, eff. June 14, 2013.

Added by Acts 2011, 82nd Leg., R.S., Ch. 767 (H.B. 1784), Sec. 1, eff. June 17, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1016 (H.B. 2562), Sec. 1, eff. June 14, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1016 (H.B. 2562), Sec. 2, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.128, eff. April 2, 2015.

See note following this section.

Sec. 531.0999. PEER SPECIALISTS. (a) With input from mental health and substance use peer specialists and the work group described by Subsection (b), the commission shall develop and the executive commissioner shall adopt:

(1) rules that establish training requirements for peer specialists so that they are able to provide services to persons with mental illness or services to persons with substance use conditions;

(2) rules that establish certification and supervision requirements for peer specialists;

(3) rules that define the scope of services that peer specialists may provide;

(4) rules that distinguish peer services from other services that a person must hold a license to provide; and

(5) any other rules necessary to protect the health and safety of persons receiving peer services.

(b) The commission shall establish a stakeholder work group to provide input for the adoption of rules under Subsection (a). The work group is composed of the following stakeholders appointed by the executive commissioner:

(1) one representative of each organization that certifies mental health and substance use peer specialists in this state;

(2) three representatives of organizations that employ mental health and substance use peer specialists;

(3) one mental health peer specialist who works in an urban area;

(4) one mental health peer specialist who works in a rural area;

(5) one substance use peer specialist who works in an urban area;

(6) one substance use peer specialist who works in a rural area;

(7) one person who trains mental health peer specialists;

(8) one person who trains substance use peer specialists;

(9) three representatives of mental health and addiction licensed health care professional groups who supervise mental health and substance use peer specialists;

(10) to the extent possible, not more than three persons with personal experience recovering from mental illness, substance use conditions, or co-occurring mental illness and substance use conditions; and

(11) any other persons considered appropriate by the executive commissioner.

(c) The executive commissioner shall appoint one member of the work group to serve as presiding officer.

(d) The work group shall meet once every month.

(e) The work group is automatically abolished on the adoption of rules under Subsection (a).

(f) The executive commissioner may not adopt rules under Subsection (a) that preclude the provision of mental health rehabilitative services under 25 T.A.C. Chapter 416, Subchapter A, as that subchapter existed on January 1, 2017.

Text of section effective on June 15, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 1015 (H.B. 1486), Sec. 5(b), which states: This Act takes effect only if the 85th Legislature appropriates money specifically for the purpose of implementing this Act. If the legislature does not appropriate money specifically for that purpose, this Act does not take effect.

Added by Acts 2017, 85th Leg., R.S., Ch. 1015 (H.B. 1486), Sec. 1, eff. June 15, 2017.

SUBCHAPTER C. MEDICAID AND OTHER HEALTH AND HUMAN SERVICES FRAUD, ABUSE, OR OVERCHARGES

Sec. 531.101. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may grant an award to an individual who reports activity that constitutes fraud or abuse of funds in Medicaid or reports overcharges in Medicaid if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human

Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity reported by the individual.

(b) The commission shall determine the amount of an award. The award may not exceed five percent of the amount of the administrative penalty imposed under Section 32.039, Human Resources Code, that resulted from the individual's disclosure. In determining the amount of the award, the commission shall consider how important the disclosure is in ensuring the fiscal integrity of Medicaid. The commission may also consider whether the individual participated in the fraud, abuse, or overcharge.

(c) A person who brings an action under Subchapter C, Chapter 36, Human Resources Code, is not eligible for an award under this section.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.16, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.18(a), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.129, eff. April 2, 2015.

Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:

(1) "Abuse" means:

(A) a practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) an unnecessary cost to Medicaid; or

(ii) the reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care; or

(B) a practice by a recipient that results in an unnecessary cost to Medicaid.

(2) "Allegation of fraud" means an allegation of

Medicaid fraud received by the commission from any source that has not been verified by the state, including an allegation based on:

(A) a fraud hotline complaint;

(B) claims data mining;

(C) data analysis processes; or

(D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.

(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by the state. An allegation is considered to be credible when the commission has:

(A) verified that the allegation has indicia of reliability; and

(B) reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(4) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. The term does not include unintentional technical, clerical, or administrative errors.

(5) "Furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual (either as an employee or in the individual's own capacity), a provider, or other supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

(6) "Payment hold" means the temporary denial of reimbursement under Medicaid for items or services furnished by a specified provider.

(7) "Physician" includes an individual licensed to practice medicine in this state, a professional association composed solely of physicians, a partnership composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, and a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code.

(8) "Practitioner" means a physician or other

individual licensed under state law to practice the individual's profession.

(9) "Program exclusion" means the suspension of a provider from being authorized under Medicaid to request reimbursement of items or services furnished by that specific provider.

(10) "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.37A, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 257, Sec. 8, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 1, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.130, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 1, eff. September 1, 2015.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 799 and S.B. 713, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.102. OFFICE OF INSPECTOR GENERAL. (a) The commission's office of inspector general is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by the Department of Family and Protective Services, and the enforcement of state law relating to the provision of those services. The commission may obtain any information or technology

necessary to enable the office to meet its responsibilities under this subchapter or other law.

(a-1) The governor shall appoint an inspector general to serve as director of the office. The inspector general serves a one-year term that expires on February 1.

(a-2) The executive commissioner shall work in consultation with the office whenever the executive commissioner is required by law to adopt a rule or policy necessary to implement a power or duty of the office, including a rule necessary to carry out a responsibility of the office under Subsection (a).

(a-3) The executive commissioner is responsible for performing all administrative support services functions necessary to operate the office in the same manner that the executive commissioner is responsible for providing administrative support services functions for the health and human services system, including functions of the office related to the following:

(1) procurement processes;

(2) contracting policies;

(3) information technology services;

(4) subject to Subsection (a-8), legal services;

(5) budgeting; and

(6) personnel and employment policies.

(a-4) The commission's internal audit division shall regularly audit the office as part of the commission's internal audit program and shall include the office in the commission's risk assessments.

(a-5) The office shall closely coordinate with the executive commissioner and the relevant staff of health and human services system programs that the office oversees in performing functions relating to the prevention of fraud, waste, and abuse in the delivery of health and human services and the enforcement of state law relating to the provision of those services, including audits, utilization reviews, provider education, and data analysis.

(a-6) The office shall conduct audits, inspections, and investigations independent of the executive commissioner and the commission but shall rely on the coordination required by

Subsection (a-5) to ensure that the office has a thorough understanding of the health and human services system for purposes of knowledgeably and effectively performing the office's duties under this section and any other law.

(a-7) The chief counsel for the commission is the final authority for all legal interpretations related to statutes, rules, and commission policy on programs administered by the commission.

(a-8) For purposes of Subsection (a-3), "legal services" includes only legal services related to open records, procurement, contracting, human resources, privacy, litigation support by the attorney general, bankruptcy, and other legal services as detailed in the memorandum of understanding or other written agreement required under Section 531.00553, as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

(b) The commission, in consultation with the inspector general, shall set clear objectives, priorities, and performance standards for the office that emphasize:

(1) coordinating investigative efforts to aggressively recover money;

(2) allocating resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and

(3) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 531.103.

(c) The commission shall train office staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.

(d) The commission may require employees of health and human services agencies to provide assistance to the office in connection with the office's duties relating to the investigation of fraud and abuse in the provision of health and human services. The office is entitled to access to any information maintained by a health and human services agency, including internal records, relevant to the functions of the office.

(e) The executive commissioner, in consultation with the inspector general, by rule shall set specific claims criteria that,

when met, require the office to begin an investigation.

(f)(1) If the commission receives a complaint or allegation of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation as provided by Section 531.118(c) to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day, and be completed not later than the 45th day, after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred.

(2) If the findings of a preliminary investigation give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in Medicaid, the office must take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions; or

(B) if there is reason to believe that a recipient has defrauded Medicaid, the office may conduct a full investigation of the suspected fraud, subject to Section 531.118(c).

(f-1) The office shall complete a full investigation of a complaint or allegation of Medicaid fraud or abuse against a provider not later than the 180th day after the date the full investigation begins unless the office determines that more time is needed to complete the investigation. Except as otherwise provided by this subsection, if the office determines that more time is needed to complete the investigation, the office shall provide notice to the provider who is the subject of the investigation stating that the length of the investigation will exceed 180 days and specifying the reasons why the office was unable to complete the investigation within the 180-day period. The office is not required to provide notice to the provider under this

subsection if the office determines that providing notice would jeopardize the investigation.

(g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(2) As authorized under state and federal law, and except as provided by Subdivisions (8) and (9), the office shall impose without prior notice a payment hold on claims for reimbursement submitted by a provider only to compel production of records, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation of fraud exists, subject to Subsections (l) and (m), as applicable. The payment hold is a serious enforcement tool that the office imposes to mitigate ongoing financial risk to the state. A payment hold imposed under this subdivision takes effect immediately. The office must notify the provider of the payment hold in accordance with 42 C.F.R. Section 455.23(b) and, except as provided by that regulation, not later than the fifth day after the date the office imposes the payment hold. In addition to the requirements of 42 C.F.R. Section 455.23(b), the notice of payment hold provided under this subdivision must also include:

(A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation, a representative sample of any documents that form the basis for the hold, and a detailed summary of the office's evidence relating to the allegation;

(B) a description of administrative and judicial due process rights and remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both; and

(C) a detailed timeline for the provider to

pursue the rights and remedies described in Paragraph (B).

(3) On timely written request by a provider subject to a payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold not later than the third day after the date the office receives the provider's request. The provider must request an expedited administrative hearing under this subdivision not later than the 10th day after the date the provider receives notice from the office under Subdivision (2). The State Office of Administrative Hearings shall hold the expedited administrative hearing not later than the 45th day after the date the State Office of Administrative Hearings receives the request for the hearing. In a hearing held under this subdivision:

(A) the provider and the office are each limited to four hours of testimony, excluding time for responding to questions from the administrative law judge;

(B) the provider and the office are each entitled to two continuances under reasonable circumstances; and

(C) the office is required to show probable cause that the credible allegation of fraud that is the basis of the payment hold has an indicia of reliability and that continuing to pay the provider presents an ongoing significant financial risk to the state and a threat to the integrity of Medicaid.

(4) The office is responsible for the costs of a hearing held under Subdivision (3), but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(5) In a hearing held under Subdivision (3), the administrative law judge shall decide if the payment hold should continue but may not adjust the amount or percent of the payment hold. Notwithstanding any other law, including Section 2001.058(e), the decision of the administrative law judge is final and may not be appealed.

(6) The executive commissioner, in consultation with the office, shall adopt rules that allow a provider subject to a payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an informal

resolution of the issues identified by the office in the notice provided under that subdivision. A provider must request an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3) for requesting an expedited administrative hearing. On receipt of a timely request, the office shall decide whether to grant the provider's request for an initial informal resolution meeting, and if the office decides to grant the request, the office shall schedule the initial informal resolution meeting. The office shall give notice to the provider of the time and place of the initial informal resolution meeting. A provider may request a second informal resolution meeting after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall decide whether to grant the provider's request for a second informal resolution meeting, and if the office decides to grant the request, the office shall schedule the second informal resolution meeting. The office shall give notice to the provider of the time and place of the second informal resolution meeting. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office. A provider's decision to seek an informal resolution under this subdivision does not extend the time by which the provider must request an expedited administrative hearing under Subdivision (3). The informal resolution process shall run concurrently with the administrative hearing process, and the informal resolution process shall be discontinued once the State Office of Administrative Hearings issues a final determination on the payment hold.

(7) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which program exclusions:

(A) may permissively be imposed on a provider; or

(B) shall automatically be imposed on a provider.

(7-a) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines regarding the imposition of payment holds authorized under Subdivision (2).

(8) In accordance with 42 C.F.R. Sections 455.23(e) and (f), on the determination that a credible allegation of fraud exists, the office may find that good cause exists to not impose a payment hold, to not continue a payment hold, to impose a payment hold only in part, or to convert a payment hold imposed in whole to one imposed only in part, if any of the following are applicable:

(A) law enforcement officials have specifically requested that a payment hold not be imposed because a payment hold would compromise or jeopardize an investigation;

(B) available remedies implemented by the state other than a payment hold would more effectively or quickly protect Medicaid funds;

(C) the office determines, based on the submission of written evidence by the provider who is the subject of the payment hold, that the payment hold should be removed;

(D) Medicaid recipients' access to items or services would be jeopardized by a full or partial payment hold because the provider who is the subject of the payment hold:

(i) is the sole community physician or the sole source of essential specialized services in a community; or

(ii) serves a large number of Medicaid recipients within a designated medically underserved area;

(E) the attorney general declines to certify that a matter continues to be under investigation; or

(F) the office determines that a full or partial payment hold is not in the best interests of Medicaid.

(9) The office may not impose a payment hold on claims for reimbursement submitted by a provider for medically necessary services for which the provider has obtained prior authorization from the commission or a contractor of the commission unless the office has evidence that the provider has materially misrepresented documentation relating to those services.

(h) In addition to performing functions and duties otherwise provided by law, the office may:

(1) assess administrative penalties otherwise authorized by law on behalf of the commission or a health and human services agency;

(2) request that the attorney general obtain an injunction to prevent a person from disposing of an asset identified by the office as potentially subject to recovery by the office due to the person's fraud or abuse;

(3) provide for coordination between the office and special investigative units formed by managed care organizations under Section 531.113 or entities with which managed care organizations contract under that section;

(4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from a health and human services agency;

(5) conduct investigations relating to the funds described by Subdivision (4); and

(6) recommend policies promoting economical and efficient administration of the funds described by Subdivision (4) and the prevention and detection of fraud and abuse in administration of those funds.

(i) Notwithstanding any other provision of law, a reference in law or rule to the commission's office of investigations and enforcement means the office of inspector general established under this section.

(j) The office shall prepare a final report on each audit, inspection, or investigation conducted under this section. The final report must include:

(1) a summary of the activities performed by the office in conducting the audit, inspection, or investigation;

(2) a statement regarding whether the audit, inspection, or investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(k) A final report on an audit, inspection, or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit, inspection, or investigation remain confidential and not subject to required disclosure in accordance with Section 531.1021(g). A confidential draft report on an audit, inspection, or investigation that

concerns the death of a child may be shared with the Department of Family and Protective Services. A draft report that is shared with the Department of Family and Protective Services remains confidential and is not subject to disclosure under Chapter 552.

(l) The office shall employ a medical director who is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules adopted under that subtitle by the Texas Medical Board, and who preferably has significant knowledge of Medicaid. The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(m) The office shall employ a dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules adopted under that subtitle by the State Board of Dental Examiners, and who preferably has significant knowledge of Medicaid. The dental director shall ensure that any investigative findings based on the necessity of dental services or the quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(n) To the extent permitted under federal law, the executive commissioner, on behalf of the office, shall adopt rules establishing the criteria for initiating a full-scale fraud or abuse investigation, conducting the investigation, collecting evidence, accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee, and establishing minimum training requirements for Medicaid provider fraud or abuse investigators.

(o) Nothing in this section limits the authority of any other state agency or governmental entity.

(p) The executive commissioner, in consultation with the office, shall adopt rules establishing criteria:

(1) for opening a case;

(2) for prioritizing cases for the efficient

management of the office's workload, including rules that direct the office to prioritize:

(A) provider cases according to the highest potential for recovery or risk to the state as indicated through the provider's volume of billings, the provider's history of noncompliance with the law, and identified fraud trends;

(B) recipient cases according to the highest potential for recovery and federal timeliness requirements; and

(C) internal affairs investigations according to the seriousness of the threat to recipient safety and the risk to program integrity in terms of the amount or scope of fraud, waste, and abuse posed by the allegation that is the subject of the investigation; and

(3) to guide field investigators in closing a case that is not worth pursuing through a full investigation.

(q) The office shall coordinate all audit and oversight activities, including the development of audit plans, risk assessments, and findings, with the commission to minimize the duplication of activities. In coordinating activities under this subsection, the office shall:

(1) on an annual basis, seek input from the commission and consider previous audits and onsite visits made by the commission for purposes of determining whether to audit a managed care organization participating in Medicaid; and

(2) request the results of any informal audit or onsite visit performed by the commission that could inform the office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

(r) The office shall review the office's investigative process, including the office's use of sampling and extrapolation to audit provider records. The review shall be performed by staff who are not directly involved in investigations conducted by the office.

(s) The office shall arrange for the Association of Inspectors General or a similar third party to conduct a peer review of the office's sampling and extrapolation techniques. Based on

the review and generally accepted practices among other offices of inspectors general, the executive commissioner, in consultation with the office, shall by rule adopt sampling and extrapolation standards to be used by the office in conducting audits.

(t) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the operation of the commission, the inspector general shall submit a report to the executive commissioner, the governor, and the legislature on:

(1) the office's activities;

(2) the office's performance with respect to performance measures established by the executive commissioner for the office;

(3) fraud trends identified by the office;

(4) any recommendations for changes in policy to prevent or address fraud, waste, and abuse in the delivery of health and human services in this state; and

(5) the amount of money recovered during the preceding quarter as a result of investigations involving peace officers employed and commissioned by the office for each program for which the office has investigative authority.

(u) The office shall publish each report required under Subsection (t) on the office's Internet website.

(v) In accordance with Section 533.015(b), the office shall consult with the executive commissioner regarding the adoption of rules defining the office's role in and jurisdiction over, and the frequency of, audits of managed care organizations participating in Medicaid that are conducted by the office and the commission.

(w) The office shall coordinate all audit and oversight activities relating to providers, including the development of audit plans, risk assessments, and findings, with the commission to minimize the duplication of activities. In coordinating activities under this subsection, the office shall:

(1) on an annual basis, seek input from the commission and consider previous audits and on-site visits made by the commission for purposes of determining whether to audit a managed care organization participating in Medicaid; and

(2) request the results of any informal audit or on-site visit performed by the commission that could inform the office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

(x) The executive commissioner, in consultation with the office, shall adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement that include:

(1) direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration:

(A) the seriousness of the violation;

(B) the prevalence of errors by the provider;

(C) the financial or other harm to the state or recipients resulting or potentially resulting from those errors; and

(D) mitigating factors the office determines appropriate; and

(2) a specific list of potential penalties, including the amount of the penalties, for fraud and other Medicaid violations.

(y) The Sunset Advisory Commission shall conduct a special-purpose review of the overall performance of the commission's office of inspector general. In conducting the review, the Sunset Advisory Commission shall particularly focus on the office's investigations and the effectiveness and efficiency of the office's processes. The review shall be conducted during the period in which state agencies abolished in 2023 are reviewed. The office is not abolished solely because the office is not explicitly continued following the review required by this subsection. This subsection expires September 1, 2023.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 1289, Sec. 3, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 2.19(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 18(a), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.11, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 3, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 2, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 5, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.131, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.132, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.133, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.14, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 2, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 277 (H.B. 2379), Sec. 1, eff. May 29, 2017.

Acts 2017, 85th Leg., R.S., Ch. 316 (H.B. 5), Sec. 27, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 8.012, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 24.001(17), eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 856 (H.B. 2523), Sec. 1, eff. June 15, 2017.

Acts 2019, 86th Leg., R.S., Ch. 596 (S.B. 619), Sec. 2.02(a), eff. June 10, 2019.

Sec. 531.1021. SUBPOENAS. (a) The office of inspector general may issue a subpoena in connection with an investigation conducted by the office. A subpoena may be issued under this

section to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence that is in this state.

(b) A subpoena may be served personally or by certified mail.

(c) If a person fails to comply with a subpoena, the office, acting through the attorney general, may file suit to enforce the subpoena in a district court in this state.

(d) On finding that good cause exists for issuing the subpoena, the court shall order the person to comply with the subpoena. The court may punish a person who fails to obey the court order.

(e) The office shall pay a reasonable fee for photocopies subpoenaed under this section in an amount not to exceed the amount the office may charge for copies of its records.

(f) The reimbursement of the expenses of a witness whose attendance is compelled under this section is governed by Section 2001.103.

(g) All information and materials subpoenaed or compiled by the office in connection with an audit, inspection, or investigation or by the office of the attorney general in connection with a Medicaid fraud investigation are confidential and not subject to disclosure under Chapter 552, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the office or the attorney general or their employees or agents involved in the audit, inspection, or investigation conducted by the office or the attorney general, except that this information may be disclosed to the state auditor's office, law enforcement agencies, and other entities as permitted by other law.

(h) A person who receives information under Subsection (g) may disclose the information only in accordance with Subsection (g) and in a manner that is consistent with the authorized purpose for which the person first received the information.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.20, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 18(b), eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 620 (S.B. 688), Sec. 4, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.134, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 3, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 277 (H.B. 2379), Sec. 2, eff. May 29, 2017.

Sec. 531.1022. PEACE OFFICERS. (a) The commission's office of inspector general shall employ and commission not more than five peace officers at any given time for the purpose of assisting the office in carrying out the duties of the office relating to the investigation of fraud, waste, and abuse in Medicaid.

(b) Peace officers employed under this section are administratively attached to the Department of Public Safety. The commission shall provide administrative support to the department necessary to support the assignment of peace officers employed under this section.

(c) A peace officer employed and commissioned by the office under this section is a peace officer for purposes of Article 2.12, Code of Criminal Procedure.

(d) A peace officer employed and commissioned under this section shall obtain prior approval from the office of attorney general before carrying out any duties requiring peace officer status.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 6, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.135, eff. April 2, 2015.

Sec. 531.1023. COMPLIANCE WITH FEDERAL CODING GUIDELINES. (a) The commission's office of inspector general, including

office staff and any third party with which the office contracts to perform coding services, and the commission's medical and utilization review appeals unit shall comply with federal coding guidelines, including guidelines for diagnosis-related group (DRG) validation and related audits.

(b) In this section, "federal coding guidelines" means the code sets and guidelines adopted by the United States Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

Added by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 11, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 680 (S.B. 2138), Sec. 2, eff. June 10, 2019.

Sec. 531.1024. HOSPITAL UTILIZATION REVIEWS AND AUDITS: PROVIDER EDUCATION PROCESS. The executive commissioner, in consultation with the office, shall by rule develop a process for the commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, to communicate with and educate providers about the diagnosis-related group (DRG) validation criteria that the office uses in conducting hospital utilization reviews and audits.

Added by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 11, eff. September 1, 2015.

Sec. 531.1025. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Notwithstanding any other law, the commission's office of inspector general may conduct a performance audit of any program or project administered or agreement entered into by the commission or a health and human services agency, including an audit related to:

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

(2) the performance of the commission or a health and human services agency.

(b) In addition to the coordination required by Section 531.102(w), the office shall coordinate the office's other audit activities with those of the commission, including the development of audit plans, the performance of risk assessments, and the reporting of findings, to minimize the duplication of audit activities. In coordinating audit activities with the commission under this subsection, the office shall:

(1) seek input from the commission and consider previous audits conducted by the commission for purposes of determining whether to conduct a performance audit; and

(2) request the results of an audit conducted by the commission if those results could inform the office's risk assessment when determining whether to conduct, or the scope of, a performance audit.

Added by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 11, eff. September 1, 2015.

Sec. 531.103. INTERAGENCY COORDINATION. (a) The commission, acting through the commission's office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law, or other violations of state or federal law under Medicaid or another program administered by the commission or a health and human services agency, including the financial assistance program under Chapter 31, Human Resources Code, the supplemental nutrition assistance program under Chapter 33, Human Resources Code, and the child health plan program. The memorandum of understanding shall require:

(1) the office of inspector general and the office of the attorney general to set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to enhance deterrence of fraud, waste, abuse, or other violations of state or federal law, including a violation of Chapter 102, Occupations Code, in the programs and maximize the imposition of penalties, the recovery of

money, and the successful prosecution of cases;

(1-a) the office of inspector general to refer each case of suspected provider fraud, waste, or abuse to the office of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(1-b) the office of the attorney general to take appropriate action in response to each case referred to the attorney general, which action may include direct initiation of prosecution, with the consent of the appropriate local district or county attorney, direct initiation of civil litigation, referral to an appropriate United States attorney, a district attorney, or a county attorney, or referral to a collections agency for initiation of civil litigation or other appropriate action;

(2) the office of inspector general to keep detailed records for cases processed by that office or the office of the attorney general, including information on the total number of cases processed and, for each case:

(A) the agency and division to which the case is referred for investigation;

(B) the date on which the case is referred; and

(C) the nature of the suspected fraud, waste, or abuse;

(3) the office of inspector general to notify each appropriate division of the office of the attorney general of each case referred by the office of inspector general;

(4) the office of the attorney general to ensure that information relating to each case investigated by that office is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse;

(5) the office of the attorney general to notify the office of inspector general of each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(6) representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case; and

(7) the office of inspector general and the office of the attorney general to submit information requested by the comptroller about each resolved case for the comptroller's use in improving fraud detection.

(b) An exchange of information under this section between the office of the attorney general and the commission, the office of inspector general, or a health and human services agency does not affect whether the information is subject to disclosure under Chapter 552.

(c) The commission and the office of the attorney general shall jointly prepare and submit an annual report to the governor, lieutenant governor, and speaker of the house of representatives concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under Medicaid or another program administered by the commission or a health and human services agency. The report may be consolidated with any other report relating to the same subject matter the commission or office of the attorney general is required to submit under other law.

(d) The commission and the office of the attorney general may not assess or collect investigation and attorney's fees on behalf of any state agency unless the office of the attorney general or other state agency collects a penalty, restitution, or other reimbursement payment to the state.

(e) In addition to the provisions required by Subsection (a), the memorandum of understanding required by this section must also ensure that no barriers to direct fraud referrals to the office of the attorney general's Medicaid fraud control unit or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are imposed, and must include procedures to facilitate the referral of cases directly to the office of the attorney general.

(f) A district attorney, county attorney, city attorney, or private collection agency may collect and retain costs associated with a case referred to the attorney or agency in accordance with procedures adopted under this section and 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.21(a), eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 37, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.136, eff. April 2, 2015.

Sec. 531.1031. DUTY TO EXCHANGE INFORMATION. (a) In this section and Sections 531.1032, 531.1033, and 531.1034:

(1) "Health care professional" means a person issued a license to engage in a health care profession.

(1-a) "License" means a license, certificate, registration, permit, or other authorization that:

(A) is issued by a licensing authority; and

(B) must be obtained before a person may practice or engage in a particular business, occupation, or profession.

(1-b) "Licensing authority" means a department, commission, board, office, or other agency of the state that issues a license.

(1-c) "Office" means the commission's office of inspector general unless a different meaning is plainly required by the context in which the term appears.

(2) "Participating agency" means:

(A) the Medicaid fraud enforcement divisions of the office of the attorney general;

(B) each licensing authority with authority to issue a license to a health care professional or managed care organization that may participate in Medicaid; and

(C) the office.

(3) "Provider" has the meaning assigned by Section 531.1011(10)(A).

(b) This section applies only to criminal history record information held by a participating agency that relates to a health care professional and information held by a participating agency that relates to a health care professional or managed care

organization that is the subject of an investigation by a participating agency for alleged fraud or abuse under Medicaid.

(c) A participating agency may submit to another participating agency a written request for information described by Subsection (b) regarding a health care professional or managed care organization. The participating agency that receives the request shall provide the requesting agency with the information regarding the health care professional or managed care organization unless:

(1) the release of the information would jeopardize an ongoing investigation or prosecution by the participating agency with possession of the information; or

(2) the release of the information is prohibited by other law.

(c-1) Notwithstanding any other law, a participating agency may enter into a memorandum of understanding or agreement with another participating agency for the purpose of exchanging criminal history record information relating to a health care professional that both participating agencies are authorized to access under Chapter 411. Confidential criminal history record information in the possession of a participating agency that is provided to another participating agency in accordance with this subsection remains confidential while in the possession of the participating agency that receives the information.

(d) A participating agency that discovers information that may indicate fraud or abuse by a health care professional or managed care organization may provide that information to any other participating agency unless the release of the information is prohibited by other law.

(e) Not later than the 30th day after the date the agency receives a request for information under Subsection (c), a participating agency that determines the agency is prohibited from releasing the requested information shall inform the agency requesting the information of that determination in writing.

(f) Confidential information shared under this section remains subject to the same confidentiality requirements and legal restrictions on access to the information that are imposed by law on the participating agency that originally obtained or collected the

information. The sharing of information under this section does not affect whether the information is subject to disclosure under Chapter 552.

(g) A participating agency that receives information from another participating agency under this section must obtain written permission from the agency that shared the information before using the information in a licensure or enforcement action.

(h) This section does not affect the participating agencies' authority to exchange information under other law.

Added by Acts 2007, 80th Leg., R.S., Ch. 127 (S.B. 1694), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.12, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.13, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.14, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 4, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 5, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 6, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.137, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.138, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.15(a), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 4, eff. September 1, 2015.

Sec. 531.1032. OFFICE OF INSPECTOR GENERAL: CRIMINAL HISTORY RECORD INFORMATION CHECK. (a) The office and each licensing authority that requires the submission of fingerprints for the purpose of conducting a criminal history record information

check of a health care professional shall enter into a memorandum of understanding to ensure that only persons who are licensed and in good standing as health care professionals participate as providers in Medicaid. The memorandum under this section may be combined with a memorandum authorized under Section 531.1031(c-1) and must include a process by which:

(1) the office may confirm with a licensing authority that a health care professional is licensed and in good standing for purposes of determining eligibility to participate in Medicaid; and

(2) the licensing authority immediately notifies the office if:

(A) a provider's license has been revoked or suspended; or

(B) the licensing authority has taken disciplinary action against a provider.

(b) The office may not, for purposes of determining a health care professional's eligibility to participate in Medicaid as a provider, conduct a criminal history record information check of a health care professional who the office has confirmed under Subsection (a) is licensed and in good standing. This subsection does not prohibit the office from performing a criminal history record information check of a provider that is required or appropriate for other reasons, including for conducting an investigation of fraud, waste, or abuse.

Text of subsection as added by Acts 2015, 84th Leg., R.S., Ch. 837, Sec. 2.15(b)

(c) For purposes of determining eligibility to participate in Medicaid and subject to Subsection (d), the office, after seeking public input from various geographic areas across this state, either in person or through teleconferencing centers, shall establish and the executive commissioner by rule shall adopt guidelines for the evaluation of criminal history record information of providers and potential providers. The guidelines must outline conduct, by provider type, that may be contained in criminal history record information that will result in exclusion

of a person from Medicaid as a provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided under Medicaid;

(2) the degree to which the person would interact with Medicaid recipients as a provider; and

(3) any previous evidence that the person engaged in fraud, waste, or abuse under Medicaid.

Text of subsection as added by Acts 2015, 84th Leg., R.S., Ch. 945, Sec. 5

(c) For purposes of determining eligibility to participate in Medicaid and subject to Subsection (d), the office, after seeking public input, shall establish and the executive commissioner by rule shall adopt guidelines for the evaluation of criminal history record information of providers and potential providers. The guidelines must outline conduct, by provider type, that may be contained in criminal history record information that will result in exclusion of a person from Medicaid as a provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided under Medicaid;

(2) the degree to which the person would interact with Medicaid recipients as a provider; and

(3) any previous evidence that the person engaged in fraud, waste, or abuse under Medicaid.

(d) The guidelines adopted under Subsection (c) may not impose stricter standards for the eligibility of a person to participate in Medicaid than a licensing authority described by Subsection (a) requires for the person to engage in a health care profession without restriction in this state.

(e) The office and the commission shall use the guidelines adopted under Subsection (c) to determine whether a provider participating in Medicaid continues to be eligible to participate in Medicaid as a provider.

(f) The provider enrollment contractor, if applicable, and a managed care organization participating in Medicaid shall defer

to the office regarding whether a person's criminal history record information precludes the person from participating in Medicaid as a provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.15(b), eff. September 1, 2015.

Added by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 5, eff. September 1, 2015.

Sec. 531.1033. MONITORING OF CERTAIN FEDERAL DATABASES. The office shall routinely check appropriate federal databases, including databases referenced in 42 C.F.R. Section 455.436, to ensure that a person who is excluded from participating in Medicaid or in the Medicare program by the federal government is not participating as a provider in Medicaid.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.15(b), eff. September 1, 2015.

Added by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 5, eff. September 1, 2015.

Sec. 531.1034. TIME TO DETERMINE PROVIDER ELIGIBILITY; PERFORMANCE METRICS. (a) Not later than the 10th day after the date the office receives the complete application of a health care professional seeking to participate in Medicaid, the office shall inform the commission or the health care professional, as appropriate, of the office's determination regarding whether the health care professional should be denied participation in Medicaid based on:

(1) information concerning the licensing status of the health care professional obtained as described by Section 531.1032(a);

(2) information contained in the criminal history record information check that is evaluated in accordance with guidelines adopted under Section 531.1032(c);

(3) a review of federal databases under Section 531.1033;

(4) the pendency of an open investigation by the office; or

(5) any other reason the office determines appropriate.

(b) Completion of an on-site visit of a health care professional during the period prescribed by Subsection (a) is not required.

(c) The office shall develop performance metrics to measure the length of time for conducting a determination described by Subsection (a) with respect to applications that are complete when submitted and all other applications.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.15(b), eff. September 1, 2015.

Added by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 5, eff. September 1, 2015.

Sec. 531.104. ASSISTING INVESTIGATIONS BY ATTORNEY GENERAL. (a) The commission and the attorney general shall execute a memorandum of understanding under which the commission shall provide investigative support as required to the attorney general in connection with cases under Subchapter B, Chapter 36, Human Resources Code. Under the memorandum of understanding, the commission shall assist in performing preliminary investigations and ongoing investigations for actions prosecuted by the attorney general under Subchapter C, Chapter 36, Human Resources Code.

(b) The memorandum of understanding must specify the type, scope, and format of the investigative support provided to the attorney general under this section.

(c) The memorandum of understanding must ensure that no barriers to direct fraud referrals to the state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the state's Medicaid fraud control unit will be imposed.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997. Amended by Acts 2003 78th Leg., ch. 198, Sec. 2.22, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 257, Sec. 11, eff. Sept. 1, 2003.

Sec. 531.105. FRAUD DETECTION TRAINING. (a) The

commission shall develop and implement a program to provide annual training to contractors who process Medicaid claims and to appropriate staff of the health and human services agencies in identifying potential cases of fraud, waste, or abuse under Medicaid. The training provided to the contractors and staff must include clear criteria that specify:

(1) the circumstances under which a person should refer a potential case to the commission; and

(2) the time by which a referral should be made.

(b) The health and human services agencies, in cooperation with the commission, shall periodically set a goal of the number of potential cases of fraud, waste, or abuse under Medicaid that each agency will attempt to identify and refer to the commission. The commission shall include information on the agencies' goals and the success of each agency in meeting the agency's goal in the report required by Section 531.103(c).

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.139, eff. April 2, 2015.

Sec. 531.106. LEARNING, NEURAL NETWORK, OR OTHER TECHNOLOGY. (a) The commission shall use learning, neural network, or other technology to identify and deter fraud in Medicaid throughout this state.

(b) The commission shall contract with a private or public entity to develop and implement the technology. The commission may require the entity it contracts with to install and operate the technology at locations specified by the commission, including commission offices.

(c) The data used for data processing shall be maintained as an independent subset for security purposes.

(d) The commission shall require each health and human services agency that performs any aspect of Medicaid to participate in the implementation and use of the technology.

(e) The commission shall maintain all information necessary

to apply the technology to claims data covering a period of at least two years.

(f) The commission shall refer cases identified by the technology to the commission's office of inspector general or the office of the attorney general, as appropriate.

(g) Each month, the technology implemented under this section must match vital statistics unit death records with Medicaid claims filed by a provider. If the commission determines that a provider has filed a claim for services provided to a person after the person's date of death, as determined by the vital statistics unit death records, the commission shall refer the case for investigation to the commission's office of inspector general.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 215, Sec. 2, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.140, eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 277 (H.B. 2379), Sec. 3, eff. May 29, 2017.

Acts 2017, 85th Leg., R.S., Ch. 277 (H.B. 2379), Sec. 4, eff. May 29, 2017.

Sec. 531.1061. FRAUD INVESTIGATION TRACKING SYSTEM. (a) The commission shall use an automated fraud investigation tracking system through the commission's office of inspector general to monitor the progress of an investigation of suspected fraud, abuse, or insufficient quality of care under Medicaid.

(b) For each case of suspected fraud, abuse, or insufficient quality of care identified by the technology required under Section 531.106, the automated fraud investigation tracking system must:

(1) receive electronically transferred records relating to the identified case from the technology;

(2) record the details and monitor the status of an investigation of the identified case, including maintaining a record of the beginning and completion dates for each phase of the case investigation;

(3) generate documents and reports related to the status of the case investigation; and

(4) generate standard letters to a provider regarding the status or outcome of an investigation.

(c) The commission shall require each health and human services agency that performs any aspect of Medicaid to participate in the implementation and use of the automated fraud investigation tracking system.

Added by Acts 1999, 76th Leg., ch. 206, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.141, eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 277 (H.B. 2379), Sec. 5, eff. May 29, 2017.

Sec. 531.1062. RECOVERY MONITORING SYSTEM. (a) The commission shall use an automated recovery monitoring system to monitor the collections process for a settled case of fraud, abuse, or insufficient quality of care under Medicaid.

(b) The recovery monitoring system must:

(1) monitor the collection of funds resulting from settled cases, including:

(A) recording monetary payments received from a provider who has agreed to a monetary payment plan; and

(B) recording deductions taken through the recoupment program from subsequent Medicaid claims filed by the provider; and

(2) provide immediate notice of a provider who has agreed to a monetary payment plan or to deductions through the recoupment program from subsequent Medicaid claims who fails to comply with the settlement agreement, including providing notice of a provider who does not make a scheduled payment or who pays less than the scheduled amount.

Added by Acts 1999, 76th Leg., ch. 206, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.142, eff. April 2, 2015.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 800, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.108. FRAUD PREVENTION. (a) The commission's office of inspector general shall compile and disseminate accurate information and statistics relating to:

(1) fraud prevention; and

(2) post-fraud referrals received and accepted or rejected from the commission's case management system or the case management system of a health and human services agency.

(b) The commission shall:

(1) aggressively publicize successful fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases; and

(2) ensure that a toll-free hotline for reporting suspected fraud in programs administered by the commission or a health and human services agency is maintained and promoted, either by the commission or by a health and human services agency.

(c) The commission shall develop a cost-effective method of identifying applicants for public assistance in counties bordering other states and in metropolitan areas selected by the commission who are already receiving benefits in other states. If economically feasible, the commission may develop a computerized matching system.

(d) The commission shall:

(1) verify automobile information that is used as criteria for eligibility; and

(2) establish a computerized matching system with the Texas Department of Criminal Justice to prevent an incarcerated individual from illegally receiving public assistance benefits administered by the commission.

(e) The commission shall submit to the governor and Legislative Budget Board an annual report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas

Department of Criminal Justice. The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1312 (S.B. 59), Sec. 38, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.144, eff. April 2, 2015.

Sec. 531.109. SELECTION AND REVIEW OF CLAIMS. (a) The commission shall annually select and review a random, statistically valid sample of all claims for reimbursement under Medicaid, including under the vendor drug program, for potential cases of fraud, waste, or abuse.

(b) In conducting the annual review of claims under Subsection (a), the commission may directly contact a recipient by telephone or in person, or both, to verify that the services for which a claim for reimbursement was submitted by a provider were actually provided to the recipient.

(c) Based on the results of the annual review of claims, the commission shall determine the types of claims at which commission resources for fraud and abuse detection should be primarily directed.

(d) Absent an allegation of fraud, waste, or abuse, the commission may conduct an annual review of claims under this section only after the commission has completed the prior year's annual review of claims.

Added by Acts 1999, 76th Leg., ch. 1289, Sec. 4, eff. Sept. 1, 1999.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.04(c), eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.145, eff. April 2, 2015.

The following section was amended by the 87th Legislature. Pending

publication of the current statutes, see S.B. 1341, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 531.110. ELECTRONIC DATA MATCHING PROGRAM. (a) The commission shall conduct electronic data matches for a Medicaid recipient at least quarterly to verify the identity, income, employment status, and other factors that affect the eligibility of the recipient.

(b) To verify eligibility of a recipient for Medicaid, the electronic data matching must match information provided by the recipient with information contained in databases maintained by appropriate federal and state agencies.

(c) The health and human services agencies shall cooperate with the commission by providing data or any other assistance necessary to conduct the electronic data matches required by this section.

(d) The commission may contract with a public or private entity to conduct the electronic data matches required by this section.

(e) The executive commissioner shall establish procedures by which the commission, or a health and human services agency designated by the commission, verifies the electronic data matches conducted by the commission under this section. Not later than the 20th day after the date the electronic data match is verified, the commission shall remove from eligibility a recipient who is determined to be ineligible for Medicaid.

(f) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(59), eff. June 17, 2011.

Added by Acts 1999, 76th Leg., ch. 1289, Sec. 4, eff. Sept. 1, 1999.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 21(8), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(59), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.146, eff. April 2, 2015.

Sec. 531.111. FRAUD DETECTION TECHNOLOGY. The commission may contract with a contractor who specializes in developing technology capable of identifying patterns of fraud exhibited by Medicaid recipients to:

(1) develop and implement the fraud detection technology; and

(2) determine if a pattern of fraud by Medicaid recipients is present in the recipients' eligibility files maintained by the commission.

Added by Acts 1999, 76th Leg., ch. 1289, Sec. 4, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.147, eff. April 2, 2015.

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

(b) The commission shall implement any methods the commission and the commission's office of inspector general determine are effective at strengthening fraud detection and deterrence.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 6(a), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.148, eff. April 2, 2015.

Sec. 531.112. EXPUNCTION OF INFORMATION RELATED TO CERTAIN CHEMICAL DEPENDENCY DIAGNOSES IN CERTAIN RECORDS. (a) In this section:

(1) "Chemical dependency" has the meaning assigned by Section 461A.002, Health and Safety Code.

(2) "Child" means a person 13 years of age or younger.

(b) Following the final conviction of a chemical dependency treatment provider for an offense, an element of which involves submitting a fraudulent claim for reimbursement for services under Medicaid, the commission or other health and human services agency that operates a portion of Medicaid shall expunge or provide for the expunction of a diagnosis of chemical dependency in a child that has been made by the treatment provider and entered in any:

(1) appropriate official record of the commission or agency;

(2) applicable medical record that is in the commission's or agency's custody; and

(3) applicable record of a company that the commission contracts with for the processing and payment of claims under Medicaid.

Added by Acts 2001, 77th Leg., ch. 1081, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.149, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.150, eff. April 2, 2015.

Sec. 531.113. MANAGED CARE ORGANIZATIONS: SPECIAL INVESTIGATIVE UNITS OR CONTRACTS. (a) Each managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program, including Medicaid and the child health plan program, shall:

(1) establish and maintain a special investigative unit within the managed care organization to investigate fraudulent claims and other types of program abuse by recipients and service providers; or

(2) contract with another entity for the investigation of fraudulent claims and other types of program abuse by recipients and service providers.

(b) Each managed care organization subject to this section shall adopt a plan to prevent and reduce fraud and abuse and annually file that plan with the commission's office of inspector

general for approval. The plan must include:

(1) a description of the managed care organization's procedures for detecting and investigating possible acts of fraud or abuse;

(2) a description of the managed care organization's procedures for the mandatory reporting of possible acts of fraud or abuse to the commission's office of inspector general;

(3) a description of the managed care organization's procedures for educating and training personnel to prevent fraud and abuse;

(4) the name, address, telephone number, and fax number of the individual responsible for carrying out the plan;

(5) a description or chart outlining the organizational arrangement of the managed care organization's personnel responsible for investigating and reporting possible acts of fraud or abuse;

(6) a detailed description of the results of investigations of fraud and abuse conducted by the managed care organization's special investigative unit or the entity with which the managed care organization contracts under Subsection (a)(2); and

(7) provisions for maintaining the confidentiality of any patient information relevant to an investigation of fraud or abuse.

(c) If a managed care organization contracts for the investigation of fraudulent claims and other types of program abuse by recipients and service providers under Subsection (a)(2), the managed care organization shall file with the commission's office of inspector general:

(1) a copy of the written contract;

(2) the names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the managed care organization has contracted; and

(3) a description of the qualifications of the principals of the entity with which the managed care organization has contracted.

(d) The commission's office of inspector general may review

the records of a managed care organization to determine compliance with this section.

(d-1) The commission's office of inspector general, in consultation with the commission, shall:

(1) investigate, including by means of regular audits, possible fraud, waste, and abuse by managed care organizations subject to this section;

(2) establish requirements for the provision of training to and regular oversight of special investigative units established by managed care organizations under Subsection (a)(1) and entities with which managed care organizations contract under Subsection (a)(2);

(3) establish requirements for approving plans to prevent and reduce fraud and abuse adopted by managed care organizations under Subsection (b);

(4) evaluate statewide fraud, waste, and abuse trends in Medicaid and communicate those trends to special investigative units and contracted entities to determine the prevalence of those trends;

(5) assist managed care organizations in discovering or investigating fraud, waste, and abuse, as needed; and

(6) provide ongoing, regular training to appropriate commission and office staff concerning fraud, waste, and abuse in a managed care setting, including training relating to fraud, waste, and abuse by service providers and recipients.

(e) The executive commissioner, in consultation with the office, shall adopt rules as necessary to accomplish the purposes of this section, including rules defining the investigative role of the commission's office of inspector general with respect to the investigative role of special investigative units established by managed care organizations under Subsection (a)(1) and entities with which managed care organizations contract under Subsection (a)(2). The rules adopted under this section must specify the office's role in:

(1) reviewing the findings of special investigative units and contracted entities;

(2) investigating cases in which the overpayment

amount sought to be recovered exceeds $100,000; and

(3) investigating providers who are enrolled in more than one managed care organization.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.25(a), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.151, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 6, eff. September 1, 2015.

Sec. 531.1131. FRAUD AND ABUSE RECOVERY BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) If a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) discovers fraud or abuse in Medicaid or the child health plan program, the organization or entity shall:

(1) immediately submit written notice to the commission's office of inspector general and the office of the attorney general in the form and manner prescribed by the office of inspector general and containing a detailed description of the fraud or abuse and each payment made to a provider as a result of the fraud or abuse;

(2) subject to Subsection (b), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with applicable rules adopted by the executive commissioner.

(b) If the amount sought to be recovered under Subsection (a)(2) exceeds $100,000, the managed care organization or the contracted entity described by Subsection (a) may not engage in payment recovery efforts if, not later than the 10th business day after the date the organization or entity notified the commission's office of inspector general and the office of the attorney general under Subsection (a)(1), the organization or entity receives a notice from either office indicating that the organization or entity is not authorized to proceed with recovery efforts.

(c) A managed care organization may retain one-half of any money recovered under Subsection (a)(2) by the organization or the contracted entity described by Subsection (a). The managed care organization shall remit the remaining amount of money recovered under Subsection (a)(2) to the commission's office of inspector general for deposit to the credit of the general revenue fund.

(c-1) If the commission's office of inspector general notifies a managed care organization under Subsection (b), proceeds with recovery efforts, and recovers all or part of the payments the organization identified as required by Subsection (a)(1), the organization is entitled to one-half of the amount recovered for each payment the organization identified after any applicable federal share is deducted. The organization may not receive more than one-half of the total amount of money recovered after any applicable federal share is deducted.

(c-2) Notwithstanding any provision of this section, if the commission's office of inspector general discovers fraud, waste, or abuse in Medicaid or the child health plan program in the performance of its duties, the office may recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this subchapter. All payments recovered by the office under this subsection shall be deposited to the credit of the general revenue fund.

(c-3) The commission's office of inspector general shall coordinate with appropriate managed care organizations to ensure that the office and an organization or an entity with which an organization contracts under Section 531.113(a)(2) do not both begin payment recovery efforts under this section for the same case of fraud, waste, or abuse.

(d) A managed care organization shall submit a quarterly report to the commission's office of inspector general detailing the amount of money recovered under Subsection (a)(2).

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by this section.

(f) In adopting rules establishing due process procedures

under Subsection (e), the executive commissioner shall require that a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) that engages in payment recovery efforts in accordance with this section and Section 531.1135 provide:

(1) written notice to a provider required to use electronic visit verification of the organization's intent to recoup overpayments in accordance with Section 531.1135; and

(2) a provider described by Subdivision (1) at least 60 days to cure any defect in a claim before the organization may begin any efforts to collect overpayments.

Added by Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 7, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.152, eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 277 (H.B. 2379), Sec. 6, eff. May 29, 2017.

Acts 2019, 86th Leg., R.S., Ch. 667 (S.B. 1991), Sec. 2, eff. September 1, 2019.

Sec. 531.1132. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Not later than December 1 of each year, the commission shall prepare and submit a report to the legislature relating to the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Sections 531.113 and 531.1131 by special investigative units or entities with which a managed care organization contracts under Section 531.113(a)(2). The report must specify the amount of money retained by each managed care organization under Section 531.1131(c).

Added by Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 7, eff. September 1, 2011.

Sec. 531.1135. MANAGED CARE ORGANIZATIONS: PROCESS TO RECOUP CERTAIN OVERPAYMENTS. (a) The executive commissioner shall adopt rules that standardize the process by which a managed care organization collects alleged overpayments that are made to a

health care provider and discovered through an audit or investigation conducted by the organization secondary to missing electronic visit verification information. In adopting rules under this section, the executive commissioner shall require that the managed care organization:

(1) provide written notice of the organization's intent to recoup overpayments not later than the 30th day after the date an audit is complete; and

(2) limit the duration of audits to 24 months.

(b) The executive commissioner shall require that the notice required under this section inform the provider:

(1) of the specific claims and electronic visit verification transactions that are the basis of the overpayment;

(2) of the process the provider should use to communicate with the managed care organization to provide information about the electronic visit verification transactions;

(3) of the provider's option to seek an informal resolution of the alleged overpayment;

(4) of the process to appeal the determination that an overpayment was made; and

(5) if the provider intends to respond to the notice, that the provider must respond not later than the 30th day after the date the provider receives the notice.

(c) Notwithstanding any other law, a managed care organization may not attempt to recover an overpayment described by Subsection (a) until the provider has exhausted all rights to an appeal.

Added by Acts 2019, 86th Leg., R.S., Ch. 667 (S.B. 1991), Sec. 3, eff. September 1, 2019.

Sec. 531.114. FINANCIAL ASSISTANCE FRAUD. (a) For purposes of establishing or maintaining the eligibility of a person and the person's family for financial assistance under Chapter 31, Human Resources Code, or for purposes of increasing or preventing a reduction in the amount of that assistance, a person may not intentionally:

(1) make a statement that the person knows is false or

misleading;

(2) misrepresent, conceal, or withhold a fact; or

(3) knowingly misrepresent a statement as being true.

(b) If after an investigation the commission determines that a person violated Subsection (a), the commission shall:

(1) notify the person of the alleged violation not later than the 30th day after the date the commission completes the investigation and provide the person with an opportunity for a hearing on the matter; or

(2) refer the matter to the appropriate prosecuting attorney for prosecution.

(c) If a person waives the right to a hearing or if a hearing officer at an administrative hearing held under this section determines that a person violated Subsection (a), the person is ineligible to receive financial assistance as provided by Subsection (d). A person who a hearing officer determines violated Subsection (a) may appeal that determination by filing a petition in the district court in the county in which the violation occurred not later than the 30th day after the date the hearing officer made the determination.

(d) A person determined under Subsection (c) to have violated Subsection (a) is not eligible for financial assistance:

(1) before the first anniversary of the date of that determination, if the person has no previous violations; and

(2) permanently, if the person was previously determined to have committed a violation.

(e) If a person is convicted of a state or federal offense for conduct described by Subsection (a), or if the person is granted deferred adjudication or placed on community supervision for that conduct, the person is permanently disqualified from receiving financial assistance.

(f) This section does not affect the eligibility for financial assistance of any other member of the household of a person ineligible as a result of Subsection (d) or (e).

(g) The executive commissioner shall adopt rules as necessary to implement this section.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.26(a), eff. Sept. 1,

2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.153, eff. April 2, 2015.

Sec. 531.115. FEDERAL FELONY MATCH. The commission shall develop and implement a system to cross-reference data collected for the programs listed under Section 531.008(c) with the list of fugitive felons maintained by the federal government.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.27, eff. Sept. 1, 2003.

Sec. 531.116. COMPLIANCE WITH LAW PROHIBITING SOLICITATION. A provider who furnishes services under Medicaid or the child health plan program is subject to Chapter 102, Occupations Code, and the provider's compliance with that chapter is a condition of the provider's eligibility to participate as a provider under those programs.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.28, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.154, eff. April 2, 2015.

Sec. 531.117. RECOVERY AUDIT CONTRACTORS. To the extent required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), the commission shall establish a program under which the commission contracts with one or more recovery audit contractors for purposes of identifying underpayments and overpayments under Medicaid and recovering the overpayments.

Added by Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 7, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.155, eff. April 2, 2015.

Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF

FRAUD OR ABUSE AND FRAUD REFERRALS. (a) The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 531.1021(g) and is subject to Section 531.1021(h).

(b) If the commission receives an allegation of fraud or abuse against a provider from any source, the commission's office of inspector general shall conduct a preliminary investigation of the allegation to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day, and be completed not later than the 45th day, after the date the commission receives or identifies an allegation of fraud or abuse.

(c) In conducting a preliminary investigation, the office must review the allegations of fraud or abuse and all facts and evidence relating to the allegation and must prepare a preliminary investigation report before the allegation of fraud or abuse may proceed to a full investigation. The preliminary investigation report must document the allegation, the evidence reviewed, if available, the procedures used to conduct the preliminary investigation, the findings of the preliminary investigation, and the office's determination of whether a full investigation is warranted.

(d) If the state's Medicaid fraud control unit or any other law enforcement agency accepts a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud may be continued until:

(1) that investigation and any associated enforcement proceedings are complete; or

(2) the state's Medicaid fraud control unit, another law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(e) If the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless the commission has

alternative federal or state authority under which it may impose a payment hold or the office makes a fraud referral to another law enforcement agency.

(f) On a quarterly basis, the office must request a certification from the state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter accepted by the unit or agency on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted.

Added by Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 3, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 7, eff. September 1, 2015.

Sec. 531.119. WEBSITE POSTING. The commission's office of inspector general shall post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider under this subchapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 3, eff. September 1, 2013.

Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the commission's office of inspector general shall provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation. The notice must include:

(1) the specific basis for the overpayment or debt;

(2) a description of facts and supporting evidence;

(3) a representative sample of any documents that form the basis for the overpayment or debt;

(4) the extrapolation methodology;

(4-a) information relating to the extrapolation methodology used as part of the investigation and the methods used

to determine the overpayment or debt in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and are fully reproducible;

(5) the calculation of the overpayment or debt amount;

(6) the amount of damages and penalties, if applicable; and

(7) a description of administrative and judicial due process remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both.

(b) A provider may request an informal resolution meeting under this section, and on receipt of the request, the office shall schedule the informal resolution meeting. The office shall give notice to the provider of the time and place of the informal resolution meeting. The informal resolution process shall run concurrently with the administrative hearing process, and the administrative hearing process may not be delayed on account of the informal resolution process.

(c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid.

Added by Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 3, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 8, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 3, eff. September 1, 2017.

Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) A provider must request an appeal under this section not later than the 30th day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider. On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of

debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall file the docketing request under this section not later than the 60th day after the date of the provider's request for an administrative hearing or not later than the 60th day after the completion of the informal resolution process, if applicable.

(b) The commission's office of inspector general is responsible for the costs of an administrative hearing held under Subsection (a), but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(c) Repealed by Acts 2015, 84th Leg., R.S., Ch. 945 , Sec. 13(1), eff. September 1, 2015.

(d) Following an administrative hearing under Subsection (a), a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

Added by Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 3, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 9, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 13(1), eff. September 1, 2015.

Sec. 531.1202. RECORD AND CONFIDENTIALITY OF INFORMAL RESOLUTION MEETINGS. (a) On the written request of the provider, the commission shall, at no expense to the provider who requested the meeting, provide for an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) to be recorded. The recording of an informal resolution meeting shall be made available to the provider who requested the meeting. The commission may not record an informal resolution meeting unless the commission receives a

written request from a provider under this subsection.

(b) Notwithstanding Section 531.1021(g) and except as provided by this section, an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) is confidential, and any information or materials obtained by the commission's office of inspector general, including the office's employees or the office's agents, during or in connection with an informal resolution meeting, including a recording made under Subsection (a), are privileged and confidential and not subject to disclosure under Chapter 552 or any other means of legal compulsion for release, including disclosure, discovery, or subpoena.

Added by Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 3, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 10, eff. September 1, 2015.

Sec. 531.1203. RIGHTS OF AND PROVISION OF INFORMATION TO PHARMACIES SUBJECT TO CERTAIN AUDITS. (a) A pharmacy has a right to request an informal hearing before the commission's appeals division to contest the findings of an audit conducted by the commission's office of inspector general or an entity that contracts with the federal government to audit Medicaid providers if the findings of the audit do not include findings that the pharmacy engaged in Medicaid fraud.

(b) In an informal hearing held under this section, staff of the commission's appeals division, assisted by staff responsible for the commission's vendor drug program who have expertise in the law governing pharmacies' participation in Medicaid, make the final decision on whether the findings of an audit are accurate. Staff of the commission's office of inspector general may not serve on the panel that makes the decision on the accuracy of an audit.

(c) In order to increase transparency, the commission's office of inspector general shall, if the office has access to the information, provide to pharmacies that are subject to audit by the office, or by an entity that contracts with the federal government to audit Medicaid providers, information relating to the

extrapolation methodology used as part of the audit and the methods used to determine whether the pharmacy has been overpaid under Medicaid in sufficient detail so that the audit results may be demonstrated to be statistically valid and are fully reproducible.

Added by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 11, eff. September 1, 2015.

SUBCHAPTER D. PLAN TO SUPPORT GUARDIANSHIPS

Sec. 531.121. DEFINITIONS. In this subchapter:

(1) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec. 3.40(a)(7), and Ch. 946 , Sec. 2.37(b)(7), eff. January 1, 2016.

(2) "Guardian" has the meaning assigned by Section 1002.012, Estates Code.

(3) "Guardianship program" has the meaning assigned by Section 111.001.

(4) "Incapacitated individual" means an incapacitated person as defined by Section 1002.017, Estates Code.

(5) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec. 3.40(a)(7), and Ch. 946 , Sec. 2.37(b)(7), eff. January 1, 2016.

(6) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec. 3.40(a)(7), and Ch. 946 , Sec. 2.37(b)(7), eff. January 1, 2016.

Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997.

Amended by:

Acts 2005, 79th Leg., Ch. 268 (S.B. 6), Sec. 3.19, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.156, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(7), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(b)(7), eff. January 1, 2016.

Sec. 531.124. COMMISSION DUTIES. The commission shall

develop and, subject to appropriations, implement a plan to:

(1) ensure that each incapacitated individual in this state who needs a guardianship or another less restrictive type of assistance to make decisions concerning the incapacitated individual's own welfare and financial affairs receives that assistance; and

(2) foster the establishment and growth of local volunteer guardianship programs.

Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997.

Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 5.03, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 268 (S.B. 6), Sec. 3.23, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 4, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.10, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.10, eff. January 1, 2016.

Sec. 531.125. GRANTS. (a) The commission in accordance with commission rules may award grants to:

(1) a local guardianship program, subject to the requirements of this section; and

(2) a local legal guardianship program to enable low-income family members and friends to have legal representation in court if they are willing and able to be appointed guardians of proposed wards who are indigent.

(b) To receive a grant under Subsection (a)(1), a local guardianship program operating in a county that has a population of at least 150,000 must offer or submit a plan acceptable to the commission to offer, among the program's services, a money management service for appropriate clients, as determined by the program. The local guardianship program may provide the money management service directly or by referring a client to a money management service that satisfies the requirements under

Subsection (c).

(c) A money management service to which a local guardianship program may refer a client must:

(1) use employees or volunteers to provide bill payment or representative payee services;

(2) provide the service's employees and volunteers with training, technical support, monitoring, and supervision;

(3) match employees or volunteers with clients in a manner that ensures that the match is agreeable to both the employee or volunteer and the client;

(4) insure each employee and volunteer, and hold the employee or volunteer harmless from liability, for damages proximately caused by acts or omissions of the employee or volunteer while acting in the course and scope of the employee's or volunteer's duties or functions within the organization;

(5) have an advisory council that meets regularly and is composed of persons who are knowledgeable with respect to issues related to guardianship, alternatives to guardianship, and related social services programs;

(6) be administered by a nonprofit corporation:

(A) formed under the Texas Nonprofit Corporation Law, as described by Section 1.008, Business Organizations Code; and

(B) exempt from federal taxation under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt entity under Section 501(c)(3) of that code; and

(7) refer clients who are in need of other services from an area agency on aging to the appropriate area agency on aging.

(d) A local guardianship program operating in a county that has a population of less than 150,000 may, at the program's option, offer, either directly or by referral, a money management service among the program's services. If the program elects to offer a money management service by referral, the service must satisfy the requirements under Subsection (c), except as provided by Subsection (e).

(e) On request by a local guardianship program, the

commission may waive a requirement under Subsection (c) if the commission determines that the waiver is appropriate to strengthen the continuum of local guardianship programs in a geographic area.

Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997.

Amended by Acts 1999, 76th Leg., ch. 1116, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 734 (H.B. 2691), Sec. 1, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.158, eff. April 2, 2015.

SUBCHAPTER D-1. PERMANENCY PLANNING

Sec. 531.151. DEFINITIONS. In this subchapter:

(1) "Child" means a person with a developmental disability who is younger than 22 years of age.

(2) "Community resource coordination group" means a coordination group established under the memorandum of understanding adopted under Section 531.055.

(3) "Institution" means:

(A) an ICF-IID, as defined by Section 531.002, Health and Safety Code;

(B) a group home operated under the authority of the commission, including a residential service provider under a Medicaid waiver program authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended, that provides services at a residence other than the child's home or agency foster home;

(C) a nursing facility;

(D) a general residential operation for children with an intellectual disability that is licensed by the commission; or

(E) another residential arrangement other than a foster home as defined by Section 42.002, Human Resources Code, that provides care to four or more children who are unrelated to each other.

(4) "Permanency planning" means a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 1276, Sec. 9.010, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.159, eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 317 (H.B. 7), Sec. 39, eff. September 1, 2017.

Sec. 531.152. POLICY STATEMENT. It is the policy of the state to strive to ensure that the basic needs for safety, security, and stability are met for each child in Texas. A successful family is the most efficient and effective way to meet those needs. The state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.1521. PREADMISSION INFORMATION. (a) The executive commissioner by rule shall develop and implement a system by which the Department of Aging and Disability Services ensures that, for each child with respect to whom the department or a local intellectual and developmental disability authority is notified of a request for placement in an institution, the child's parent or guardian is fully informed before the child is placed in the institution of all community-based services and any other service and support options for which the child may be eligible. The system must be designed to ensure that the department provides the information through:

(1) a local intellectual and developmental disability authority;

(2) any private entity that has knowledge and expertise regarding the needs of and full spectrum of care options available to children with disabilities as well as the philosophy and purpose of permanency planning; or

(3) a department employee.

(b) An institution in which a child's parent or guardian is considering placing the child may provide information required under Subsection (a), but the information must also be provided by a local intellectual and developmental disability authority, private entity, or employee of the Department of Aging and Disability Services as required by Subsection (a).

(c) The Department of Aging and Disability Services shall develop comprehensive information consistent with the policy stated in Section 531.152 to explain to a parent or guardian considering placing a child in an institution:

(1) options for community-based services;

(2) the benefits to the child of living in a family or community setting;

(3) that the placement of the child in an institution is considered temporary in accordance with Section 531.159; and

(4) that an ongoing permanency planning process is required under this subchapter and other state law.

(d) Except as otherwise provided by this subsection and Subsection (e), the Department of Aging and Disability Services shall ensure that, not later than the 14th working day after the date the department is notified of a request for the placement of a child in an institution, the child's parent or guardian is provided the information described by Subsections (a) and (c). The department may provide the information after the 14th working day after the date the department is notified of the request if the child's parent or guardian waives the requirement that the information be provided within the period otherwise required by this subsection.

(e) The requirements of this section do not apply to a request for the placement of a child in an institution if the child:

(1) is involved in an emergency situation, as defined by rules adopted by the executive commissioner; or

(2) has been committed to an institution under Chapter 46B, Code of Criminal Procedure, or Chapter 55, Family Code.

Added by Acts 2005, 79th Leg., Ch. 1131 (H.B. 2579), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.160, eff. April 2, 2015.

Sec. 531.153. DEVELOPMENT OF PERMANENCY PLAN. (a) To further the policy stated in Section 531.152 and except as provided by Subsection (b), the commission and each appropriate health and human services agency shall develop procedures to ensure that a permanency plan is developed for each child who resides in an institution in this state on a temporary or long-term basis or with respect to whom the commission or appropriate health and human services agency is notified in advance that institutional care is sought.

(b) The Department of Family and Protective Services shall develop a permanency plan as required by this subchapter for each child who resides in an institution in this state for whom the department has been appointed permanent managing conservator. The department is not required to develop a permanency plan under this subchapter for a child for whom the department has been appointed temporary managing conservator, but may incorporate the requirements of this subchapter in a permanency plan developed for the child under Section 263.3025, Family Code.

(c) In developing procedures under Subsection (a), the commission and other appropriate health and human services agencies shall develop to the extent possible uniform procedures applicable to each of the agencies and each child who is the subject of a permanency plan that promote efficiency for the agencies and stability for each child.

(d) In implementing permanency planning procedures under Subsection (a) to develop a permanency plan for each child, the Department of Aging and Disability Services shall:

(1) delegate the department's duty to develop a permanency plan to a local intellectual and developmental disability authority, as defined by Section 531.002, Health and Safety Code, or enter into a memorandum of understanding with the local intellectual and developmental disability authority to develop the permanency plan for each child who resides in an institution in this state or with respect to whom the department is notified in advance that institutional care is sought;

(2) contract with a private entity, other than an entity that provides long-term institutional care, to develop a permanency plan for a child who resides in an institution in this state or with respect to whom the department is notified in advance that institutional care is sought; or

(3) perform the department's duties regarding permanency planning procedures using department personnel.

(d-1) A contract or memorandum of understanding under Subsection (d) must include performance measures by which the Department of Aging and Disability Services may evaluate the effectiveness of a local intellectual and developmental disability authority's or private entity's permanency planning efforts.

(d-2) In implementing permanency planning procedures under Subsection (a) to develop a permanency plan for each child, the Department of Aging and Disability Services shall engage in appropriate activities in addition to those required by Subsection (d) to minimize the potential conflicts of interest that, in developing the plan, may exist or arise between:

(1) the institution in which the child resides or in which institutional care is sought for the child; and

(2) the best interest of the child.

(e) The commission, the Department of Aging and Disability Services, and the Department of Family and Protective Services may solicit and accept gifts, grants, and donations to support the development of permanency plans for children residing in institutions by individuals or organizations not employed by or affiliated with those institutions.

(f) A health and human services agency that contracts with a private entity under Subsection (d) to develop a permanency plan

shall ensure that the entity is provided training regarding the permanency planning philosophy under Section 531.151 and available resources that will assist a child residing in an institution in making a successful transition to a community-based residence.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997.

Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 783 (S.B. 40), Sec. 1, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.161, eff. April 2, 2015.

Sec. 531.1531. ASSISTANCE WITH PERMANENCY PLANNING EFFORTS. An institution in which a child resides shall assist with providing effective permanency planning for the child by:

(1) cooperating with the health and human services agency, local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan; and

(2) participating in meetings to review the child's permanency plan as requested by a health and human services agency, local intellectual and developmental disability authority, or private entity responsible for developing the child's permanency plan.

Added by Acts 2005, 79th Leg., Ch. 783 (S.B. 40), Sec. 2, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.162, eff. April 2, 2015.

Sec. 531.1532. INTERFERENCE WITH PERMANENCY PLANNING EFFORTS. An entity that provides information to a child's parent or guardian relating to permanency planning shall refrain from providing the child's parent or guardian with inaccurate or misleading information regarding the risks of moving the child to another facility or community setting.

Added by Acts 2005, 79th Leg., Ch. 783 (S.B. 40), Sec. 2, eff. September 1, 2005.

Sec. 531.1533. REQUIREMENTS ON ADMISSIONS OF CHILDREN TO CERTAIN INSTITUTIONS. On the admission of a child to an institution described by Section 531.151(3)(A), (B), or (D), the Department of Aging and Disability Services shall require the child's parent or guardian to submit:

(1) an admission form that includes:

(A) the parent's or guardian's:

(i) name, address, and telephone number;

(ii) driver's license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(iii) place of employment and the employer's address and telephone number; and

(B) the name, address, and telephone number of a relative of the child or other person whom the department or institution may contact in an emergency, a statement indicating the relation between that person and the child, and at the parent's or guardian's option, that person's:

(i) driver's license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer; and

(2) a signed acknowledgment of responsibility stating that the parent or guardian agrees to:

(A) notify the institution in which the child is placed of any changes to the information submitted under Subdivision (1)(A); and

(B) make reasonable efforts to participate in the child's life and in planning activities for the child.

Added by Acts 2005, 79th Leg., Ch. 1131 (H.B. 2579), Sec. 1, eff. September 1, 2005.

Renumbered from Government Code, Section 531.1532 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(37), eff.

September 1, 2007.

Sec. 531.154. NOTIFICATION REQUIRED. (a) Not later than the third day after the date a child is initially placed in an institution, the institution shall notify:

(1) the Department of Aging and Disability Services, if the child is placed in a nursing facility;

(2) the local intellectual and developmental disability authority, as defined by Section 531.002, Health and Safety Code, where the institution is located, if the child:

(A) is placed in an ICF-IID, as defined by Section 531.002, Health and Safety Code; or

(B) is placed by a child protective services agency in a general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services;

(3) the community resource coordination group in the county of residence of a parent or guardian of the child;

(4) if the child is at least three years of age, the school district for the area in which the institution is located; and

(5) if the child is less than three years of age, the local early childhood intervention program for the area in which the institution is located.

(b) The Department of Aging and Disability Services shall notify the local intellectual and developmental disability authority, as defined by Section 531.002, Health and Safety Code, of a child's placement in a nursing facility if the child is known or suspected to have an intellectual disability or another disability for which the child may receive services through the Department of Aging and Disability Services.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997.

Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.163, eff. April 2, 2015.

Sec. 531.155. OFFER OF SERVICES. Each entity receiving notice of the initial placement of a child in an institution under Section 531.154 may contact the child's parent or guardian to ensure that the parent or guardian is aware of:

(1) services and support that could provide alternatives to placement of the child in the institution;

(2) available placement options; and

(3) opportunities for permanency planning.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997.
Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.156. DESIGNATION OF ADVOCATE. (a) The Department of Aging and Disability Services shall designate a person, including a member of a community-based organization, to serve as a volunteer advocate for a child residing in an institution to assist in developing a permanency plan for the child if:

(1) the child's parent or guardian requests the assistance of an advocate;

(2) the institution in which the child is placed cannot locate the child's parent or guardian; or

(3) the child resides in an institution operated by the department.

(b) The person designated to serve as the child's volunteer advocate under this section may be:

(1) a person selected by the child's parent or guardian, except that the person may not be employed by or under a contract with the institution in which the child resides;

(2) an adult relative of the child; or

(3) a representative of a child advocacy group.

(c) The Department of Aging and Disability Services shall provide to each person designated to serve as a child's volunteer advocate information regarding permanency planning under this subchapter.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.164, eff. April 2, 2015.

Sec. 531.157. COMMUNITY-BASED SERVICES. A state agency that receives notice of a child's placement in an institution shall ensure that, on or before the third day after the date the agency is notified of the child's placement in the institution, the child is also placed on a waiting list for waiver program services under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended, appropriate to the child's needs.
Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.158. LOCAL PERMANENCY PLANNING SITES. The commission shall develop an implementation system that consists initially of four or more local sites and that is designed to coordinate planning for a permanent living arrangement and relationship for a child with a family. In developing the system, the commission shall:

(1) include criteria to identify children who need permanency plans;

(2) require the establishment of a permanency plan for each child who lives outside the child's family or for whom care or protection is sought in an institution;

(3) include a process to determine the agency or entity responsible for developing and overseeing implementation of a child's permanency plan;

(4) identify, blend, and use funds from all available sources to provide customized services and programs to implement a child's permanency plan;

(5) clarify and expand the role of a local community resource coordination group in ensuring accountability for a child who resides in an institution or who is at risk of being placed in an institution;

(6) require reporting of each placement or potential placement of a child in an institution or other living arrangement outside of the child's home; and

(7) assign in each local permanency planning site area

a single gatekeeper for all children in the area for whom placement in an institution through a program funded by the state is sought with authority to ensure that:

(A) family members of each child are aware of:

(i) intensive services that could prevent placement of the child in an institution; and

(ii) available placement options; and

(B) permanency planning is initiated for each child.

Added by Acts 1997, 75th Leg., ch. 421, Sec. 1, eff. May 23, 1997. Renumbered from Sec. 531.154 by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.159. MONITORING OF PERMANENCY PLANNING EFFORTS. (a) The commission and each appropriate health and human services agency shall require a person who develops a permanency plan for a child residing in an institution to identify and document in the child's permanency plan all ongoing permanency planning efforts at least semiannually to ensure that, as soon as possible, the child will benefit from a permanent living arrangement with an enduring and nurturing parental relationship.

(b) The chief executive officer of each appropriate health and human services agency or the officer's designee must approve the placement of a child in an institution. The initial placement of the child in the institution is temporary and may not exceed six months unless the appropriate chief executive officer or the officer's designee approves an extension of an additional six months after conducting a review of documented permanency planning efforts to unite the child with a family in a permanent living arrangement. After the initial six-month extension of a child's placement in an institution approved under this subsection, the chief executive officer or the officer's designee shall conduct a review of the child's placement in the institution at least semiannually to determine whether a continuation of that placement is warranted. If, based on the review, the chief executive officer or the officer's designee determines that an additional extension is warranted, the officer or the officer's designee shall recommend

to the executive commissioner that the child continue residing in the institution.

(c) On receipt of a recommendation made under Subsection (b) for an extension of a child's placement, the executive commissioner, the executive commissioner's designee, or another person with whom the commission contracts shall conduct a review of the child's placement. Based on the results of the review, the executive commissioner or the executive commissioner's designee may approve a six-month extension of the child's placement if the extension is appropriate.

(d) The child may continue residing in the institution after the six-month extension approved under Subsection (c) only if the chief executive officer of the appropriate health and human services agency or the officer's designee makes subsequent recommendations as provided by Subsection (b) for each additional six-month extension and the executive commissioner or the executive commissioner's designee approves each extension as provided by Subsection (c).

(e) The executive commissioner or the executive commissioner's designee shall conduct a semiannual review of data received from health and human services agencies regarding all children who reside in institutions in this state. The executive commissioner, the executive commissioner's designee, or a person with whom the commission contracts shall also review the recommendations of the chief executive officers of each appropriate health and human services agency or the officer's designee if the officer or the officer's designee repeatedly recommends that children continue residing in an institution.

(f) The executive commissioner by rule shall develop procedures by which to conduct the reviews required by Subsections (c), (d), and (e). In developing the procedures, the commission may seek input from the work group on children's long-term services, health services, and mental health services established under Section 22.035, Human Resources Code.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 388 (S.B. 50), Sec. 2, eff.

September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.165, eff. April 2, 2015.

Sec. 531.1591. ANNUAL REAUTHORIZATION OF PLANS OF CARE FOR CERTAIN CHILDREN. (a) The executive commissioner shall adopt rules under which the Department of Aging and Disability Services requires a nursing facility in which a child resides to request from the child's parent or guardian a written reauthorization of the child's plan of care.

(b) The rules adopted under this section must require that the written reauthorization be requested annually.

Added by Acts 2005, 79th Leg., Ch. 1131 (H.B. 2579), Sec. 1, eff. September 1, 2005.

Sec. 531.160. INSPECTIONS. As part of each inspection, survey, or investigation of an institution, including a nursing facility, general residential operation for children with an intellectual disability that is licensed by the Department of Family and Protective Services, or ICF-IID, as defined by Section 531.002, Health and Safety Code, in which a child resides, the agency or the agency's designee shall determine the extent to which the nursing facility, general residential operation, or ICF-IID is complying with the permanency planning requirements under this subchapter.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.166, eff. April 2, 2015.

Sec. 531.161. ACCESS TO RECORDS. Each institution in which a child resides shall allow the following to have access to the child's records to assist in complying with the requirements of this subchapter:

(1) the commission;

(2) appropriate health and human services agencies; and

(3) to the extent not otherwise prohibited by state or federal confidentiality laws, a local intellectual and developmental disability authority or private entity that enters into a contract or memorandum of understanding under Section 531.153(d) to develop a permanency plan for the child.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 783 (S.B. 40), Sec. 3, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.167, eff. April 2, 2015.

Sec. 531.162. PERMANENCY REPORTING. (a) For each of the local permanency planning sites, the commission shall develop a reporting system under which each appropriate health and human services agency responsible for permanency planning under this subchapter is required to provide to the commission semiannually:

(1) the number of permanency plans developed by the agency for children residing in institutions or children at risk of being placed in institutions;

(2) progress achieved in implementing permanency plans;

(3) the number of children served by the agency residing in institutions;

(4) the number of children served by the agency at risk of being placed in an institution served by the local permanency planning sites;

(5) the number of children served by the agency reunited with their families or placed with alternate permanent families; and

(6) cost data related to the development and implementation of permanency plans.

(b) The executive commissioner shall submit a semiannual report to the governor and the committees of each house of the legislature that have primary oversight jurisdiction over health and human services agencies regarding:

(1) the number of children residing in institutions in

this state and, of those children, the number for whom a recommendation has been made for a transition to a community-based residence but who have not yet made that transition;

(2) the circumstances of each child described by Subdivision (1), including the type of institution and name of the institution in which the child resides, the child's age, the residence of the child's parents or guardians, and the length of time in which the child has resided in the institution;

(3) the number of permanency plans developed for children residing in institutions in this state, the progress achieved in implementing those plans, and barriers to implementing those plans;

(4) the number of children who previously resided in an institution in this state and have made the transition to a community-based residence;

(5) the number of children who previously resided in an institution in this state and have been reunited with their families or placed with alternate families;

(6) the community supports that resulted in the successful placement of children described by Subdivision (5) with alternate families; and

(7) the community supports that are unavailable but necessary to address the needs of children who continue to reside in an institution in this state after being recommended to make a transition from the institution to an alternate family or community-based residence.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Renumbered from Sec. 531.155 and amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.168, eff. April 2, 2015.

Sec. 531.163. EFFECT ON OTHER LAW. This subchapter does not affect responsibilities imposed by federal or other state law on a physician or other professional.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.164. DUTIES OF CERTAIN INSTITUTIONS. (a) This section applies only to an institution described by Section 531.151(3)(A), (B), or (D).

(b) An institution described by Section 531.151(3)(A) or (B) shall notify the local intellectual and developmental disability authority for the region in which the institution is located of a request for placement of a child in the institution. An institution described by Section 531.151(3)(D) shall notify the Department of Aging and Disability Services of a request for placement of a child in the institution.

(c) An institution must make reasonable accommodations to promote the participation of the parent or guardian of a child residing in the institution in all planning and decision-making regarding the child's care, including participation in:

(1) the initial development of the child's permanency plan and periodic review of the plan;

(2) an annual review and reauthorization of the child's service plan;

(3) decision-making regarding the child's medical care;

(4) routine interdisciplinary team meetings; and

(5) decision-making and other activities involving the child's health and safety.

(d) Reasonable accommodations that an institution must make under this section include:

(1) conducting a meeting in person or by telephone, as mutually agreed upon by the institution and the parent or guardian;

(2) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the institution and the parent or guardian;

(3) if a parent or guardian has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.), including providing an accessible meeting location or a sign language interpreter, as applicable; and

(4) providing a language interpreter, if applicable.

(e) Except as otherwise provided by Subsection (f):

(1) an ICF-IID must:

(A) attempt to notify the parent or guardian of a child who resides in the ICF-IID in writing of a periodic permanency planning meeting or annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian; and

(2) a nursing facility must:

(A) attempt to notify the parent or guardian of a child who resides in the facility in writing of an annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian.

(f) If an emergency situation involving a child residing in an ICF-IID or nursing facility occurs, the ICF-IID or nursing facility, as applicable, must:

(1) attempt to notify the child's parent or guardian as soon as possible; and

(2) request a response from the parent or guardian.

(g) If a child's parent or guardian does not respond to a notice under Subsection (e) or (f), the ICF-IID or nursing facility, as applicable, must attempt to locate the parent or guardian by contacting another person whose information was provided by the parent or guardian under Section 531.1533(1)(B).

(h) Not later than the 30th day after the date an ICF-IID or nursing facility determines that it is unable to locate a child's parent or guardian for participation in activities listed under Subsection (e)(1) or (2), the ICF-IID or nursing facility must notify the Department of Aging and Disability Services of that determination and request that the department initiate a search for the child's parent or guardian.

Added by Acts 2005, 79th Leg., Ch. 1131 (H.B. 2579), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.002(7), eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.169, eff. April 2, 2015.

Sec. 531.165. SEARCH FOR PARENT OR GUARDIAN OF A CHILD. (a) The Department of Aging and Disability Services shall develop and implement a process by which the department, on receipt of notification under Section 531.164(h) that a child's parent or guardian cannot be located, conducts a search for the parent or guardian. If, on the first anniversary of the date the department receives the notification under Section 531.164(h), the department has been unsuccessful in locating the parent or guardian, the department shall refer the case to:

(1) the child protective services division of the Department of Family and Protective Services if the child is 17 years of age or younger; or

(2) the adult protective services division of the Department of Family and Protective Services if the child is 18 years of age or older.

(b) On receipt of a referral under Subsection (a)(1), the child protective services division of the Department of Family and Protective Services shall exercise intense due diligence in attempting to locate the child's parent or guardian. If the division is unable to locate the child's parent or guardian, the department shall file a suit affecting the parent-child relationship requesting an order appointing the department as the child's temporary managing conservator.

(c) A child is considered abandoned for purposes of the Family Code if the child's parent or guardian cannot be located following the exercise of intense due diligence in attempting to locate the parent or guardian by the Department of Family and Protective Services under Subsection (b).

(d) On receipt of a referral under Subsection (a)(2), the adult protective services division of the Department of Family and Protective Services shall notify the court that appointed the child's guardian that the guardian cannot be located.

Added by Acts 2005, 79th Leg., Ch. 1131 (H.B. 2579), Sec. 1, eff. September 1, 2005.

Sec. 531.166. TRANSFER OF CHILD BETWEEN INSTITUTIONS. (a) This section applies only to an institution described by Section 531.151(3)(A), (B), or (D) in which a child resides.

(b) Before transferring a child who is 17 years of age or younger, or a child who is at least 18 years of age and for whom a guardian has been appointed, from one institution to another institution, the institution in which the child resides must attempt to obtain consent for the transfer from the child's parent or guardian unless the transfer is in response to an emergency situation, as defined by rules adopted by the executive commissioner.

Added by Acts 2005, 79th Leg., Ch. 1131 (H.B. 2579), Sec. 1, eff. September 1, 2005.

Sec. 531.167. COLLECTION OF INFORMATION REGARDING INVOLVEMENT OF CERTAIN PARENTS AND GUARDIANS. (a) The Department of Aging and Disability Services shall collect and maintain aggregate information regarding the involvement of parents and guardians of children residing in institutions described by Sections 531.151(3)(A), (B), and (D) in the lives of and planning activities relating to those children. The department shall obtain input from stakeholders concerning the types of information that are most useful in assessing the involvement of those parents and guardians.

(b) The Department of Aging and Disability Services shall make the aggregate information available to the public on request.

Added by Acts 2005, 79th Leg., Ch. 1131 (H.B. 2579), Sec. 1, eff. September 1, 2005.

SUBCHAPTER E. HEALTH AND HUMAN SERVICES LEGISLATIVE OVERSIGHT

Sec. 531.171. COMMITTEE DUTIES. (a) The standing or other committees of the house of representatives and the senate that have jurisdiction over the commission and other agencies relating to

implementation of this chapter, as identified by the speaker of the house of representatives and the lieutenant governor, shall:

(1) monitor the commission's implementation of Section 531.0055 and the commission's other duties in consolidating and integrating health and human services to ensure implementation consistent with law;

(2) recommend, as needed, adjustments to the implementation of Section 531.0055 and the commission's other duties in consolidating and integrating health and human services; and

(3) review the rulemaking process used by the commission, including the commission's plan for obtaining public input.

(b) The commission shall provide copies of all required reports to the committees and shall provide the committees with copies of proposed rules before the rules are published in the Texas Register. At the request of a committee or the executive commissioner, a health and human services agency shall provide other information to the committee, including information relating to the health and human services system, and shall report on agency progress in implementing statutory directives identified by the committee and the directives of the commission.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 11.01, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.170, eff. April 2, 2015.

SUBCHAPTER F. TEXAS INTEGRATED ENROLLMENT SERVICES

Sec. 531.191. INTEGRATED ELIGIBILITY DETERMINATION. (a) The commission, subject to the approval of the governor and the Legislative Budget Board, shall develop and implement a plan for the integration of services and functions relating to eligibility determination and service delivery by health and human services agencies, the Texas Workforce Commission, and other agencies. The plan must include a reengineering of eligibility

determination business processes, streamlined service delivery, a unified and integrated process for the transition from welfare to work, and improved access to benefits and services for clients. In developing and implementing the plan, the commission:

(1) shall give priority to the design and development of computer hardware and software for and provide technical support relating to the integrated eligibility determination system;

(2) shall consult with agencies whose programs are included in the plan, including the Department of Aging and Disability Services, the Department of State Health Services, and the Texas Workforce Commission;

(3) may contract for appropriate professional and technical assistance; and

(4) may use the staff and resources of agencies whose programs are included in the plan.

(b) The integrated eligibility determination and service delivery system shall be developed and implemented to achieve increased quality of and client access to services and savings in the cost of providing administrative and other services and staff resulting from streamlining and eliminating duplication of services. The commission, subject to any spending limitation prescribed in the General Appropriations Act, may use the resulting savings to further develop the integrated system and to provide other health and human services.

(c) The commission shall examine cost-effective methods to address:

(1) fraud in the assistance programs; and

(2) the error rate in eligibility determination.

(d) On receipt by the state of any necessary federal approval and subject to the approval of the governor and the Legislative Budget Board, the commission may contract for implementation of all or part of the plan required by Subsection (a) if the commission determines that contracting may advance the objectives of Subsections (a) and (b) and meets the criteria set out in the cost-benefit analysis described in this subsection. Before the awarding of a contract, the commission shall provide a detailed cost-benefit analysis to the governor and the Legislative Budget

Board. The analysis must demonstrate the cost-effectiveness of the plan, mechanisms for monitoring performance under the plan, and specific improvements to the service delivery system and client access made by the plan. The commission shall make the analysis available to the public. Within 10 days after the release of a request for bids, proposals, offers, or other applicable expressions of interest relating to the development or implementation of the plan required by Subsection (a), the commission shall hold a public hearing and receive public comment on the request.

(e) If requested by the commission, the agencies whose programs are included in the plan required by Subsection (a) shall cooperate with the commission to provide available staff and resources that will be subject to the direction of the commission.

(f) The design, development, and operation of an automated data processing system to support the plan required by Subsection (a) may be financed through the issuance of bonds or other obligations under Chapter 1232.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.08, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 1420, Sec. 8.238, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.171, eff. April 2, 2015.

SUBCHAPTER G. RURAL HOSPITALS

Sec. 531.201. STRATEGIC PLAN; REPORT. (a) The commission shall develop and implement a strategic plan to ensure that the citizens of this state residing in rural areas have access to hospital services.

(b) The strategic plan must include:

(1) a proposal for using at least one of the following methods to ensure access to hospital services in the rural areas of this state:

(A) an enhanced cost reimbursement methodology for the payment of rural hospitals participating in the Medicaid

managed care program in conjunction with a supplemental payment program for rural hospitals to cover costs incurred in providing services to recipients;

(B) a hospital rate enhancement program that applies only to rural hospitals;

(C) a reduction of punitive actions under the Medicaid program that require reimbursement for Medicaid payments made to the provider, if the provider is a rural hospital, a reduction of the frequency of payment reductions under the Medicaid program made to rural hospitals, and an enhancement of payments made under merit-based programs or similar programs for rural hospitals;

(D) a reduction of state regulatory-related costs related to the commission's review of rural hospitals; or

(E) in accordance with rules adopted by the Centers for Medicare and Medicaid Services, the establishment of a minimum fee schedule that applies to payments made by managed care organizations to rural hospitals; and

(2) target dates for achieving goals related to the proposal described by Subdivision (1).

(c) Not later than January 1, 2020, the commission shall submit the strategic plan developed under Subsection (b) to the Legislative Budget Board for review and comment. The commission may not begin implementation of the proposal contained in the strategic plan until the strategic plan is approved by the Legislative Budget Board.

(d) Not later than November 1 of each even-numbered year, the commission shall submit a report regarding the commission's development and implementation of the strategic plan described by Subsection (b) to:

(1) the legislature;

(2) the governor; and

(3) the Legislative Budget Board.

Added by Acts 2019, 86th Leg., R.S., Ch. 560 (S.B. 1621), Sec. 2, eff. September 1, 2019.

Sec. 531.202. ADVISORY COMMITTEE ON RURAL HOSPITALS.

(a) The commission shall establish the Rural Hospital Advisory Committee, either as another advisory committee or as a subcommittee of the Hospital Payment Advisory Committee, to advise the commission on issues relating specifically to rural hospitals.

(b) The Rural Hospital Advisory Committee is composed of interested persons appointed by the executive commissioner. Section 2110.002 does not apply to the advisory committee.

(c) A member of the advisory committee serves without compensation.

Added by Acts 2019, 86th Leg., R.S., Ch. 560 (S.B. 1621), Sec. 2, eff. September 1, 2019.

Sec. 531.203. COLLABORATION WITH OFFICE OF RURAL AFFAIRS. The commission shall collaborate with the Office of Rural Affairs to ensure that this state is pursuing to the fullest extent possible federal grants, funding opportunities, and support programs available to rural hospitals as administered by the Health Resources and Services Administration and the Office of Minority Health in the United States Department of Health and Human Services.

Added by Acts 2019, 86th Leg., R.S., Ch. 560 (S.B. 1621), Sec. 2, eff. September 1, 2019.

SUBCHAPTER G-1. DEVELOPING LOCAL MENTAL HEALTH SYSTEMS OF CARE FOR CERTAIN CHILDREN

Sec. 531.251. TEXAS SYSTEM OF CARE FRAMEWORK. (a) In this section:

(1) "Minor" means an individual younger than 18 years of age.

(2) "Serious emotional disturbance" means a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment that substantially interferes with or limits a person's role or ability to function in family, school, or community activities.

(3) "System of care framework" means a framework for

collaboration among state agencies, minors who have a serious emotional disturbance or are at risk of developing a serious emotional disturbance, and the families of those minors that improves access to services and delivers effective community-based services that are family-driven, youth- or young adult-guided, and culturally and linguistically competent.

(b) The commission shall implement a system of care framework to develop local mental health systems of care in communities for minors who are receiving residential mental health services and supports or inpatient mental health hospitalization, have or are at risk of developing a serious emotional disturbance, or are at risk of being removed from the minor's home and placed in a more restrictive environment to receive mental health services and supports, including an inpatient mental health hospital, a residential treatment facility, or a facility or program operated by the Department of Family and Protective Services or an agency that is part of the juvenile justice system.

(c) The commission shall:

(1) maintain a comprehensive plan for the delivery of mental health services and supports to a minor and a minor's family using a system of care framework, including best practices in the financing, administration, governance, and delivery of those services;

(2) enter memoranda of understanding with the Department of State Health Services, the Department of Family and Protective Services, the Texas Education Agency, the Texas Juvenile Justice Department, and the Texas Correctional Office on Offenders with Medical or Mental Impairments that specify the roles and responsibilities of each agency in implementing the comprehensive plan described by Subdivision (1);

(3) identify appropriate local, state, and federal funding sources to finance infrastructure and mental health services and supports needed to support state and local system of care framework efforts;

(4) develop an evaluation system to measure cross-system performance and outcomes of state and local system of care framework efforts; and

(5) in implementing the provisions of this section, consult with stakeholders, including:

(A) minors who have or are at risk of developing a serious emotional disturbance or young adults who received mental health services and supports as a minor with or at risk of developing a serious emotional disturbance; and

(B) family members of those minors or young adults.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1165 (S.B. 421), Sec. 2, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.172, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.16(a), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(11), eff. January 1, 2016.

Reenacted by Acts 2017, 85th Leg., R.S., Ch. 312 (S.B. 1021), Sec. 3, eff. May 29, 2017.

Sec. 531.255. EVALUATION. The commission shall monitor the implementation of a system of care framework under Section 531.251 and adopt rules as necessary to facilitate or adjust that implementation.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1165 (S.B. 421), Sec. 3, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1165 (S.B. 421), Sec. 5, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.16(b), eff. September 1, 2015.

Sec. 531.257. TECHNICAL ASSISTANCE FOR PROJECTS. The commission may provide technical assistance to a community that implements a local system of care.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1165 (S.B. 421), Sec. 4, eff. September 1, 2013.

SUBCHAPTER H. OFFICE OF HEALTH COORDINATION AND CONSUMER SERVICES

Sec. 531.281. DEFINITION. In this chapter, "office" means the Office of Health Coordination and Consumer Services.
Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.174, eff. April 2, 2015.

Sec. 531.282. OFFICE; STAFF. (a) The Office of Health Coordination and Consumer Services is an office within the commission.

(b) The executive commissioner shall employ staff as needed to carry out the duties of the office.
Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.175, eff. April 2, 2015.

Sec. 531.283. GOALS. The goals of the office are to:

(1) promote community support for parents of all children younger than six years of age through an integrated state and local-level decision-making process; and

(2) provide for the seamless delivery of health and human services to all children younger than six years of age to ensure that all children are prepared to succeed in school.
Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.284. STRATEGIC PLAN. (a) The office shall create and implement a statewide strategic plan for the delivery of health and human services to children younger than six years of age.

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

shall:

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

(A) community resource coordination groups;

(B) the Texas System of Care;

(C) the Texas Information and Referral Network; and

(D) efforts to create a 2-1-1 telephone number for access to human services;

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

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

(c) The statewide strategic plan must address the needs of children younger than six years of age with disabilities.

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.176, eff. April 2, 2015.

Sec. 531.285. POWERS AND DUTIES. (a) The office shall identify:

(1) gaps in early childhood services by functional area and geographical area;

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

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

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

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

(6) quantifiable benchmarks for success within early

childhood service delivery; and

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

(b) The office shall establish outreach efforts to communities and ensure adequate communication lines that provide the office with information about community-level efforts and communities with information about funds and programs available to communities.

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

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

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

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

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.177, eff. April 2, 2015.

Sec. 531.287. TEXAS HOME VISITING PROGRAM TRUST FUND. (a) The Texas Home Visiting Program trust fund is created as a trust fund outside the treasury with the comptroller and shall be administered by the office under this section and rules adopted by the executive commissioner. Credits of money in the fund are not state funds or subject to legislative appropriation.

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

(c) Money in the fund may be spent without appropriation by the office only for the purpose of the Texas Home Visiting Program administered by the commission.

(d) Interest and income from the assets of the trust fund shall be credited to and deposited in the trust fund.

Added by Acts 2013, 83rd Leg., R.S., Ch. 820 (S.B. 1836), Sec. 2, eff. June 14, 2013.

SUBCHAPTER I. STATE PRESCRIPTION DRUG PROGRAM

Sec. 531.301. DEVELOPMENT AND IMPLEMENTATION OF STATE PROGRAM; FUNDING. (a) The commission shall develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to Medicaid recipients.

(b) A person is eligible for prescription drug benefits under the state program if the person is:

(1) a qualified Medicare beneficiary, as defined by 42 U.S.C. Section 1396d(p)(1), as amended;

(2) a specified low-income Medicare beneficiary who is eligible for assistance under Medicaid for Medicare cost-sharing payments under 42 U.S.C. Section 1396a(a)(10)(E)(iii), as amended;

(3) a qualified disabled and working individual, as defined by 42 U.S.C. Section 1396d(s), as amended; or

(4) a qualifying individual who is eligible for that assistance under 42 U.S.C. Section 1396a(a)(10)(E)(iv).

(c) Prescription drugs under the state program may be funded only with state money, unless funds are available under federal law to fund all or part of the program.

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.178, eff. April 2, 2015.

Sec. 531.302. RULES. (a) The executive commissioner shall adopt all rules necessary for implementation of the state prescription drug program.

(b) In adopting rules for the state prescription drug program, the executive commissioner may:

(1) require a person who is eligible for prescription drug benefits to pay a cost-sharing payment;

(2) authorize the use of a prescription drug formulary

to specify which prescription drugs the state program will cover;

(3) to the extent possible, require clinically appropriate prior authorization for prescription drug benefits in the same manner as prior authorization is required under the vendor drug program; and

(4) establish a drug utilization review program to ensure the appropriate use of prescription drugs under the state program.

(c) In adopting rules for the state prescription drug program, the executive commissioner shall consult with an advisory panel composed of an equal number of physicians, pharmacists, and pharmacologists appointed by the executive commissioner.

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.179, eff. April 2, 2015.

Sec. 531.303. GENERIC EQUIVALENT AUTHORIZED. In adopting rules under the state program, the executive commissioner may require that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, the pharmacist may select a generic equivalent of the prescribed drug.

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.180, eff. April 2, 2015.

Sec. 531.304. PROGRAM FUNDING PRIORITIES. If money available for the state prescription drug program is insufficient to provide prescription drug benefits to all persons who are eligible under Section 531.301(b), the commission shall limit the number of enrollees based on available funding and shall provide the prescription drug benefits to eligible persons in the following order of priority:

(1) persons eligible under Section 531.301(b)(1);

(2) persons eligible under Section 531.301(b)(2); and

(3) persons eligible under Sections 531.301(b)(3) and (4).

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.181, eff. April 2, 2015.

SUBCHAPTER J. PROVISION OF INFORMATION ABOUT PATIENT ASSISTANCE PROGRAMS

Sec. 531.351. DEFINITION. In this subchapter, "patient assistance program" means a program offered by a pharmaceutical company under which the company provides a drug to persons in need of assistance at no charge or at a substantially reduced cost. The term does not include the provision of a drug as part of a clinical trial.

Added by Acts 2001, 77th Leg., ch. 1277, Sec. 1, eff. Sept. 1, 2001.

Renumbered from Government Code Sec. 531.301 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(74), eff. Sept. 1, 2003.

Sec. 531.352. PROVIDING INFORMATION TO COMMISSION. Each pharmaceutical company that does business in this state and that offers a patient assistance program shall inform the commission of the existence of the program, the eligibility requirements for the program, the drugs covered by the program, and information such as a telephone number used for applying for the program.

Added by Acts 2001, 77th Leg., ch. 1277, Sec. 1, eff. Sept. 1, 2001.

Renumbered from Government Code Sec. 531.302 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(74), eff. Sept. 1, 2003.

Sec. 531.353. TOLL-FREE TELEPHONE NUMBER. (a) The commission shall establish a system under which members of the public can call a toll-free telephone number to obtain information about available patient assistance programs. The commission shall ensure that the system is staffed at least during normal business hours with persons who can:

(1) determine whether a patient assistance program is

offered for a particular drug;

(2) determine whether a person may be eligible to participate in a program; and

(3) assist persons who wish to apply for a program.

(b) The commission shall publicize the telephone number to pharmacies and prescribers of drugs.

Added by Acts 2001, 77th Leg., ch. 1277, Sec. 1, eff. Sept. 1, 2001. Renumbered from Government Code Sec. 531.303 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(74), eff. Sept. 1, 2003.

SUBCHAPTER J-1. ASSISTANCE PROGRAM FOR DOMESTIC VICTIMS OF TRAFFICKING

Sec. 531.381. DEFINITIONS. In this subchapter:

(1) "Domestic victim" means a victim of trafficking who is a permanent legal resident or citizen of the United States.

(2) "Victim of trafficking" has the meaning assigned by 22 U.S.C. Section 7102.

Added by Acts 2009, 81st Leg., R.S., Ch. 1002 (H.B. 4009), Sec. 2, eff. September 1, 2009.

Sec. 531.382. VICTIM ASSISTANCE PROGRAM ESTABLISHED. The commission shall develop and implement a program designed to assist domestic victims, including victims who are children, in accessing necessary services. The program must consist of at least the following components:

(1) a searchable database of assistance programs for domestic victims, including programs that provide mental health services, other health services, services to meet victims' basic needs, case management services, and any other services the commission considers appropriate, that may be used to match victims with appropriate resources;

(2) the grant program described by Section 531.383;

(3) recommended training programs for judges, prosecutors, and law enforcement personnel; and

(4) an outreach initiative to ensure that victims, judges, prosecutors, and law enforcement personnel are aware of the

availability of services through the program.

Added by Acts 2009, 81st Leg., R.S., Ch. 1002 (H.B. 4009), Sec. 2, eff. September 1, 2009.

Sec. 531.383. GRANT PROGRAM. (a) Subject to available funds, the commission shall establish a grant program to award grants to public and nonprofit organizations that provide assistance to domestic victims, including organizations that provide public awareness activities, community outreach and training, victim identification services, and legal services.

(b) To apply for a grant under this section, an applicant must submit an application in the form and manner prescribed by the commission. An applicant must describe in the application the services the applicant intends to provide to domestic victims if the grant is awarded.

(c) In awarding grants under this section, the commission shall give preference to organizations that have experience in successfully providing the types of services for which the grants are awarded.

(d) A grant recipient shall provide reports as required by the commission regarding the use of grant funds.

(e) Not later than December 1 of each even-numbered year, the commission shall submit a report to the legislature summarizing the activities, funding, and outcomes of programs awarded a grant under this section and providing recommendations regarding the grant program.

(f) For purposes of Subchapter I, Chapter 659:

(1) the commission, for the sole purpose of administering the grant program under this section, is considered an eligible charitable organization entitled to participate in the state employee charitable campaign; and

(2) a state employee is entitled to authorize a deduction for contributions to the commission for the purposes of administering the grant program under this section as a charitable contribution under Section 659.132, and the commission may use the contributions as provided by Subsection (a).

Added by Acts 2009, 81st Leg., R.S., Ch. 1002 (H.B. 4009), Sec. 2,

eff. September 1, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 858 (H.B. 432), Sec. 1, eff. June 14, 2013.

Sec. 531.384. TRAINING PROGRAMS. The commission, with assistance from the Office of Court Administration of the Texas Judicial System, the Department of Public Safety, and local law enforcement agencies, shall create training programs designed to increase the awareness of judges, prosecutors, and law enforcement personnel of the needs of domestic victims, the availability of services under this subchapter, the database of services described by Section 531.382, and potential funding sources for those services.

Added by Acts 2009, 81st Leg., R.S., Ch. 1002 (H.B. 4009), Sec. 2, eff. September 1, 2009.

Sec. 531.385. FUNDING. (a) The commission may use appropriated funds and may accept gifts, grants, and donations from any sources for purposes of the victim assistance program established under this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 1002 (H.B. 4009), Sec. 2, eff. September 1, 2009.

SUBCHAPTER L. PROVISION OF SERVICES FOR CERTAIN CHILDREN WITH MULTIAGENCY NEEDS

Sec. 531.421. DEFINITIONS. In this subchapter:

(1) "Children with severe emotional disturbances" includes:

(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 Family and Protective 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.

(2) "Community resource coordination group" means a coordination group established under a memorandum of understanding adopted under Section 531.055.

(3) "Systems of care services" means a comprehensive state system of mental health services and other necessary and related services that is organized as a coordinated network to meet the multiple and changing needs of children with severe emotional disturbances and their families.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.183, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 1.07, eff. September 1, 2019.

Sec. 531.422. EVALUATIONS BY COMMUNITY RESOURCE COORDINATION GROUPS. (a) Each community resource coordination group shall evaluate the provision of systems of care services in the community that the group serves. Each evaluation must:

(1) describe and prioritize services needed by children with severe emotional disturbances in the community;

(2) review and assess the systems of care services that are available in the community to meet those needs;

(3) assess the integration of the provision of those services; and

(4) identify any barriers to the effective provision of those services.

(b) Each community resource coordination group shall create a report that includes the evaluation in Subsection (a) and makes related recommendations, including:

(1) suggested policy and statutory changes at agencies that provide systems of care services; and

(2) recommendations for overcoming barriers to the

provision of systems of care services and improving the integration of those services.

(c) Each community resource coordination group shall submit the report described by Subsection (b) to the commission. The commission shall provide to each group a deadline for submitting the reports that is coordinated with any regional reviews by the commission of the delivery of related services.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 1.08, eff. September 1, 2019.

Sec. 531.423. SUMMARY REPORT BY COMMISSION. (a) The commission shall create a summary report based on the evaluations in the reports submitted to the commission by community resource coordination groups under Section 531.422. The commission's report must include recommendations for policy and statutory changes at each agency that is involved in the provision of systems of care services and the outcome expected from implementing each recommendation.

(b) The commission shall coordinate, where appropriate, the recommendations in the report created under this section with recommendations in the assessment developed under Chapter 23 (S.B. 491), Acts of the 78th Legislature, Regular Session, 2003, and with the continuum of care developed under Section 533.040(d), Health and Safety Code.

(c) The commission may include in the report created under this section recommendations for the statewide expansion of sites participating in the Texas System of Care and the integration of services provided at those sites with services provided by community resource coordination groups.

(d) The commission shall provide a copy of the report created under this section to each agency for which the report makes a recommendation and to other agencies as appropriate.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.185, eff. April 2, 2015.

Acts 2019, 86th Leg., R.S., Ch. 573 (S.B. 241), Sec. 1.09, eff. September 1, 2019.

Sec. 531.424. AGENCY IMPLEMENTATION OF RECOMMENDATIONS. As appropriate, the person or entity responsible for adopting rules for an agency described by Section 531.423(a) shall adopt rules, and the agency shall implement policy changes and enter into memoranda of understanding with other agencies, to implement the recommendations in the report created under Section 531.423.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.186, eff. April 2, 2015.

SUBCHAPTER M. COORDINATION OF QUALITY INITIATIVES

Sec. 531.451. OPERATIONAL PLAN TO COORDINATE INITIATIVES. (a) The commission shall develop and implement a comprehensive, coordinated operational plan to ensure a consistent approach across the major quality initiatives of the health and human services system for improving the quality of health care.

(b) The operational plan developed under this section must include broad goals for the improvement of the quality of health care in this state, including health care services provided through Medicaid.

(c) The operational plan under this section may evaluate: the Delivery System Reform Incentive Payment (DSRIP) program under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), enhancing funding to disproportionate share hospitals in the state, Section 1332 of 42 U.S.C. Section 18052, enhancing uncompensated care pool payments to

hospitals in the state under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), home and community-based services state plan options under Section 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n), and a contingency plan in the event the commission does not obtain an extension or renewal of the uncompensated care pool provisions or any other provisions of the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315).

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.17(a), eff. September 1, 2015.

Sec. 531.452. REVISION OF MAJOR INITIATIVES. Notwithstanding any other law, the commission shall revise major quality initiatives of the health and human services system in accordance with the operational plan and health care quality improvement goals developed under Section 531.451. To the extent it is possible, the commission shall ensure that outcome measure data is collected and reported consistently across all major quality initiatives to improve the evaluation of the initiatives' statewide impact.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.17(a), eff. September 1, 2015.

Sec. 531.453. INCENTIVES FOR INITIATIVE COORDINATION. The commission shall consider and, if the commission determines it appropriate, develop incentives that promote coordination among the various major quality initiatives in accordance with this subchapter, including projects and initiatives approved under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315).

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.17(a), eff. September 1, 2015.

SUBCHAPTER M-1. STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL

Sec. 531.471. DEFINITION. In this subchapter, "council" means the statewide behavioral health coordinating council.
Added by Acts 2019, 86th Leg., R.S., Ch. 856 (H.B. 2813), Sec. 1, eff. June 10, 2019.

Sec. 531.472. PURPOSE. The council is established to ensure a strategic statewide approach to behavioral health services.
Added by Acts 2019, 86th Leg., R.S., Ch. 856 (H.B. 2813), Sec. 1, eff. June 10, 2019.

Sec. 531.473. COMPOSITION OF COUNCIL. (a) The council is composed of at least one representative designated by each of the following entities:

(1) the governor's office;

(2) the Texas Veterans Commission;

(3) the commission;

(4) the Department of State Health Services;

(5) the Department of Family and Protective Services;

(6) the Texas Civil Commitment Office;

(7) The University of Texas Health Science Center at Houston;

(8) The University of Texas Health Science Center at Tyler;

(9) the Texas Tech University Health Sciences Center;

(10) the Texas Department of Criminal Justice;

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

(12) the Commission on Jail Standards;

(13) the Texas Indigent Defense Commission;

(14) the court of criminal appeals;

(15) the Texas Juvenile Justice Department;

(16) the Texas Military Department;

(17) the Texas Education Agency;

(18) the Texas Workforce Commission;

(19) the Health Professions Council, representing:

(A) the State Board of Dental Examiners;

(B) the Texas State Board of Pharmacy;

(C) the State Board of Veterinary Medical Examiners;

(D) the Texas Optometry Board;

(E) the Texas Board of Nursing; and

(F) the Texas Medical Board; and

(20) the Texas Department of Housing and Community Affairs.

(b) The executive commissioner shall determine the number of representatives that each entity may designate to serve on the council.

(c) The council may authorize another state agency or institution that provides specific behavioral health services with the use of appropriated money to designate a representative to the council.

(d) A council member serves at the pleasure of the designating entity.

Added by Acts 2019, 86th Leg., R.S., Ch. 856 (H.B. 2813), Sec. 1, eff. June 10, 2019.

Sec. 531.474. PRESIDING OFFICER. The mental health statewide coordinator shall serve as the presiding officer of the council.

Added by Acts 2019, 86th Leg., R.S., Ch. 856 (H.B. 2813), Sec. 1, eff. June 10, 2019.

Sec. 531.475. MEETINGS. The council shall meet at least once quarterly or more frequently at the call of the presiding officer.

Added by Acts 2019, 86th Leg., R.S., Ch. 856 (H.B. 2813), Sec. 1, eff. June 10, 2019.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see H.B. 4074, 87th Legislature, Regular Session, for amendments affecting the

following section.

Sec. 531.476. POWERS AND DUTIES. The council:

(1) shall develop and monitor the implementation of a five-year statewide behavioral health strategic plan;

(2) shall develop a biennial coordinated statewide behavioral health expenditure proposal;

(3) shall annually publish an updated inventory of behavioral health programs and services that are funded by the state that includes a description of how those programs and services further the purpose of the statewide behavioral health strategic plan;

(4) may create subcommittees to carry out the council's duties under this subchapter; and

(5) may facilitate opportunities to increase collaboration for the effective expenditure of available federal and state funds for behavioral and mental health services in this state.

Added by Acts 2019, 86th Leg., R.S., Ch. 856 (H.B. 2813), Sec. 1, eff. June 10, 2019.

SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL TRUST FUND

Sec. 531.501. DEFINITION. In this subchapter, "fund" means the Texas health opportunity pool trust fund established under Section 531.503.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a), eff. September 1, 2007.

Sec. 531.502. DIRECTION TO OBTAIN FEDERAL WAIVER. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan to allow the commission to more efficiently and effectively use federal money paid to this state under various programs to defray costs associated with providing uncompensated health care in this state by using that federal money, appropriated state money to the extent necessary, and any other money described by this section for purposes consistent with this subchapter.

(b) The executive commissioner may include the following federal money in the waiver:

(1) money provided under the disproportionate share hospitals or upper payment limit supplemental payment program, or both;

(2) money provided by the federal government in lieu of some or all of the payments under one or both of 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:

(A) federal money and money identified under Subsection (c);

(B) gifts, grants, or donations for that purpose;

(C) local funds received by this state through intergovernmental transfers; and

(D) if approved in the waiver, federal money obtained through the use of certified public expenditures.

(c) The commission shall seek to optimize federal funding by:

(1) identifying health care related state and local funds and program expenditures that, before September 1, 2011, are not being matched with federal money; and

(2) exploring the feasibility of:

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

(B) depositing federal matching money received as provided by Paragraph (A) with other federal money deposited as provided by Section 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) The terms of a waiver approved under this section must:

(1) include safeguards to ensure that the total amount of federal money provided under the disproportionate share

hospitals or upper payment limit supplemental payment program that is deposited as provided by Section 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 2011, 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) be used to supplement Medicaid hospital reimbursements under a waiver that includes terms that are consistent with, or that produce revenues consistent with, disproportionate share hospital and upper payment limit principles;

(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) In a waiver under this section, the executive commissioner shall 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) The executive commissioner shall seek broad-based stakeholder input in the development of the waiver under this section and shall provide information to stakeholders regarding the terms and components of the waiver for which the executive commissioner seeks federal approval.

(g) Repealed by Acts 2011, 82nd Leg., 1st C.S., Ch. 7, Sec. 1.11(d), eff. September 28, 2011.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a), eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.11(a), eff. September 28, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.11(d), eff. September 28, 2011.

Sec. 531.503. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL TRUST FUND. Subject to approval of the waiver authorized by Section 531.502, 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.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a), eff. September 1, 2007.

Sec. 531.504. DEPOSITS TO FUND. (a) The comptroller shall deposit in the fund:

(1) federal money provided to this state under the disproportionate share hospitals supplemental payment program or the hospital upper payment limit supplemental payment program, or

both, other than money provided under those programs to state-owned and operated hospitals, and all other non-supplemental payment program federal money provided to this state that is included in the waiver authorized by Section 531.502; and

(2) state money appropriated to the fund.

(b) The commission and comptroller may accept gifts, grants, and donations from any source, and receive intergovernmental transfers, for purposes consistent with this subchapter and the terms of the waiver. The comptroller shall deposit a gift, grant, or donation made for those purposes in the fund. Any intergovernmental transfer received, including associated federal matching funds, shall be used, if feasible, for the purposes intended by the transferring entity and in accordance with the terms of the waiver.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a), eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.11(b), eff. September 28, 2011.

Sec. 531.505. USE OF FUND IN GENERAL; RULES FOR ALLOCATION. (a) 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:

(A) are based on the providers' costs related to providing uncompensated care; and

(B) compensate the providers for at least a portion of those costs;

(2) to reduce the number of 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) On approval of the waiver, the executive commissioner shall:

(1) seek input from a broad base of stakeholder representatives on the development of rules with respect to, and the administration of, the fund; and

(2) by rule develop a methodology for allocating money in the fund that is consistent with the terms of the waiver.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a), eff. September 1, 2007.

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

(b) 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) regional or local health care programs;

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

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

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

(c) The allocation methodology 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).

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a),

eff. September 1, 2007.

Sec. 531.507. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) 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) The commission and the Texas Department of Insurance shall 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) The commission shall implement the premium payment assistance program developed under Subsection (b), subject to availability of money in the fund for that purpose.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a), eff. September 1, 2007.

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

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

(c) Not more than 10 percent of the total amount of the money in the fund used in a state fiscal year for purposes other than providing reimbursements to hospitals for uncompensated health care may be used for infrastructure improvements described by Subsection (b).

(d) Money from the fund may not be used to finance the construction, improvement, or renovation of a building or land unless the construction, improvement, or renovation is approved by the commission, according to rules adopted by the executive commissioner for that purpose.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 7(a), eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.11(c), eff. September 28, 2011.

SUBCHAPTER O. UNCOMPENSATED HOSPITAL CARE

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS. (a) The executive commissioner shall 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 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:

(A) are not patient-specific; and

(B) are used to offset the hospital's initially computed amount of uncompensated care; 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) The rules adopted by the executive commissioner under Subsection (a)(3) may provide for procedures by which the commission may periodically verify the completeness and accuracy of the information reported by hospitals.

(c) The commission shall 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). On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in the amount of $1,000 for each day after the date the report was due that the hospital has not submitted the report, not to exceed $10,000.

(d) If the commission determines through the procedures adopted under Subsection (b) that a hospital submitted a report with incomplete or inaccurate information, the commission shall notify the hospital of the specific information the hospital must submit and prescribe a date by which the hospital must provide that information. If the hospital fails to submit the specified information on or before the date prescribed by the commission, the commission shall notify the attorney general of that failure. On receipt of the notice, the attorney general shall impose an administrative penalty on the hospital in an amount not to exceed $10,000. In determining the amount of the penalty to be imposed, the attorney general shall consider:

(1) the seriousness of the violation;

(2) whether the hospital had previously committed a violation; and

(3) the amount necessary to deter the hospital from

committing future violations.

(e) 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) The attorney general shall 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) 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. If the hospital timely requests a hearing, the attorney general shall conduct the hearing in accordance with Chapter 2001, Government Code. If the hearing results in a finding that a violation has occurred, the attorney general shall:

(1) provide to the hospital written notice of:

(A) the findings established at the hearing; and

(B) the amount of the penalty; and

(2) enter an order requiring the hospital to pay the amount of the penalty.

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

(1) pay the amount of the administrative penalty;

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

(3) without paying the amount of the penalty, 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) The attorney general's order is subject to judicial review as a contested case under Chapter 2001, Government Code.

(j) 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, the attorney general shall remit the appropriate amount to the hospital not later than the 30th day after the date the court's judgment becomes final.

(k) If the court sustains the occurrence of the violation:

(1) the court:

(A) shall order the hospital to pay the amount of the administrative penalty; and

(B) may award to the attorney general the attorney's fees and court costs 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) If the hospital does not pay the amount of the administrative penalty after the attorney general's order becomes final for all purposes, the attorney general may enforce the penalty as provided by law for legal judgments.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 8(a), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.187, eff. April 2, 2015.

SUBCHAPTER S. COMMUNITY-BASED NAVIGATOR PROGRAM

Sec. 531.751. DEFINITIONS. In this subchapter:

(1) "Community-based organization" and "faith-based organization" have the meanings assigned by Section 535.001.

(2) "Navigator" means a person who is:

(A) a volunteer or other representative of a faith- or community-based organization; and

(B) certified by the commission to provide or facilitate the provision of information or assistance through the faith- or community-based organization to individuals applying or seeking to apply online through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system for public assistance benefits administered by the commission.

Added by Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. 2610), Sec. 1, eff. September 1, 2011.

Sec. 531.752. ESTABLISHMENT OF COMMUNITY-BASED NAVIGATOR PROGRAM. If the executive commissioner determines that a statewide community-based navigator program can be established and operated using existing resources and without disrupting other commission functions, the commission shall establish a statewide community-based navigator program through which the commission will train and certify as navigators volunteers and other representatives of faith- and community-based organizations to assist individuals applying or seeking to apply online for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system. In establishing the navigator program, the commission shall solicit the expertise and assistance of interested persons, including faith- and community-based organizations, and may establish a work group or other temporary, informal group of interested persons to provide input and assistance.

Added by Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. 2610), Sec. 1, eff. September 1, 2011.

Sec. 531.753. PROGRAM STANDARDS. The executive commissioner shall adopt standards to implement this subchapter, including standards:

(1) subject to Section 531.754, regarding the qualifications and training required for certification as a

navigator;

(2) regarding the suspension, revocation, and, if appropriate, periodic renewal of a navigator certificate;

(3) to protect the confidentiality of applicant information handled by navigators; and

(4) regarding any other issues the executive commissioner determines are appropriate.

Added by Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. 2610), Sec. 1, eff. September 1, 2011.

Sec. 531.754. TRAINING PROGRAM. The commission shall develop and administer a training program for navigators. The program must include training on:

(1) how to complete an online application for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS);

(2) the importance of maintaining the confidentiality of information handled by a navigator;

(3) the importance of obtaining and submitting complete and accurate information when completing an application for public assistance benefits online through the Texas Integrated Eligibility Redesign System (TIERS);

(4) the financial assistance program, the supplemental nutrition assistance program, Medicaid, the child health plan program, and any other public assistance benefits program for which an individual may complete an online application through the Texas Integrated Eligibility Redesign System (TIERS); and

(5) how an individual may apply for other public assistance benefits for which an individual may not complete an online application through the Texas Integrated Eligibility Redesign System (TIERS).

Added by Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. 2610), Sec. 1, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.192, eff. April 2, 2015.

Sec. 531.755. PUBLICATION OF NAVIGATOR LIST. The commission shall maintain and publish on the commission's Internet website a list of certified navigators.

Added by Acts 2011, 82nd Leg., R.S., Ch. 537 (H.B. 2610), Sec. 1, eff. September 1, 2011.

SUBCHAPTER U. MORTALITY REVIEW FOR CERTAIN INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

Sec. 531.8501. DEFINITION. In this subchapter, "contracted organization" means an entity that contracts with the commission for the provision of services as described by Section 531.851(c).

Added by Acts 2013, 83rd Leg., R.S., Ch. 1027 (H.B. 2673), Sec. 4, eff. June 14, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.195, eff. April 2, 2015.

Sec. 531.851. MORTALITY REVIEW. (a) The executive commissioner shall establish an independent mortality review system to review the death of a person with an intellectual or developmental disability who, at the time of the person's death or at any time during the 24-hour period before the person's death:

(1) resided in or received services from:

(A) an ICF-IID operated or licensed by the Department of Aging and Disability Services or a community center; or

(B) the ICF-IID component of the Rio Grande State Center; or

(2) received services through a Section 1915(c) waiver program for individuals who are eligible for ICF-IID services.

(b) A review under this subchapter must be conducted in addition to any review conducted by the facility in which the person resided or the facility, agency, or provider from which the person received services. A review under this subchapter must be

conducted after any investigation of alleged or suspected abuse, neglect, or exploitation is completed.

(c) The executive commissioner shall contract with an institution of higher education or a health care organization or association with experience in conducting research-based mortality studies to conduct independent mortality reviews of persons with an intellectual or developmental disability. The contract must require the contracted organization to form a review team consisting of:

(1) a physician with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(2) a registered nurse with expertise regarding the medical treatment of individuals with an intellectual or developmental disability;

(3) a clinician or other professional with expertise in the delivery of services and supports for individuals with an intellectual or developmental disability; and

(4) any other appropriate person as provided by the executive commissioner.

(d) The executive commissioner shall adopt rules regarding the manner in which the death of a person described by Subsection (a) must be reported to the contracted organization by a facility or waiver program provider described by that subsection.

(e) To ensure consistency across mortality review systems, a review under this section must collect information consistent with the information required to be collected by any other independent mortality review process established specifically for persons with an intellectual or developmental disability.

Added by Acts 2009, 81st Leg., R.S., Ch. 284 (S.B. 643), Sec. 9, eff. June 11, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1027 (H.B. 2673), Sec. 5, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.196, eff. April 2, 2015.

Sec. 531.852. ACCESS TO INFORMATION. (a) A contracted organization may request information and records regarding a deceased person as necessary to carry out the contracted organization's duties. Records and information that may be requested under this section include:

(1) medical, dental, and mental health care information; and

(2) information and records maintained by any state or local government agency, including:

(A) a birth certificate;

(B) law enforcement investigative data;

(C) medical examiner investigative data;

(D) juvenile court records;

(E) parole and probation information and records; and

(F) adult or child protective services information and records.

(b) On request of the contracted organization, the custodian of the relevant information and records relating to a deceased person shall provide those records to the contracted organization at no charge.

Added by Acts 2009, 81st Leg., R.S., Ch. 284 (S.B. 643), Sec. 9, eff. June 11, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1027 (H.B. 2673), Sec. 6, eff. June 14, 2013.

Sec. 531.853. MORTALITY REVIEW REPORT. Subject to Section 531.854, a contracted organization shall submit:

(1) to the Department of Aging and Disability Services, the Department of Family and Protective Services, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report of the findings of the mortality review; and

(2) semiannually to the governor, the lieutenant governor, the speaker of the house of representatives, and the standing committees of the senate and house of representatives with

primary jurisdiction over the Department of Aging and Disability Services, the Department of Family and Protective Services, the office of independent ombudsman for state supported living centers, and the commission's office of inspector general a report that contains:

(A) aggregate information regarding the deaths for which the contracted organization performed an independent mortality review;

(B) trends in the causes of death identified by the contracted organization; and

(C) any suggestions for system-wide improvements to address conditions that contributed to deaths reviewed by the contracted organization.

Added by Acts 2009, 81st Leg., R.S., Ch. 284 (S.B. 643), Sec. 9, eff. June 11, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1027 (H.B. 2673), Sec. 7, eff. June 14, 2013.

Sec. 531.854. USE AND PUBLICATION RESTRICTIONS; CONFIDENTIALITY. (a) The commission may use or publish information under this subchapter only to advance statewide practices regarding the treatment and care of individuals with an intellectual or developmental disability. A summary of the data in the contracted organization's reports or a statistical compilation of data reports may be released by the commission for general publication if the summary or statistical compilation does not contain any information that would permit the identification of an individual or that is confidential or privileged under this subchapter or other state or federal law.

(b) Information and records acquired by the contracted organization in the exercise of its duties under this subchapter are confidential and exempt from disclosure under the open records law, Chapter 552, and may be disclosed only as necessary to carry out the contracted organization's duties.

(c) The identity of a person whose death was reviewed in accordance with this subchapter is confidential and may not be

revealed.

(d) The identity of a health care provider or the name of a facility or agency that provided services to or was the residence of a person whose death was reviewed in accordance with this subchapter is confidential and may not be revealed.

(e) Reports, information, statements, memoranda, and other information furnished under this subchapter to the contracted organization and any findings or conclusions resulting from a review by the contracted organization are privileged.

(f) A contracted organization's report of the findings of the independent mortality review conducted under this subchapter and any records developed by the contracted organization relating to the review:

(1) are confidential and privileged;

(2) are not subject to discovery or subpoena; and

(3) may not be introduced into evidence in any civil, criminal, or administrative proceeding.

(g) A member of the contracted organization's review team may not testify or be required to testify in a civil, criminal, or administrative proceeding as to observations, factual findings, or conclusions that were made in conducting a review under this subchapter.

Added by Acts 2009, 81st Leg., R.S., Ch. 284 (S.B. 643), Sec. 9, eff. June 11, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1027 (H.B. 2673), Sec. 8, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.197, eff. April 2, 2015.

Sec. 531.855. LIMITATION ON LIABILITY. A health care provider or other person is not civilly or criminally liable for furnishing information to the contracted organization or to the commission for use by the contracted organization in accordance with this subchapter unless the person acted in bad faith or knowingly provided false information to the contracted organization or the commission.

Added by Acts 2009, 81st Leg., R.S., Ch. 284 (S.B. 643), Sec. 9, eff. June 11, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1027 (H.B. 2673), Sec. 9, eff. June 14, 2013.

SUBCHAPTER V. HEALTH INFORMATION EXCHANGE SYSTEMS

Sec. 531.901. DEFINITIONS. In this subchapter:

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

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

(3) "Health information exchange system" means a health information exchange system created under this subchapter that moves health-related information among entities according to nationally recognized standards.

(4) "Local or regional health information exchange" means a health information exchange operating in this state that securely exchanges electronic health information, including information for patients receiving services under the child health plan program or Medicaid, among hospitals, clinics, physicians' offices, and other health care providers that are not owned by a single entity or included in a single operational unit or network.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.198, eff. April 2, 2015.

Sec. 531.903. ELECTRONIC HEALTH INFORMATION EXCHANGE

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

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

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

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

(C) Chapter 552;

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

(E) Section 12.003, Human Resources Code; and

(F) federal and state rules and regulations, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The commission shall implement the health information exchange system in stages as described by this chapter, except that the commission may deviate from those stages if technological advances make a deviation advisable or more efficient.

(d) The health information exchange system must be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid and State Operations and conform to other standards required under federal law.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.199, eff.

April 2, 2015.

Sec. 531.9051. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ENCOUNTER DATA. In stage one of implementing the health information exchange system, the commission shall require for purposes of the implementation each managed care organization with which the commission contracts under Chapter 533 for the provision of Medicaid managed care services or Chapter 62, Health and Safety Code, for the provision of child health plan program services to submit to the commission complete and accurate encounter data not later than the 30th day after the last day of the month in which the managed care organization adjudicated the claim. Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Sec. 531.906. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE ONE: ELECTRONIC PRESCRIBING. (a) In stage one of implementing the health information exchange system, the commission shall support and coordinate electronic prescribing tools used by health care providers and health care facilities under the child health plan program and Medicaid.

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

(1) are integrated with existing electronic prescribing systems otherwise in use in the public and private sectors; and

(2) to the extent feasible:

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

(B) support the electronic transmission of a prescription.

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

developed by the commission.

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.201, eff. April 2, 2015.

Sec. 531.907. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE TWO: EXPANSION. (a) Based on feedback provided by interested parties, the commission in stage two of implementing the health information exchange system may expand the system by:

(1) providing an electronic health record for each child enrolled in the child health plan program;

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

(3) improving data-gathering capabilities for an electronic health record so that the record may include basic health and clinical information in addition to available claims information, as determined by the executive commissioner;

(4) using evidence-based technology tools to create a unique health profile to alert health care providers regarding the

need for additional care, education, counseling, or health management activities for specific patients; and

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

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.202, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.11, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.11, eff. January 1, 2016.

Sec. 531.908. ELECTRONIC HEALTH INFORMATION EXCHANGE SYSTEM STAGE THREE: EXPANSION. In stage three of implementing the health information exchange system, the commission may expand the system by:

(1) developing evidence-based benchmarking tools that can be used by health care providers to evaluate their own performances on health care outcomes and overall quality of care as compared to aggregated performance data regarding peers; and

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

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Sec. 531.909. INCENTIVES. The commission shall develop strategies to encourage health care providers to use the health

information exchange system, including incentives, education, and outreach tools to increase usage.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.12, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.12, eff. January 1, 2016.

Sec. 531.911. RULES. The executive commissioner may adopt rules to implement Sections 531.903 through 531.909.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.203, eff. April 2, 2015.

Sec. 531.912. COMMON PERFORMANCE MEASUREMENTS AND PAY-FOR-PERFORMANCE INCENTIVES FOR CERTAIN NURSING FACILITIES. (a) In this section, "nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term care services, as defined by Section 22.0011, Human Resources Code, to Medicaid recipients.

(b) If feasible, the executive commissioner by rule may establish an incentive payment program for nursing facilities that choose to participate. The program must be designed to improve the quality of care and services provided to Medicaid recipients. Subject to Subsection (f), the program may provide incentive payments in accordance with this section to encourage facilities to participate in the program.

(c) In establishing an incentive payment program under this section, the executive commissioner shall, subject to Subsection (d), adopt common performance measures to be used in evaluating nursing facilities that are related to structure, process, and outcomes that positively correlate to nursing facility quality and

improvement. The common performance measures:

(1) must be:

(A) recognized by the executive commissioner as valid indicators of the overall quality of care received by Medicaid recipients; and

(B) designed to encourage and reward evidence-based practices among nursing facilities; and

(2) may include measures of:

(A) quality of care, as determined by clinical performance ratings published by the federal Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency;

(B) direct-care staff retention and turnover;

(C) recipient satisfaction, including the satisfaction of recipients who are short-term and long-term residents of facilities, and family satisfaction, as determined by the Nursing Home Consumer Assessment of Healthcare Providers and Systems surveys relied upon by the federal Centers for Medicare and Medicaid Services;

(D) employee satisfaction and engagement;

(E) the incidence of preventable acute care emergency room services use;

(F) regulatory compliance;

(G) level of person-centered care; and

(H) direct-care staff training, including a facility's utilization of independent distance learning programs for the continuous training of direct-care staff.

(d) The executive commissioner shall maximize the use of available information technology and limit the number of performance measures adopted under Subsection (c) to achieve administrative cost efficiency and avoid an unreasonable administrative burden on participating nursing facilities.

(e) The executive commissioner may:

(1) determine the amount of any incentive payment under the program; and

(2) enter into a contract with a qualified person, as determined by the executive commissioner, for the following

services related to the program:

(A) data collection;

(B) data analysis; and

(C) technical support.

(f) The commission may make incentive payments under the program only if money is appropriated for that purpose.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.13(a), eff. September 28, 2011.

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.13(b), eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.204, eff. April 2, 2015.

SUBCHAPTER W. ADVERSE LICENSING, LISTING, OR REGISTRATION DECISIONS

Sec. 531.951. APPLICABILITY. (a) This subchapter applies only to the final licensing, listing, or registration decisions of a health and human services agency with respect to a person under the law authorizing the agency to regulate the following types of persons:

(1) a youth camp licensed under Chapter 141, Health and Safety Code;

(2) a home and community support services agency licensed under Chapter 142, Health and Safety Code;

(3) a hospital licensed under Chapter 241, Health and Safety Code;

(4) an institution licensed under Chapter 242, Health and Safety Code;

(5) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(6) a special care facility licensed under Chapter 248, Health and Safety Code;

(7) an intermediate care facility licensed under

Chapter 252, Health and Safety Code;

(8) a chemical dependency treatment facility licensed under Chapter 464, Health and Safety Code;

(9) a mental hospital or mental health facility licensed under Chapter 577, Health and Safety Code;

(10) a child-care facility or child-placing agency licensed under or a family home listed or registered under Chapter 42, Human Resources Code; or

(11) a day activity and health services facility licensed under Chapter 103, Human Resources Code.

(b) This subchapter does not apply to an agency decision that did not result in a final order or that was reversed on appeal.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1051 (S.B. 78), Sec. 1, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1231 (S.B. 1999), Sec. 1, eff. June 19, 2015.

Sec. 531.952. RECORD OF FINAL DECISION. (a) Each health and human services agency that regulates a person described by Section 531.951 shall in accordance with this section and executive commissioner rule maintain a record of:

(1) each application for a license, including a renewal license or a license that does not expire, a listing, or a registration that is denied by the agency under the law authorizing the agency to regulate the person; and

(2) each license, listing, or registration that is revoked, suspended, or terminated by the agency under the applicable law.

(b) The record of an application required by Subsection (a)(1) must be maintained until the 10th anniversary of the date the application is denied. The record of the license, listing, or registration required by Subsection (a)(2) must be maintained until the 10th anniversary of the date of the revocation, suspension, or termination.

(c) The record required under Subsection (a) must include:

(1) the name and address of the applicant for a

license, listing, or registration that is denied as described by Subsection (a)(1);

(2) the name and address of each person listed in the application for a license, listing, or registration that is denied as described by Subsection (a)(1);

(3) the name of each person determined by the applicable regulatory agency to be a controlling person of an entity for which an application, license, listing, or registration is denied, revoked, suspended, or terminated as described by Subsection (a);

(4) the specific type of license, listing, or registration that was denied, revoked, suspended, or terminated by the agency;

(5) a summary of the terms of the denial, revocation, suspension, or termination; and

(6) the period the denial, revocation, suspension, or termination was effective.

(d) Each health and human services agency that regulates a person described by Section 531.951 each month shall provide a copy of the records maintained under this section to each other health and human services agency that regulates a person described by Section 531.951.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1051 (S.B. 78), Sec. 1, eff. September 1, 2011.

Sec. 531.953. DENIAL OF APPLICATION BASED ON ADVERSE AGENCY DECISION. A health and human services agency that regulates a person described by Section 531.951 may deny an application for a license, including a renewal license or a license that does not expire, a listing, or a registration included in that section if:

(1) any of the following persons are listed in a record maintained under Section 531.952:

(A) the applicant;

(B) a person listed on the application; or

(C) a person determined by the applicable regulating agency to be a controlling person of an entity for which the license, including a renewal license or a license that does not

expire, the listing, or the registration is sought; and

(2) the agency's action that resulted in the person being listed in a record maintained under Section 531.952 is based on:

(A) an act or omission that resulted in physical or mental harm to an individual in the care of the applicant or person;

(B) a threat to the health, safety, or well-being of an individual in the care of the applicant or person;

(C) the physical, mental, or financial exploitation of an individual in the care of the applicant or person; or

(D) a determination by the agency that the applicant or person has committed an act or omission that renders the applicant unqualified or unfit to fulfill the obligations of the license, listing, or registration.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1051 (S.B. 78), Sec. 1, eff. September 1, 2011.

Sec. 531.954. REQUIRED APPLICATION INFORMATION. An applicant submitting an initial or renewal application for a license, including a renewal license or a license that does not expire, a listing, or a registration described under Section 531.951 must include with the application a written statement of:

(1) the name of any person who is or will be a controlling person, as determined by the applicable agency regulating the person, of the entity for which the license, listing, or registration is sought; and

(2) any other relevant information required by executive commissioner rule.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1051 (S.B. 78), Sec. 1, eff. September 1, 2011.

SUBCHAPTER X. TEXAS HOME VISITING PROGRAM

Sec. 531.981. DEFINITIONS. In this subchapter:

(1) "Home visiting program" means a

voluntary-enrollment program in which early childhood and health professionals such as nurses, social workers, or trained and supervised paraprofessionals repeatedly visit over a period of at least six months the homes of pregnant women or families with children under the age of six who are born with or exposed to one or more risk factors.

(2) "Risk factors" means factors that make a child more likely to experience adverse experiences leading to negative consequences, including preterm birth, poverty, low parental education, having a teenaged mother or father, poor maternal health, and parental underemployment or unemployment.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Sec. 531.982. IMPLEMENTATION OF TEXAS HOME VISITING PROGRAM. (a) The commission shall maintain a strategic plan to serve at-risk pregnant women and families with children under the age of six through home visiting programs that improve outcomes for parents and families.

(b) A pregnant woman or family is considered at-risk for purposes of this section and may be eligible for voluntary enrollment in a home visiting program if the woman or family is exposed to one or more risk factors.

(c) The commission may determine if a risk factor or combination of risk factors experienced by an at-risk pregnant woman or family qualifies the woman or family for enrollment in a home visiting program.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.205, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.206, eff. April 2, 2015.

Sec. 531.983. TYPES OF HOME VISITING PROGRAMS. (a) A home visiting program is classified as either an evidence-based program

or a promising practice program.

(b) An evidence-based program is a home visiting program that:

(1) is research-based and grounded in relevant, empirically based knowledge and program-determined outcomes;

(2) is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive standards that ensure high-quality service delivery and continuously improving quality;

(4) has demonstrated significant positive short-term and long-term outcomes;

(5) has been evaluated by at least one rigorous randomized controlled research trial across heterogeneous populations or communities, the results of at least one of which has been published in a peer-reviewed journal;

(6) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(7) employs well-trained and competent staff and provides continual relevant professional development opportunities;

(8) demonstrates strong links to other community-based services; and

(9) ensures compliance with home visiting standards.

(c) A promising practice program is a home visiting program that:

(1) has an active impact evaluation program or can demonstrate a timeline for implementing an active impact evaluation program;

(2) has been evaluated by at least one outcome-based study demonstrating effectiveness or a randomized controlled trial in a homogeneous sample;

(3) follows with fidelity a program manual or design that specifies the purpose, outcomes, duration, and frequency of the services that constitute the program;

(4) employs well-trained and competent staff and

provides continual relevant professional development opportunities;

(5) demonstrates strong links to other community-based services; and

(6) ensures compliance with home visiting standards.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Sec. 531.984. FUNDING. (a) The commission shall ensure that at least 75 percent of funds appropriated for home visiting programs are used in evidence-based programs, with any remaining funds dedicated to promising practice programs.

(b) The commission shall actively seek and apply for any available federal funds to support home visiting programs, including federal funds from the Temporary Assistance for Needy Families program.

(c) The commission may accept gifts, donations, and grants to support home visiting programs.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Sec. 531.985. OUTCOMES. The commission shall ensure that a home visiting program achieves favorable outcomes in at least two of the following areas:

(1) improved maternal or child health outcomes;

(2) improved cognitive development of children;

(3) increased school readiness of children;

(4) reduced child abuse, neglect, and injury;

(5) improved child safety;

(6) improved social-emotional development of children;

(7) improved parenting skills, including nurturing and bonding;

(8) improved family economic self-sufficiency;

(9) reduced parental involvement with the criminal justice system; and

(10) increased father involvement and support.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Sec. 531.986. EVALUATION OF HOME VISITING PROGRAM. (a) The commission shall adopt outcome indicators to measure the effectiveness of a home visiting program in achieving desired outcomes.

(b) The commission may work directly with the model developer of a home visiting program to identify appropriate outcome indicators for the program and to ensure that the program demonstrates fidelity to its research model.

(c) The commission shall develop internal processes to work with home visiting programs to share data and information to aid in making relevant analysis of the performance of a home visiting program.

(d) The commission shall use data gathered under this section to monitor, conduct ongoing quality improvement on, and evaluate the effectiveness of home visiting programs.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Sec. 531.9871. REPORTS TO LEGISLATURE. (a) Not later than December 1 of each even-numbered year, the commission shall prepare and submit a report on state-funded home visiting programs to the Senate Committee on Health and Human Services and the House Human Services Committee or their successors.

(b) A report submitted under this section must include:

(1) a description of home visiting programs being implemented and the associated models;

(2) data on the number of families being served and their demographic information;

(3) the goals and achieved outcomes of home visiting programs;

(4) data on cost per family served, including third-party return-on-investment analysis, if available; and

(5) data explaining what percentage of funding has been used on evidence-based programs and what percentage of funding

has been used on promising practice programs.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Sec. 531.988. RULES. The executive commissioner may adopt rules as necessary to implement this subchapter.

Added by Acts 2013, 83rd Leg., R.S., Ch. 421 (S.B. 426), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.207, eff. April 2, 2015.

SUBCHAPTER Y. OMBUDSMAN FOR THE DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

See note following this section.

Sec. 531.991. DEFINITIONS. In this subchapter:

(1) "Department" means the Department of Family and Protective Services.

(2) "Ombudsman" means the individual appointed as the ombudsman for the Department of Family and Protective Services.

Amendments to Subdivision (2) of this section made by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), take effect on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 2, eff. September 1, 2017.

See note following this section.

Sec. 531.992. OMBUDSMAN FOR THE DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES. (a) The governor shall appoint an ombudsman

for the Department of Family and Protective Services to serve at the will of the governor.

(b) The ombudsman is administratively attached to the office of the ombudsman for the commission.

(c) Subject to the appropriation of money for that purpose, the ombudsman may employ staff to assist the ombudsman in performing the ombudsman's duties under this subchapter.

(d) The ombudsman may not use the name or any logo of the department on any forms or other materials produced and distributed by the ombudsman.

Amendments to this section made by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), take effect on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 3, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 4, eff. September 1, 2017.

See note following this section.

Sec. 531.9921. CONFLICT OF INTEREST. A person may not serve as ombudsman if the person or the person's spouse:

(1) is employed by or participates in the management of a business entity or other organization receiving funds from the department;

(2) owns or controls, directly or indirectly, any interest in a business entity or other organization receiving funds from the department; or

(3) is required to register as a lobbyist under Chapter 305 because of the person's activities for compensation on behalf of a profession related to the operation of the department.

Text of section effective on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 5, eff. September 1, 2017.

See note following this section.

Sec. 531.993. DUTIES OF OMBUDSMAN. (a) The ombudsman serves as a neutral party in assisting:

(1) children and youth in the conservatorship of the department with complaints regarding issues within the authority of the department or another health and human services agency; and

(2) persons with a complaint against the department regarding case-specific activities of the programs of the department, including adult protective services, child protective services, child-care licensing, and statewide intake.

(b) The ombudsman shall:

(1) develop and implement statewide procedures to:

(A) receive complaints from children and youth in the conservatorship of the department and other persons with a complaint against the department;

(B) review complaints filed with the ombudsman and take appropriate action, including:

(i) conducting an investigation into individual complaints that allege violations of department or agency procedure or policy or other violations; and

(ii) referring to department or agency management for resolution any trends or systemic issues identified in complaints;

(C) provide any necessary assistance to children and youth in the conservatorship of the department in making complaints and reporting allegations of abuse or neglect to the department;

(D) maintain the confidentiality of:

(i) the ombudsman's communications and records;

(ii) records of another person that have been provided to the ombudsman; and

(iii) communications of another person with the ombudsman; and

(E) ensure that the department and any person or a child or youth in the conservatorship of the department who files a complaint with the ombudsman are informed of the results of the ombudsman's investigation of the complaint, including whether the ombudsman was able to substantiate the person's, child's, or youth's complaint;

(2) collaborate with the department to develop and implement an annual outreach plan to promote awareness of the ombudsman among the public, children and youth in the conservatorship of the department, family members and caretakers of those children, and facilities licensed by the department and that includes:

(A) how the office may be contacted;

(B) the purpose of the office; and

(C) the services the office provides;

(3) issue and file with the department and any applicable health and human services agency a report that contains the ombudsman's final determination regarding a complaint and any recommended corrective actions to be taken as a result of the complaint;

(4) establish a secure form of communication with any individual who files a complaint with the ombudsman;

(5) collaborate with the department to identify consequences for any retaliatory action related to a complaint filed with the ombudsman, in accordance with Section 40.0041(g), Human Resources Code; and

(6) monitor and evaluate the department's corrective actions taken in response to a recommendation by the ombudsman.

(c) The ombudsman's final determination in a report described by Subsection (b)(3) must include a determination of whether there was wrongdoing or negligence by the department or an

agent of the department or whether the complaint was frivolous and without merit. If the ombudsman determines there was wrongdoing or negligence, the ombudsman shall recommend corrective actions to be taken by the department.

(d) The ombudsman may attend any judicial proceeding related to a complaint filed with the office.

Amendments to this section made by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), take effect on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 6, eff. September 1, 2017.

See note following this section.

Sec. 531.9931. DIVISION OF OMBUDSMAN FOR CHILDREN AND YOUTH IN FOSTER CARE. (a) The division of the ombudsman for children and youth in foster care is created within the office of the ombudsman for the purpose of:

(1) receiving complaints from children and youth in the conservatorship of the department as provided under Section 531.993(a)(1);

(2) informing children and youth in the conservatorship of the department who file a complaint under this subchapter about the result of the ombudsman's investigation of the complaint, including whether the ombudsman was able to substantiate the child's or youth's complaint; and

(3) collaborating with the department to develop an outreach plan for children and youth in the conservatorship of the department to promote awareness of the ombudsman.

(b) If a child or youth in the conservatorship of the department contacts the ombudsman by telephone call to report a

complaint under this subchapter, the call shall be transferred directly to a person employed by the division of the ombudsman created under this section.

Text of section effective on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 7, eff. September 1, 2017.

Sec. 531.994. INVESTIGATION OF UNREPORTED COMPLAINTS. If, during the investigation of a complaint, the ombudsman discovers unreported violations of the department's or a health and human services agency's rules and policies, the ombudsman shall open a new investigation for each unreported violation.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

See note following this section.

Sec. 531.9941. DISPUTES REGARDING FOSTER CHILDREN. (a) A child-placing agency responsible for a foster child may refer a dispute regarding the child's placement or the permanency plan for the child to the ombudsman by filing a complaint with the ombudsman.

(b) The complaint filed with the ombudsman must include a clear explanation of the dispute and the requested remedy.

(c) The ombudsman shall notify the court with jurisdiction over the child's case of any investigation of a complaint filed under this subchapter.

Text of section effective on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 8,

eff. September 1, 2017.

Sec. 531.995. ACCESS TO INFORMATION. The department and each health and human services agency shall provide the ombudsman access to the department's or agency's records that relate to a complaint the ombudsman is reviewing or investigating.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

Sec. 531.996. COMMUNICATION AND CONFIDENTIALITY. (a) A person may communicate with the ombudsman relating to a complaint by telephone, by mail, by electronic mail, or by any other means the ombudsman determines to be feasible, secure, and accessible to children and youth.

(b) A communication with the ombudsman is confidential during an investigation or review of a complaint and remains confidential after the complaint is resolved.

(c) The records of the ombudsman are confidential and must be maintained in a manner that preserves the confidentiality of the records.

(d) The disclosure of confidential information to the ombudsman under this section or Section 531.995 does not constitute a waiver of confidentiality. Any information disclosed to the ombudsman under this section or Section 531.995 remains confidential and privileged following disclosure.

(e) The ombudsman is not prohibited from communicating with the department or another health and human services agency regarding confidential information disclosed to the ombudsman by the department or agency.

(f) The ombudsman may make reports relating to an investigation of a complaint public after the complaint is resolved. A report may not include information that identifies an individual complainant, client, parent, or employee or any other person involved in the complaint.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

See note following this section.

Sec. 531.997. RETALIATION PROHIBITED. The department or another health and human services agency may not retaliate against a department employee, a child or youth in the conservatorship of the department, or any other person who in good faith makes a complaint to the ombudsman or against any person who cooperates with the ombudsman in an investigation.

Amendments to this section made by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), take effect on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 9, eff. September 1, 2017.

See note following this section.

Sec. 531.998. REPORT. (a) The ombudsman shall prepare an annual report that contains:

(1) a description of the ombudsman's work;

(2) any change made by the department or another health and human services agency in response to a substantiated complaint;

(3) a description of any trends in the nature of complaints received by the ombudsman, any recommendations related to addressing those trends, and an evaluation of the feasibility of the ombudsman's recommendations;

(4) a glossary of terms used in the report;

(5) a description of the methods used to promote awareness of the ombudsman under Section 531.993(b) and the ombudsman's promotion plan for the next year; and

(6) any public feedback received by the ombudsman relating to the ombudsman's previous annual reports.

(b) The report must be submitted to the governor, the lieutenant governor, each standing committee of the legislature with jurisdiction over matters involving the department, each member of the legislature, the executive commissioner, and the commissioner of the department not later than December 1 of each year. On receipt of the report, the department and the commission shall make the report publicly available on the department's and the commission's Internet websites.

Amendments to Subsection (b) of this section made by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), take effect on September 1, 2017, but only if a specific appropriation is provided as described by Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 12, which states: This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 85th Legislature.

Added by Acts 2015, 84th Leg., R.S., Ch. 1168 (S.B. 830), Sec. 1, eff. September 1, 2015.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 906 (S.B. 213), Sec. 10, eff. September 1, 2017.