HUMAN RESOURCES CODE

TITLE 2. HUMAN SERVICES AND PROTECTIVE SERVICES IN GENERAL

SUBTITLE C. ASSISTANCE PROGRAMS

CHAPTER 32. MEDICAL ASSISTANCE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 32.001. PURPOSE OF CHAPTER. The purpose of this chapter is to enable the state to provide medical assistance on behalf of needy individuals and to enable the state to obtain all benefits for those persons authorized under the Social Security Act or any other federal act.

Acts 1979, 66th Leg., p. 2348, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979.

Sec. 32.002. CONSTRUCTION OF CHAPTER. (a) This chapter shall be liberally construed and applied in relation to applicable federal laws and regulations so that adequate and high quality health care may be made available to all children and adults who need the care and are not financially able to pay for it.

(b) If a provision of this chapter conflicts with a provision of the Social Security Act or any other federal act and renders the state program out of conformity with federal law to the extent that federal matching money is not available to the state, the conflicting provision of state law shall be inoperative to the extent of the conflict but shall not affect the remainder of this chapter.

Acts 1979, 66th Leg., p. 2348, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979.

Sec. 32.003. DEFINITIONS. In this chapter:

(1) "Health and human services agencies" has the meaning assigned by Section 531.001, Government Code.

(2) "Local health department" means a local health department established under Subchapter D, Chapter 121, Health and Safety Code.

(3) "Local health unit" means a local health unit

described by Section 121.004, Health and Safety Code.

(3-a) "Local public health entity" means:

(A) a local health unit;

(B) a local health department; and

(C) a public health district.

(4) "Medical assistance" and "Medicaid" include all of the health care and related services and benefits authorized or provided under federal law for needy individuals of this state.

(5) "Public health district" means a public health district established under Subchapter E, Chapter 121, Health and Safety Code.

Acts 1979, 66th Leg., p. 2349, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1995, 74th Leg., ch. 6, Sec. 2, eff. March 23, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.073, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.465(a)(35), eff. April 2, 2015.

Acts 2021, 87th Leg., R.S., Ch. 535 (S.B. 73), Sec. 1, eff. September 1, 2021.

## SUBCHAPTER B. ADMINISTRATIVE PROVISIONS

Sec. 32.021. ADMINISTRATION OF THE PROGRAM. (a) The commission is the single state agency designated to administer the medical assistance program provided in this chapter in accordance with 42 U.S.C. Section 1396a(a)(5). Subject to applicable federal law, the commission may delegate the operation of a part of the medical assistance program to another state agency. Notwithstanding any delegation, the commission retains ultimate authority over the medical assistance program.

(a-1) To the extent the commission delegates the operation of a part of the medical assistance program to another state agency, or to the extent that state law assigns a function of the medical assistance program to another health and human services agency operating under the commission's oversight, a reference in this

chapter to the commission with respect to that part of the medical assistance program means the state agency to which the operation of that part is delegated or assigned.

(b) The commission shall enter into agreements with any federal agency designated by federal law to administer medical assistance when the commission determines the agreements to be compatible with the state's participation in the medical assistance program and within the limits of appropriated funds. The commission shall cooperate with federal agencies designated by federal law to administer medical assistance in any reasonable manner necessary to qualify for federal funds.

(c) The executive commissioner shall establish methods of administration and adopt necessary rules for the proper and efficient operation of the medical assistance program.

(d) The commission shall include in its contracts for the delivery of medical assistance by nursing facilities provisions for monetary penalties to be assessed for violations as required by 42 U.S.C. Section 1396r, including without limitation the Omnibus Budget Reconciliation Act (OBRA), Pub. L. No. 100-203, Nursing Home Reform Amendments of 1987, provided that the executive commissioner shall:

(1) provide for an informal dispute resolution process in the commission as provided by Section 531.058, Government Code; and

(2) develop rules to adjudicate claims in contested cases, including claims unresolved by the informal dispute resolution process of the commission.

(e) Rules governing the application of penalties shall include the following:

(1) specific and objective criteria which describe the scope and severity of a contract violation which results in a recommendation for each specific penalty. Penalties must be appropriate to the violation, and the most severe financial penalties must be reserved for situations which create an immediate and serious threat to the health and safety of residents; "immediate and serious threat" means a situation in which there is a high probability that serious harm or injury to

residents could occur at any time or already has occurred and may well occur again if residents are not protected effectively from the harm or if the threat is not removed;

(2) a system to ensure standard and consistent application of penalties among surveyors and different areas of the state;

(3) due process for nursing facilities providers, including an appeals procedure consistent with Chapter 2001, Government Code; and

(4) per diem and/or minimum penalties. The executive commissioner may by rule prescribe a minimum penalty period; however, once a facility gives the Department of Aging and Disability Services notice that deficiencies have been corrected, if surveyors are unable to revisit the facility within five days and the deficiencies are later shown to be corrected, the per diem penalties cease as of the day the facility gave notice to the Department of Aging and Disability Services or on the last day of the minimum penalty period established by the executive commissioner, whichever is later.

(f) To encourage facilities to provide the best possible care, the commission shall develop an incentive program to recognize facilities providing the highest quality care to Medicaid residents.

(g) Funds collected as a result of the imposition of penalties shall be applied to the protection of the health or property of residents of nursing facilities, including the cost of relocation of residents to other facilities and maintenance or operation of a facility pending correction of deficiencies or closure, or to incentive programs which recognize the highest quality care to residents who are entitled to Medicaid.

(h) Medicaid nursing facilities shall also comply with state licensure rules, which may be more stringent than the requirements for certification. The Department of Aging and Disability Services shall use appropriate civil, administrative, or criminal remedies authorized by state or federal law with respect to a facility that is in violation of a certification or licensing requirement.

(i) Repealed by Acts 2003, 78th Leg., ch. 204, Sec. 16.03(1).

(j) Repealed by Acts 2001, 77th Leg., ch. 1284, Sec. 3.04, eff. June 15, 2001.

(k) Repealed by Acts 2003, 78th Leg., ch. 204, Sec. 16.03(1).

(l) The commission may not include as a reimbursable item to a nursing facility an administrative or civil penalty assessed against the facility under this chapter or under Chapter 242, Health and Safety Code.

(m) Notwithstanding any provision of law to the contrary, the commission shall terminate a nursing facility's provider agreement if the Department of Aging and Disability Services has imposed required Category 2 or Category 3 remedies on the facility three times within a 24-month period. The executive commissioner by rule shall establish criteria under which the requirement to terminate the provider agreement may be waived. In this subsection, "Category 2 remedies" and "Category 3 remedies" have the meanings assigned by 42 C.F.R. Section 488.408.

(n) An assessment of monetary penalties under this section is subject to arbitration under Subchapter H-2, Chapter 242, Health and Safety Code.

(o) In any circumstance in which a nursing facility would otherwise be required to admit a resident transferred from another facility, because of an emergency or otherwise, the nursing facility may not admit a resident whose needs cannot be met through service from the facility's staff or in cooperation with community resources or other providers under contract. If a nursing facility refuses to admit a resident under this subsection, the nursing facility shall provide a written statement of the reasons for the refusal to the Department of Aging and Disability Services within a period specified by rule. A nursing facility that fails to provide the written statement, or that includes false or misleading information in the statement, is subject to monetary penalties assessed in accordance with this chapter.

(p) In order to increase the personal needs allowance under Section 32.024(w), the commission shall develop an early warning

system to detect fraud in the handling of the personal needs allowance and other funds of residents of long-term care facilities.

(q) The commission shall include in its contracts for the delivery of medical assistance by nursing facilities clearly defined minimum standards that relate directly to the quality of care for residents of those facilities. The commission shall include in each contract:

(1) specific performance measures by which the commission may evaluate the extent to which the nursing facility is meeting the standards; and

(2) provisions that allow the commission to terminate the contract if the nursing facility is not meeting the standards.

(r) The commission may not award a contract for the delivery of medical assistance to a nursing facility that does not meet the minimum standards that would be included in the contract as required by Subsection (q). The commission shall terminate a contract for the delivery of medical assistance by a nursing facility that does not meet or maintain the minimum standards included in the contract in a manner consistent with the terms of the contract.

(s) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(106), eff. June 17, 2011.

Acts 1979, 66th Leg., p. 2349, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1991, 72nd Leg., 1st C.S., ch. 15, Sec. 5.22, eff. Sept. 1, 1991; Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49), eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 1049, Sec. 1, eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 1159, Sec. 2.01, eff. Sept. 1, 1997; Acts 2001, 77th Leg., ch. 974, Sec. 2, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1284, Sec. 3.01, 3.04, 7.04, eff. June 15, 2001; Acts 2003, 78th Leg., ch. 198, Sec. 2.92(a), eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 204, Sec. 16.03(1), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 809 (S.B. 1318), Sec. 1, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec.

27.002(11), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 23(5), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(106), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.074, eff. April 2, 2015.

Sec. 32.0211. RESTRICTIONS ON EXECUTIVE COMMISSIONERS, FORMER MEMBERS OF A BOARD, COMMISSIONERS, AND THEIR BUSINESS PARTNERS. (a) After service in the commission or a health and human services agency, including an agency that formerly operated part of the medical assistance program but that has been abolished, ends, a former executive commissioner, member of the board, or commissioner of the applicable agency may not knowingly represent a person before an agency or court:

(1) in a matter related to the medical assistance program in which the agency the person served or the federal government has a direct interest and in which the executive commissioner, board member, or commissioner participated personally while employed with the agency; or

(2) for two years after the date on which service ends in a matter related to the medical assistance program if the commission, the health and human services agency, or the federal government has a direct interest in the matter, the matter was pending during the executive commissioner's or commissioner's last year of service to the applicable agency, and the matter was one for which the executive commissioner or commissioner had responsibility.

(b) Subsection (a) does not apply to a former executive commissioner, board member, or commissioner who holds one of the following positions and is acting in the scope of that position:

(1) employee or officer of federal, state, or local government;

(2) employee of a nonprofit hospital or medical research organization; or

(3) employee of an accredited degree-granting college

or university.

(c) The current executive commissioner or a current commissioner of a health and human services agency may not knowingly participate in the course of the executive commissioner's or commissioner's service in a matter related to the medical assistance program in which the agency the person serves or the federal government has a direct interest and in which the executive commissioner or commissioner, or the executive commissioner's or commissioner's spouse, minor child, or business partner, has a substantial financial interest.

(d) A business partner of a current executive commissioner or a current commissioner of a health and human services agency may not knowingly represent a person before an agency or court in a matter related to the medical assistance program:

(1) in which the executive commissioner or commissioner participates or has participated personally and substantially; or

(2) that is under the official responsibility of the executive commissioner or commissioner.

(e) A past or present executive commissioner, a past board member of a health and human services agency, including an abolished agency, or a past or present commissioner of a health and human services agency is subject to a civil penalty of $5,000 for each violation of this section. A partner of a current executive commissioner or commissioner is subject to a civil penalty of $2,500 for each violation of this section. Each appearance before an agency or court constitutes a separate offense.

(f) If it appears that this section has been violated, the commission may request the attorney general to conduct a suit in the name of the State of Texas to enjoin the prohibited activity and to recover the penalty provided for in this section.

Added by Acts 1981, 67th Leg., p. 755, ch. 287, Sec. 1, eff. Aug. 31, 1981.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.075, eff. April 2, 2015.

Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE. Notwithstanding any other law and subject to Section 533.0025, Government Code, the commission shall provide medical assistance for acute care services through the Medicaid managed care system implemented under Chapter 533, Government Code, or another Medicaid capitated managed care program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.95, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.10, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.075, eff. April 2, 2015.

Sec. 32.0213. NURSING FACILITY BED CERTIFICATION AND DECERTIFICATION. (a) The executive commissioner by rule shall establish procedures for:

(1) controlling the number of Medicaid beds in nursing facilities;

(2) decertification of unused Medicaid beds in nursing facilities; and

(3) reallocation of nursing facility beds decertified under Subdivision (2) to other nursing facilities.

(b) The procedures established under this section must take into account the occupancy rate of the nursing facility.

(c) The executive commissioner may exempt a nursing facility from the procedures established under this section if the facility:

(1) is affiliated with a state-supported medical school;

(2) is located on land owned or controlled by the state-supported medical school; and

(3) serves as a teaching facility for physicians and related health care professionals.

(d) The executive commissioner by rule may require an applicant for Medicaid beds in a nursing facility under a Medicaid bed waiver application to provide a performance bond in the amount

of $500,000 or other financial security as determined by the Department of Aging and Disability Services to ensure that the applicant provides the Medicaid beds granted to the applicant under the waiver within the time frame required by the Department of Aging and Disability Services. A performance bond provided under this subsection must:

(1) be executed by a corporate surety in accordance with Subchapter A, Chapter 3503, Insurance Code;

(2) be in a form approved by the Department of Aging and Disability Services; and

(3) clearly and prominently display on the face of the bond or on an attachment to the bond:

(A) the name, mailing address, physical address, and telephone number, including the area code, of the surety company to which any notice of claim should be sent; or

(B) the toll-free telephone number maintained by the Texas Department of Insurance under Subchapter B, Chapter 521, Insurance Code, and a statement that the address of the surety company to which any notice of claim should be sent may be obtained from the Texas Department of Insurance by calling the toll-free telephone number.

(e) The executive commissioner may not require an applicant for Medicaid beds in a nursing facility to obtain a performance bond from a specific insurance or surety agency, agent, or broker.

(f) The executive commissioner by rule shall adopt criteria to exempt certain applicants for Medicaid beds from the requirements of Subsection (d), including applicants that are licensed facilities with existing Medicaid bed allocations, criminal justice facilities, teaching facilities, and state veterans homes, and any other applicants that the executive commissioner finds good cause to exempt. The executive commissioner may modify the criteria for granting exemptions under this subsection as necessary to meet the objectives of Subsection (d).

Added by Acts 1997, 75th Leg., ch. 1159, Sec. 2.02, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1487, Sec. 1, eff. June 19, 1999.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1063 (H.B. 3196), Sec. 3, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.076, eff. April 2, 2015.

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

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

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 15, eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.077, eff. April 2, 2015.

Sec. 32.0215. HOME OR COMMUNITY CARE PROVIDERS: CIVIL MONETARY PENALTIES. (a) The commission may include in a contract for the delivery of medical assistance by a home or community care provider a provision for monetary penalties to be assessed for a contract violation or any violation of home or community care requirements, as required by 42 U.S.C. Section 1396t(j).

(b) The executive commissioner shall adopt rules governing the application of civil money penalties, including rules prescribing:

(1) criteria that describe when and how a civil money penalty may be assessed and the amount of the penalty;

(2) a system to ensure standard and consistent application of the penalties throughout the state; and

(3) an administrative appeals process to adjudicate claims in contested cases in accordance with Chapter 2001, Government Code.

(c) Rules adopted under this section must be designed to minimize the time between the identification of a violation and the final imposition of a penalty. Rules adopted under this section may authorize the imposition of a penalty that assesses and collects a monetary penalty, with interest, for a minimum penalty period and on a subsequent per diem basis.

(d) A penalty must be appropriate to the violation. The commission may assess incrementally more severe penalties for repeated or uncorrected violations.

(e) The commission shall review a penalized provider within 10 working days after the provider notifies the Department of Aging and Disability Services that the deficiency that caused the imposition of the penalty has been corrected. If the commission is unable to review the provider within that 10-working-day period, the penalty ceases on the earlier of the last day of the minimum penalty period or the date the provider gives notice to the Department of Aging and Disability Services.

(f) Money collected as a result of the imposition of penalties may be used for the protection of the health or property of an individual whose personal property was lost due to a failure of a home or community care provider to meet the requirements for participation as a provider of home or community care.

Added by Acts 1993, 73rd Leg., ch. 132, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49), eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.078, eff. April 2, 2015.

Sec. 32.022. MEDICAL AND HOSPITAL CARE ADVISORY COMMITTEES. (a) The executive commissioner shall appoint a medical care advisory committee to advise the executive commissioner and the

commission in developing and maintaining the medical assistance program and in making immediate and long-range plans for reaching the program's goal of providing access to high quality, comprehensive medical and health care services to medically indigent persons in the state. To ensure that qualified applicants receive services, the committee shall consider changes in the process the commission uses to determine eligibility.

(b) The executive commissioner shall appoint the committee in compliance with the requirements of the federal agency administering medical assistance. The appointments shall:

(1) provide for a balanced representation of the general public, providers, consumers, and other persons, state agencies, or groups with knowledge of and interest in the committee's field of work; and

(2) include one member who is the representative of a managed care organization.

(c) The executive commissioner shall adopt rules for membership on the committee to provide for efficiency of operation, rotation, stability, and continuity.

(d) The executive commissioner may appoint regional and local medical care advisory committees and other advisory committees as considered necessary.

Acts 1979, 66th Leg., p. 2349, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1987, 70th Leg., ch. 1052, Sec. 2.01, eff. Sept. 1, 1987; Acts 1989, 71st Leg., ch. 1027, Sec. 10, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.079, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.36(a), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(c), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.33(a), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(d), eff. January 1, 2016.

Sec. 32.023. COOPERATION WITH OTHER STATE AGENCIES. (a) The commission's plan for administering medical assistance must include procedures for using health services administered by other state agencies pursuant to cooperative arrangements.

(b) The commission may enter into agreements with appropriate state agencies that will enable the commission to implement Title XIX of the federal Social Security Act (42 U.S.C. Section 1396 et seq.) to provide medical assistance for individuals in institutions or in alternate care arrangements. The agreements must comply with federal law and rules. The commission may make medical assistance payments in accordance with the agreements. The agreements are not subject to Chapter 771, Government Code.

(c) State agencies responsible for the administration or supervision of facilities to which medical assistance payments may be made under federal law shall enter into the agreements with the commission and maintain compliance with the agreements so that the commission may receive federal matching funds to support the medical assistance program.

(d) The commission may pay medical assistance to other facilities as required under federal law and rules.

Acts 1979, 66th Leg., p. 2349, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.079, eff. April 2, 2015.

Sec. 32.0231. ANNOUNCEMENT OF FUNDING OR PROGRAM CHANGE. (a) The executive commissioner shall publish notice in the Texas Register of:

(1) any attempt to obtain a waiver of federal regulations in the medical assistance program;

(2) any attempt to obtain or the receipt of funding under Title XIX of the federal Social Security Act (42 U.S.C. Section 1396 et seq.) for a pilot program; and

(3) any amendment to the state medical assistance

plan.

(b) The notice must include the name and telephone number of a commission employee who can provide information relating to the matter for which notice was published under this section.

(c) The commission shall provide to any requestor information relating to a matter for which notice was published, including the effect and cost of the change, any possible cost savings, the criteria for receiving services, and the number of people to be served.

Added by Acts 1989, 71st Leg., ch. 1085, Sec. 2, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.079, eff. April 2, 2015.

See note following this section.

Sec. 32.024. AUTHORITY AND SCOPE OF PROGRAM; ELIGIBILITY. (a) The commission shall provide medical assistance to all persons who receive financial assistance from the state under Chapter 31 and to other related groups of persons if the provision of medical assistance to those persons is required by federal law and rules as a condition for obtaining federal matching funds for the support of the medical assistance program.

(b) The commission may provide medical assistance to other persons who are financially unable to meet the cost of medical services if federal matching funds are available for that purpose. The executive commissioner shall adopt rules governing the eligibility of those persons for the services.

(c) The executive commissioner shall establish standards governing the amount, duration, and scope of services provided under the medical assistance program. The standards may not be lower than the minimum standards required by federal law and rule as a condition for obtaining federal matching funds for support of the program.

(c-1) The commission shall ensure that money spent for purposes of the demonstration project for women's health care services under former Section 32.0248 or a similar successor program is not used to perform or promote elective abortions, or to

contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions.

(d) The executive commissioner may establish standards that increase the amount, duration, and scope of the services provided only if federal matching funds are available for the optional services and payments and if the executive commissioner determines that the increase is feasible and within the limits of appropriated funds. The executive commissioner may establish and maintain priorities for the provision of the optional medical services.

(e) The commission may not authorize the provision of any service to any person under the program unless federal matching funds are available to pay the cost of the service.

(f) The executive commissioner shall set the income eligibility cap for persons qualifying for nursing facility care at an amount that is not less than $1,104 and that does not exceed the highest income for which federal matching funds are payable. The executive commissioner shall set the cap at a higher amount than the minimum provided by this subsection if appropriations made by the legislature for a fiscal year will finance benefits at the higher cap for at least the same number of recipients of the benefits during that year as were served during the preceding fiscal year, as estimated by the commission. In setting an income eligibility cap under this subsection, the executive commissioner shall consider the cost of the adjustment required by Subsection (g).

(g) During a fiscal year for which the cap described by Subsection (f) has been set, the executive commissioner shall adjust the cap in accordance with any percentage change in the amount of benefits being paid to social security recipients during the year.

(h) Subject to the amount of the cap set as provided by Subsections (f) and (g), and to the extent permitted by federal law, the income eligibility cap for the community care for aged and disabled persons program shall be the same as the income eligibility cap for nursing facility care. The executive commissioner shall ensure that the eligibility requirements for persons receiving other services under the medical assistance

program are not affected.

(i) The executive commissioner in adopting rules may establish a medically needy program that serves pregnant women, children, and caretakers who have high medical expenses, subject to the availability of appropriated funds.

(j) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(36), eff. April 2, 2015.

(k) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(36), eff. April 2, 2015.

(l) The executive commissioner shall set the income eligibility cap for medical assistance for pregnant women and infants up to age one at not less than 130 percent of the federal poverty guidelines.

(l-1) The commission shall continue to provide medical assistance to a woman who is eligible for medical assistance for pregnant women for a period of not less than six months following the date the woman delivers or experiences an involuntary miscarriage.

(m) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(36), eff. April 2, 2015.

(n) The executive commissioner, in the adoption of rules and standards governing the scope of hospital and long-term services, shall authorize the providing of respite care by hospitals.

(o) The executive commissioner, in the rules and standards governing the scope of hospital and long-term services, shall establish a swing bed program in accordance with federal regulations to provide reimbursement for skilled nursing patients who are served in hospital settings provided that the length of stay is limited to 30 days per year and the hospital is located in a county with a population of 100,000 or less. If the swing beds are used for more than one 30-day length of stay per year, per patient, the hospital must comply with the minimum licensing standards as mandated by Chapter 242, Health and Safety Code, and the Medicaid standards for nursing facility certification, as promulgated by the executive commissioner.

(p) The commission shall provide home respiratory therapy services for ventilator-dependent persons to the extent permitted

by federal law.

(q) The commission shall provide physical therapy services.

(r) The commission, from funds otherwise appropriated to the commission for the early and periodic screening, diagnosis, and treatment program, shall provide to a child who is 14 years of age or younger, permanent molar sealants as dental service under that program as follows:

(1) sealant shall be applied only to the occlusal buccal and lingual pits and fissures of a permanent molar within four years of its eruption;

(2) teeth to be sealed must be free of proximal caries and free of previous restorations on the surface to be sealed;

(3) if a second molar is the prime tooth to be sealed, a non-restored first molar may be sealed at the same sitting, if the fee for the first molar sealing is no more than half the usual sealant fee;

(4) the sealing of premolars and primary molars will not be reimbursed; and

(5) replacement sealants will not be reimbursed.

(s) The executive commissioner, in the rules governing the early and periodic screening, diagnosis, and treatment program, shall:

(1) revise the periodicity schedule to allow for periodic visits at least as often as the frequency recommended by the American Academy of Pediatrics and allow for interperiodic screens without prior approval when there are indications that it is medically necessary; and

(2) require, as a condition for eligibility for reimbursement under the program for the cost of services provided at a visit or screening, that a child younger than 15 years of age be accompanied at the visit or screening by:

(A) the child's parent or guardian; or

(B) another adult, including an adult related to the child, authorized by the child's parent or guardian to accompany the child.

(s-1) Subsection (s)(2) does not apply to services provided by a school health clinic, Head Start program, or child-care

facility, as defined by Section 42.002, if the clinic, program, or facility:

(1) obtains written consent to the services from the child's parent or guardian within the one-year period preceding the date on which the services are provided, and that consent has not been revoked; and

(2) encourages parental involvement in and management of the health care of children receiving services from the clinic, program, or facility.

(t) The executive commissioner by rule shall require a physician, nursing facility, health care provider, or other responsible party to obtain authorization from the commission or a person authorized to act on behalf of the commission on the same day or the next business day following the day of transport when an ambulance is used to transport a recipient of medical assistance under this chapter in circumstances not involving an emergency and the request is for the authorization of the provision of transportation for only one day. If the request is for authorization of the provision of transportation on more than one day, the executive commissioner by rule shall require a physician, nursing facility, health care provider, or other responsible party to obtain a single authorization before an ambulance is used to transport a recipient of medical assistance under this chapter in circumstances not involving an emergency. The rules must provide that:

(1) except as provided by Subdivision (3), a request for authorization must be evaluated based on the recipient's medical needs and may be granted for a length of time appropriate to the recipient's medical condition;

(2) except as provided by Subdivision (3), a response to a request for authorization must be made not later than 48 hours after receipt of the request;

(3) a request for authorization must be immediately granted and must be effective for a period of not more than 180 days from the date of issuance if the request includes a written statement from a physician that:

(A) states that alternative means of

transporting the recipient are contraindicated; and

(B) is dated not earlier than the 60th day before the date on which the request for authorization is made;

(4) a person denied payment for ambulance services rendered is entitled to payment from the nursing facility, health care provider, or other responsible party that requested the services if:

(A) payment under the medical assistance program is denied because of lack of prior authorization; and

(B) the person provides the nursing facility, health care provider, or other responsible party with a copy of the bill for which payment was denied;

(5) a person denied payment for services rendered because of failure to obtain prior authorization or because a request for prior authorization was denied is entitled to appeal the denial of payment to the commission; and

(6) the commission or a person authorized to act on behalf of the commission must be available to evaluate requests for authorization under this subsection not less than 12 hours each day, excluding weekends and state holidays.

(t-1) The executive commissioner, in the rules governing the medical transportation program, may not prohibit a recipient of medical assistance from receiving transportation services through the program to obtain renal dialysis treatment on the basis that the recipient resides in a nursing facility.

(u) The executive commissioner by rule shall require a health care provider who arranges for durable medical equipment for a child who receives medical assistance under this chapter to:

(1) ensure that the child receives the equipment prescribed, the equipment fits properly, if applicable, and the child or the child's parent or guardian, as appropriate considering the age of the child, receives instruction regarding the equipment's use; and

(2) maintain a record of compliance with the requirements of Subdivision (1) in an appropriate location.

(v) The executive commissioner by rule shall provide a screening test for hearing loss in accordance with Chapter 47,

Health and Safety Code, and any necessary diagnostic follow-up care related to the screening test to a child younger than 30 days old who receives medical assistance.

(w) The executive commissioner shall set a personal needs allowance of not less than $60 a month for a resident of a convalescent or nursing facility or related institution licensed under Chapter 242, Health and Safety Code, assisted living facility, ICF-IID facility, or other similar long-term care facility who receives medical assistance. The commission may send the personal needs allowance directly to a resident who receives Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.). This subsection does not apply to a resident who is participating in a medical assistance waiver program administered by the commission.

(x) The commission shall provide dental services annually to a resident of a nursing facility who is a recipient of medical assistance under this chapter. The dental services must include:

(1) a dental examination by a licensed dentist;

(2) a prophylaxis by a licensed dentist or licensed dental hygienist, if practical considering the health of the resident; and

(3) diagnostic dental x-rays, if possible.

(y) The commission shall provide medical assistance to a person in need of treatment for breast or cervical cancer who is eligible for that assistance under the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Pub. L. No. 106-354) for a continuous period during which the person requires that treatment. The executive commissioner shall simplify the provider enrollment process for a provider of that medical assistance and shall adopt rules to provide for certification of presumptive eligibility of a person for that assistance. In determining a person's eligibility for medical assistance under this subsection, the executive commissioner, to the extent allowed by federal law, may not require a personal interview.

(y-1) A woman who receives a breast or cervical cancer screening service under Title XV of the Public Health Service Act (42 U.S.C. Section 300k et seq.) and who otherwise meets the

eligibility requirements for medical assistance for treatment of breast or cervical cancer as provided by Subsection (y) is eligible for medical assistance under that subsection, regardless of whether federal Medicaid matching funds are available for that medical assistance. A screening service of a type that is within the scope of screening services under that title is considered to be provided under that title regardless of whether the service was provided by a provider who receives or uses funds under that title.

(z) In the executive commissioner's rules and standards governing the vendor drug program, the executive commissioner, to the extent allowed by federal law and if the executive commissioner determines the policy to be cost-effective, may ensure that a recipient of prescription drug benefits under the medical assistance program does not, unless authorized by the commission in consultation with the recipient's attending physician or advanced practice nurse, receive under the medical assistance program:

(1) more than four different outpatient brand-name prescription drugs during a month; or

(2) more than a 34-day supply of a brand-name prescription drug at any one time.

(z-1) Subsection (z) does not affect any other limit on prescription medications otherwise prescribed by commission rule.

(z-2) The limits on prescription drugs and medications under the medical assistance program provided by Subsections (z) and (z-1) do not apply to a prescription for an opioid for the treatment of acute pain under Section 481.07636, Health and Safety Code.

(aa) The commission shall incorporate physician-oriented instruction on the appropriate procedures for authorizing ambulance service into current medical education courses.

(bb) The commission may not provide an erectile dysfunction medication under the Medicaid vendor drug program to a person required to register as a sex offender under Chapter 62, Code of Criminal Procedure, to the maximum extent federal law allows the commission to deny that medication.

(cc) In this subsection, "deaf" and "hard of hearing" have the meanings assigned by Section 81.001. Subject to the

availability of funds, the commission shall provide interpreter services as requested during the receipt of medical assistance under this chapter to:

(1) a person receiving that assistance who is deaf or hard of hearing; or

(2) a parent or guardian of a person receiving that assistance if the parent or guardian is deaf or hard of hearing.

(dd) Nothwithstanding any other law, an inmate released on medically recommended intensive supervision under Section 508.146, Government Code, who otherwise meets the eligibility requirements for the medical assistance program is not ineligible for the program solely on the basis of the conviction or adjudication for which the inmate was sentenced to confinement.

(ff) The executive commissioner shall establish a separate provider type for prosthetic and orthotic providers for purposes of enrollment as a provider of and reimbursement under the medical assistance program. The executive commissioner may not classify prosthetic and orthotic providers under the durable medical equipment provider type.

(gg) Notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the commission shall ensure that advanced practice registered nurses and physician assistants may be selected by and assigned to recipients of medical assistance as the primary care providers of those recipients regardless of whether the physician supervising the advanced practice registered nurse is included in any directory of providers of medical assistance maintained by the commission. This subsection may not be construed as authorizing the commission to supervise or control the practice of medicine as prohibited by Subtitle B, Title 3, Occupations Code. The commission must require that advanced practice registered nurses and physician assistants be treated in the same manner as primary care physicians with regard to:

(1) selection and assignment as primary care providers; and

(2) inclusion as primary care providers in any directory of providers of medical assistance maintained by the commission.

(ii) The commission shall provide medical assistance reimbursement to a pharmacist who is licensed to practice pharmacy in this state, is authorized to administer immunizations in accordance with rules adopted by the Texas State Board of Pharmacy, and administers an immunization to a recipient of medical assistance to the same extent the commission provides reimbursement to a physician or other health care provider participating in the medical assistance program for the administration of that immunization.

(jj) The executive commissioner shall establish a separate provider type for prescribed pediatric extended care centers licensed under Chapter 248A, Health and Safety Code, for purposes of enrollment as a provider for and reimbursement under the medical assistance program.

(kk) The commission in its rules and standards governing the scope of services provided under the medical assistance program shall include peer services provided by certified peer specialists to the extent permitted by federal law.

Text of subsection as added by Acts 2021, 87th Leg., R.S., Ch. 535 (S.B. 73), Sec. 2

(ll) The executive commissioner shall establish a separate provider type for a local public health entity for purposes of enrollment as a provider for and reimbursement under the medical assistance program.

Text of subsection as added by Acts 2021, 87th Leg., R.S., Ch. 966 (S.B. 1921), Sec. 2

Text of subsection effective on September 01, 2022

(ll) The commission shall provide medical assistance reimbursement to an authorized wound care education and training services provider and establish outcome measures for evaluating the physical health care outcomes of recipients who receive wound care education and training services from an authorized wound care education and training services provider.

(oo) The commission shall provide medical assistance reimbursement to a treating health care provider who participates in Medicaid for the provision to a child or adult medical assistance recipient of behavioral health services that are classified by a Current Procedural Terminology code as collaborative care management services.

Text of Subsection (kk) 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.

Acts 1979, 66th Leg., p. 2350, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1989, 71st Leg., ch. 1027, Sec. 11, eff. Sept. 1, 1989; Acts 1989, 71st Leg., ch. 1085, Sec. 3, eff. Sept. 1, 1989; Acts 1989, 71st Leg., ch. 1107, Sec. 1, eff. Sept. 1, 1989; Acts 1989, 71st Leg., ch. 1219, Sec. 1, eff. Sept. 1, 1989; Acts 1990, 71st Leg., 6th C.S., ch. 12, Sec. 2(11) to (13), eff. Sept. 6, 1990; Acts 1991, 72nd Leg., ch. 690, Sec. 1, eff. Aug. 26, 1991; Acts 1995, 74th Leg., ch. 6, Sec. 3, eff. March 23, 1995; Acts 1997, 75th Leg., ch. 1153, Sec. 2.01(a), 2.02(a), eff. June 20, 1997; Acts 1999, 76th Leg., ch. 766, Sec. 1, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1333, Sec. 1, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1347, Sec. 3, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1505, Sec. 1.06, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 220, Sec. 1, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 348, Sec. 1, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 974, Sec. 1, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1420, Sec. 21.001(81), eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 198, Sec. 2.96, 2.97(a), 2.207(a), eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 215, Sec. 1, eff. June 18, 2003; Acts 2003, 78th Leg., ch. 1251, Sec. 6, eff. June 20, 2003; Acts 2003, 78th Leg., ch. 1275, Sec. 2(97), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 22, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(57), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1314 (H.B. 3235), Sec. 1, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 16, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 442 (H.B. 52), Sec. 1, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(50), eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 1308 (S.B. 909), Sec. 45, eff. June 15, 2007.

Acts 2009, 81st Leg., R.S., Ch. 745 (S.B. 531), Sec. 2, eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 858 (S.B. 2424), Sec. 1, eff. June 19, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 35 (S.B. 874), Sec. 1, eff. May 9, 2011.

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

Acts 2013, 83rd Leg., R.S., Ch. 418 (S.B. 406), Sec. 25, eff. November 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1168 (S.B. 492), Sec. 6, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.080, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.081, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.465(a)(36), eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 302 (S.B. 654), Sec. 3, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 1015 (H.B. 1486), Sec. 2, eff. June 15, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1105 (H.B. 2174), Sec. 12, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 370 (S.B. 672), Sec. 1, eff.

September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 535 (S.B. 73), Sec. 2, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 629 (H.B. 133), Sec. 3, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 966 (S.B. 1921), Sec. 2, eff. September 1, 2022.

Sec. 32.0241. REVIEW OF WAIVER REQUEST. The commission shall, at least biennially, review the feasibility of requesting a waiver for the elderly under Section 1915(c), federal Social Security Act (42 U.S.C. Section 1396n), if the reimbursement rates for nursing facilities under the medical assistance program have increased since the preceding review.

Added by Acts 1989, 71st Leg., ch. 1085, Sec. 2, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.082, eff. April 2, 2015.

Sec. 32.0242. VERIFICATION OF CERTAIN INFORMATION. To the extent possible, the commission shall verify an applicant's residential address at the time the application for medical assistance is filed.

Added by Acts 1999, 76th Leg., ch. 1289, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.082, eff. April 2, 2015.

Sec. 32.0243. PERIODIC REVIEW OF ELIGIBILITY FOR CERTAIN RECIPIENTS. (a) The commission, in cooperation with the United States Social Security Administration, shall periodically review the eligibility of a recipient of medical assistance who is eligible on the basis of the recipient's eligibility for Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq., as amended.

(b) In reviewing the eligibility of a recipient as required by Subsection (a), the commission shall ensure that only recipients

who reside in this state and who continue to be eligible for Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq., as amended, remain eligible for medical assistance. Added by Acts 1999, 76th Leg., ch. 1289, Sec. 1, eff. Sept. 1, 1999. Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.082, eff. April 2, 2015.

Sec. 32.0244. NURSING FACILITY BEDS IN CERTAIN COUNTIES. (a) At the request of the commissioners court of a county in which not more than two nursing facilities are certified to participate in the state Medicaid program, and subject to Subsection (d), the commission may contract for additional nursing facility beds under the state Medicaid program in the county without regard to the occupancy rate of available Medicaid beds.

(b) A commissioners court that intends to make a request under Subsection (a) shall publish notice of its intent in the Texas Register and in a newspaper of general circulation in the county. The notice must request:

(1) comments on whether the request should be made; and

(2) proposals from persons interested in providing additional Medicaid beds in the county, including persons providing Medicaid beds in a nursing facility with a high occupancy rate.

(c) A commissioners court shall determine whether to proceed with a request after considering all comments and proposals received in response to the notices provided under Subsection (b). If the commissioners court proceeds with the request, the court may recommend that the commission contract with a specific nursing facility that submitted a proposal. In determining whether to proceed with the request and whether to recommend a specific nursing facility, the commissioners court shall consider:

(1) the demographic and economic needs of the county;

(2) the quality of existing nursing facility services under the state Medicaid program in the county;

(3) the quality of the proposals submitted; and

(4) the degree of community support for additional

nursing facility services.

(d) The commission may not contract under this section for more than 120 additional nursing facility beds per county per year and may not exceed 500 additional nursing facility beds statewide in a calendar year.

Added by Acts 1997, 75th Leg., ch. 555, Sec. 1, eff. Sept. 1, 1997. Renumbered from Sec. 32.0246 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(73), eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.083, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.084, eff. April 2, 2015.

Sec. 32.0245. NURSING FACILITY BEDS FOR CERTAIN FACILITIES TREATING ALZHEIMER'S DISEASE. The commission shall waive for a nursing facility a restriction imposed by state law on the authority to contract under the state Medicaid program for nursing facility beds based on the percentage of beds that are occupied in a geographical area if the facility:

(1) is affiliated with a medical school operated by the state;

(2) is participating in a research program for the care and treatment of persons with Alzheimer's disease; and

(3) is designed to separate and treat Alzheimer's disease by stage or functional level.

Added by Acts 1995, 74th Leg., ch. 841, Sec. 1, eff. Aug. 28, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.085, eff. April 2, 2015.

Sec. 32.02451. ADDITIONAL PERSONAL NEEDS ALLOWANCE FOR GUARDIANSHIP EXPENSES OF CERTAIN RECIPIENTS. (a) In this section, "applied income" has the meaning assigned by Section 1155.201, Estates Code.

(b) To the extent allowed by federal law, the commission, in computing the applied income of a recipient of medical assistance,

shall deduct in the manner provided by this section an additional personal needs allowance from the earned and unearned income of the recipient or, if applicable, the recipient and the recipient's spouse, for compensation and costs ordered to be deducted under Section 1155.202, Estates Code. Subject to Subsection (f), a deduction ordered by the court under Section 1155.202, Estates Code, is effective beginning on the later of:

(1) the month in which the order is signed; or

(2) the first month of medical assistance eligibility for which the recipient is subject to a copayment.

(c) The commission shall compute the applied income of a recipient of medical assistance as follows:

(1) the commission shall deduct from the earned and unearned income the personal needs allowance authorized by Section 32.024(w) before making any other deduction;

(2) if after the deduction under Subdivision (1) the recipient has remaining income, the commission shall deduct the lesser of the following:

(A) the amount of the remaining income; or

(B) the amount of the additional personal needs allowance for compensation and costs ordered to be deducted under Section 1155.202, Estates Code; and

(3) if after the deductions under Subdivisions (1) and (2) the recipient has remaining income, the commission shall deduct any other authorized allowances.

(d) The amount of income remaining, if any, after the commission makes the deductions as provided by Subsection (c) is the amount of the applied income of the recipient of medical assistance.

(e) The executive commissioner shall adopt rules providing a procedure by which a recipient of medical assistance for whom amounts are ordered deducted under Section 1155.202, Estates Code, may submit to the commission a copy of the court order issued under that section to receive a deduction of those amounts from the recipient's income as provided by this section.

(f) The commission may not allow a deduction for the additional personal needs allowance for compensation and costs

ordered to be deducted under Section 1155.202, Estates Code, if the order is issued after the recipient of medical assistance dies.

Added by Acts 2009, 81st Leg., R.S., Ch. 859 (S.B. 2435), Sec. 1, eff. September 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 599 (S.B. 220), Sec. 2, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.086, eff. April 2, 2015.

Text of section effective on September 01, 2022

Sec. 32.0246. MEDICAL ASSISTANCE REIMBURSEMENT FOR CERTAIN BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES. (a) In this section, "behavioral health services" has the meaning assigned by Section 533.00255(a), Government Code, and includes targeted case management and psychiatric rehabilitation services.

(b) The commission shall provide to a public or private provider of behavioral health services medical assistance reimbursement through a fee-for-service delivery model for behavioral health or physical health services provided to a recipient before that recipient's enrollment with and receipt of medical assistance services through a managed care organization under Chapter 533, Government Code.

(c) The commission shall ensure that a public or private provider of behavioral health services who is reimbursed under Subsection (b) through a fee-for-service delivery model is provided medical assistance reimbursement through a managed care model for behavioral health or physical health services provided to a recipient after that recipient's enrollment with and receipt of medical assistance services through a managed care organization under Chapter 533, Government Code.

Added by Acts 2021, 87th Leg., R.S., Ch. 966 (S.B. 1921), Sec. 1, eff. September 1, 2022.

Sec. 32.0247. MEDICAL ASSISTANCE FOR CERTAIN PERSONS MAKING TRANSITION FROM FOSTER CARE TO INDEPENDENT LIVING. (a) In this section, "independent foster care adolescent" has the meaning

assigned by 42 U.S.C. Section 1396d(w)(1), as amended.

(b) The commission shall provide medical assistance, in accordance with commission rules, to an independent foster care adolescent who:

(1) is not otherwise eligible for medical assistance; and

(2) is not covered by a health benefits plan offering adequate benefits, as determined by the commission.

(c) To the extent allowed by federal law, the executive commissioner shall by rule establish a specific set of income, assets, or resources allowable for recipients under this section. The income level shall not be less than 200 percent or more than 400 percent of the federal poverty level. Allowable asset or resource levels shall not be less than:

(1) the levels allowed for individuals who are in foster care; and

(2) the levels allowed for a person under 19 years of age who is eligible for the medical assistance program.

(d) In setting allowable income, asset, or resource levels, the executive commissioner shall, to the extent allowed by federal law, exclude:

(1) any financial benefit used for the purpose of educational or vocational training, such as scholarships, student loans, or grants;

(2) any financial benefit used for the purpose of housing; and

(3) any grants or subsidies obtained as a result of the Foster Care Independence Act of 1999 (Pub. L. No. 106-169).

(e) The Department of Family and Protective Services shall certify the income, assets, or resources of each individual on the date the individual exits substitute care. An individual qualifying for medical assistance as established by this section shall remain eligible for the maximum period permitted under federal law before any recertification is required.

(f) If recertification is required, the recertification process for individuals who are eligible for medical assistance under this section must:

(1) comply with Section 32.024715; and

(2) include the option of recertifying online or by mail or phone.

Added by Acts 2001, 77th Leg., ch. 1218, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.087, eff. April 2, 2015.

Acts 2021, 87th Leg., R.S., Ch. 432 (S.B. 1059), Sec. 1, eff. September 1, 2021.

Sec. 32.02471. MEDICAL ASSISTANCE FOR CERTAIN FORMER FOSTER CARE ADOLESCENTS ENROLLED IN HIGHER EDUCATION. (a) In this section, "independent foster care adolescent" has the meaning assigned by Section 32.0247.

(b) The commission shall provide medical assistance to a person who:

(1) is 21 years of age or older but younger than 23 years of age;

(2) would be eligible to receive assistance as an independent foster care adolescent under Section 32.0247 if the person were younger than 21 years of age; and

(3) is enrolled in an institution of higher education, as defined by Section 61.003(8), Education Code, or a private or independent institution of higher education, as defined by Section 61.003(15), Education Code, that is located in this state and is making satisfactory academic progress as determined by the institution.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 17, eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.088, eff. April 2, 2015.

Sec. 32.024715. STREAMLINED ELIGIBILITY DETERMINATION PROCESS FOR CERTAIN FORMER FOSTER CARE YOUTH. (a) This section applies to a former foster care youth who is eligible for Medicaid under Section 1902(a)(10)(A)(i)(IX), Social Security Act (42

U.S.C. Section 1396a(a)(10)(A)(i)(IX)), or any other law.

(b) The commission, in consultation with the Department of Family and Protective Services, shall design and implement a streamlined process for determining a former foster care youth's eligibility for Medicaid. The streamlined process must:

(1) provide for the automatic enrollment and recertification of a former foster care youth in the STAR Health program, the STAR Medicaid managed care program, or another Medicaid program, as appropriate;

(2) be designed to prevent any unnecessary interruption of the youth's Medicaid benefits, including any interruption related to having to recertify the youth for benefits; and

(3) if recertification is required under federal law, use a simple application and recertification process that:

(A) to the extent permitted by federal law, does not require that a youth verify that the youth is a resident of this state unless the commission determines that the youth is receiving Medicaid benefits outside of this state; or

(B) if federal law requires that a youth verify that the youth is a resident of this state, allows the youth to attest to that fact without providing additional documentation or evidence that proves the youth is a resident of this state.

Added by Acts 2021, 87th Leg., R.S., Ch. 432 (S.B. 1059), Sec. 2, eff. September 1, 2021.

Sec. 32.0249. MENTAL HEALTH SCREENINGS IN TEXAS HEALTH STEPS PROGRAM. The executive commissioner, in the rules governing the Texas Health Steps program, shall allow a provider to:

(1) conduct a mental health screening using one or more validated, standardized mental health screening tools during each annual medical exam of a recipient who is at least 12 years of age but younger than 19 years of age; and

(2) be reimbursed for conducting one mental health screening using one or more validated, standardized mental health screening tools during each annual medical exam of a recipient described by Subdivision (1).

Added by Acts 2017, 85th Leg., R.S., Ch. 1028 (H.B. 1600), Sec. 1, eff. September 1, 2017.

Sec. 32.025. APPLICATION FOR MEDICAL ASSISTANCE. (a) A recipient of benefits under Chapter 31 or supplemental security income from the federal government is automatically eligible for medical assistance, and an application for benefits under these programs constitutes an application for medical assistance.

(b) The executive commissioner shall prescribe application forms for persons who are not recipients of benefits under Chapter 31 or supplemental security income from the federal government and shall adopt rules for processing the applications.

(c) The commission shall inform applicants for nursing facility care of any community services which might be available under the community care for the aged and disabled program.

(d) The executive commissioner shall adopt an application form and procedures for a request for medical assistance provided to a child under 19 years of age. To the extent allowed by federal law and except as otherwise provided by this section, the application form and procedures must be the same as the form and procedures adopted under Section 62.103, Health and Safety Code. The executive commissioner shall coordinate the form and procedures adopted under this subsection with the form and procedures adopted under Section 62.103, Health and Safety Code, to ensure that there is a single consolidated application for a child under 19 years of age to seek medical assistance or to request coverage under the state child health plan under Chapter 62, Health and Safety Code.

(e) The executive commissioner shall permit an application requesting medical assistance for a child under 19 years of age to be conducted by mail instead of through a personal appearance at an office, unless the executive commissioner determines that the information needed to verify eligibility cannot be obtained in that manner. The executive commissioner by rule may develop procedures requiring an application for a child described by this subsection to be conducted through a personal interview with a commission representative only if the executive commissioner determines that

information needed to verify eligibility cannot be obtained in any other manner.

(f) The executive commissioner by rule may develop procedures by which:

(1) any office of a health and human services agency may accept an application requesting medical assistance for a child under 19 years of age; and

(2) the commission may contract with hospital districts, hospitals, including state-owned teaching hospitals, federally qualified health centers, and county health departments to accept applications requesting medical assistance for a child under 19 years of age.

(g) The application form, including a renewal form, adopted under this section must include:

(1) for an applicant who is pregnant, a question regarding whether the pregnancy is the woman's first gestational pregnancy;

(2) for all applicants, a question regarding the applicant's preferences for being contacted by a managed care organization or health plan provider that provides the applicant with the option to be contacted by telephone, text message, or e-mail about health care matters, including reminders for appointments and information about immunizations or well check visits; and

(3) language that:

(A) notifies the applicant that, if determined eligible for benefits, all preferred contact methods listed on the application and renewal forms will be shared with the applicant's managed care organization or health plan provider;

(B) allows the applicant to consent to being contacted through the preferred contact methods by the applicant's managed care organization or health plan provider; and

(C) explains the security risks of electronic communication.

(h) For purposes of Subsections (g)(2) and (3), the commission shall implement a process to:

(1) transmit the applicant's preferred contact methods

and consent to the managed care organization or health plan provider;

(2) allow an applicant to change the applicant's preferences in the future, including providing for an option to opt out of electronic communication; and

(3) communicate updated information to the managed care organization or health plan provider.

Acts 1979, 66th Leg., p. 2350, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1989, 71st Leg., ch. 1085, Sec. 5, eff. Sept. 1, 1989; Acts 2001, 77th Leg., ch. 584, Sec. 2; Acts 2003, 78th Leg., ch. 376, Sec. 2, eff. June 18, 2003; Acts 2003, 78th Leg., ch. 1251, Sec. 7, eff. June 20, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.089, eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 852 (H.B. 2466), Sec. 2(a), eff. September 1, 2017.

Acts 2021, 87th Leg., R.S., Ch. 622 (S.B. 1911), Sec. 1, eff. June 14, 2021.

Acts 2021, 87th Leg., R.S., Ch. 624 (H.B. 4), Sec. 10, eff. June 15, 2021.

Sec. 32.0251. ELIGIBILITY NOTIFICATION AND REVIEW FOR CERTAIN CHILDREN. (a) The executive commissioner shall establish and the commission shall implement procedures under which the commission automatically reviews a child's eligibility for medical assistance if:

(1) the child originally establishes eligibility for medical assistance on the basis of receipt of financial assistance under Chapter 31, as provided by Section 32.025(a); and

(2) that receipt of financial assistance under Chapter 31 ceases.

(b) If the review required by this section indicates that the child may be eligible for medical assistance on a basis other than receipt of financial assistance under Chapter 31, the commission may provide for provisional eligibility for medical assistance for the child pending a recertification review. The

provisional eligibility period authorized by this subsection may not exceed one month.

(c) In addition to the review required by this section, the commission shall also promote continued medical assistance for a child described by Subsection (a) through:

(1) revising client education and notification policies relating to a child's eligibility for medical assistance; and

(2) providing specific notification of a child's potential eligibility for medical assistance to the child's parent or other caretaker at the time the parent or caretaker is notified of:

(A) a scheduled eligibility recertification review; or

(B) the termination of financial assistance.

Added by Acts 1999, 76th Leg., ch. 704, Sec. 1, eff. June 18, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.090, eff. April 2, 2015.

Sec. 32.0255. TRANSITIONAL MEDICAL ASSISTANCE. (a) The commission shall provide transitional medical assistance, in accordance with state rules and federal law, to a person who was receiving financial assistance under Chapter 31 but is no longer eligible to receive the assistance because:

(1) the person's household income has increased; or

(2) the person has exhausted the person's benefits under Section 31.0065.

(b) Except as provided by Section 31.012(c), the commission may provide the medical assistance only until the earlier of:

(1) the end of the applicable period prescribed by Section 31.0065 for the provision of transitional benefits; or

(2) the first anniversary of the date on which the person becomes ineligible for financial assistance because of increased household income.

Added by Acts 1995, 74th Leg., ch. 655, Sec. 3.03, eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.090, eff. April 2, 2015.

Sec. 32.0256. CONTINUATION OF MEDICAL ASSISTANCE FOR CERTAIN INDIVIDUALS. (a) A recipient described by Section 32.025(a) who experiences a temporary increase in income of a duration of one month or less that would result in the recipient being ineligible for medical assistance continues to be eligible for that assistance if the individual:

(1) either:

(A) receives services through a program for individuals with an intellectual or developmental disability authorized under Section 1915(c), Social Security Act (42 U.S.C. Section 1396n(c)); or

(B) resides in an ICF-IID facility; and

(2) continues to meet the functional and diagnostic criteria for the receipt of services under a program described by Subdivision (1)(A) or for residency in an ICF-IID facility.

(b) To continue to be eligible for medical assistance, a recipient described by Subsection (a) must submit an application for medical assistance in accordance with Section 32.025(b) not later than the 90th day after the date on which the recipient is determined ineligible.

Added by Acts 2017, 85th Leg., R.S., Ch. 1072 (H.B. 3292), Sec. 1, eff. September 1, 2017.

Sec. 32.026. CERTIFICATION OF ELIGIBILITY AND NEED FOR MEDICAL ASSISTANCE. (a) The executive commissioner shall promulgate rules for determining and certifying a person's eligibility and need for medical assistance.

(b) The executive commissioner shall promulgate rules to provide for determination and certification of presumptive eligibility for any pregnant woman who applies for Medicaid and who meets the basic eligibility requirements under Title XIX of the federal Social Security Act (42 U.S.C. Section 1396 et seq.).

(c) Medical assistance payments may not be made on a

person's behalf until the person's eligibility and need for medical assistance have been certified in accordance with commission rules.

(d) In adopting rules under this section, the executive commissioner shall ensure, to the extent allowed by federal law, that documentation and verification procedures used in determining and certifying the eligibility and need for medical assistance of a child under 19 years of age, including the documentation and verification procedures used to evaluate the assets and resources of the child, the child's parents, or the child's other caretaker for that purpose, if applicable, are the same as the documentation and verification procedures used to determine and certify a child's eligibility for coverage under Chapter 62, Health and Safety Code, except that the documentation and verification procedures adopted in accordance with this subsection may not be more stringent than the documentation and verification procedures existing on January 1, 2001, for determination and certification of a child's eligibility for coverage under Chapter 62, Health and Safety Code.

(d-1) In adopting rules under this section, the executive commissioner shall, to the extent allowed by federal law, develop and implement an expedited process for determining eligibility for and enrollment in the medical assistance program for an active duty member of the United States armed forces, reserves, or National Guard or of the state military forces, or the spouse or dependent of that person.

(e) The executive commissioner shall permit a recertification review of the eligibility and need for medical assistance of a child under 19 years of age to be conducted by telephone or mail instead of through a personal appearance at an office, unless the commission determines that the information needed to verify eligibility cannot be obtained in that manner. The executive commissioner by rule may develop procedures to determine whether there is a need for a recertification review of a child described by this subsection to be conducted through a personal interview with a commission representative. Procedures developed under this subsection shall be based on objective, risk-based factors and conditions and shall focus on a targeted group of recertification reviews for which there is a high

probability that eligibility will not be recertified.

(f) In adopting rules under this section, the executive commissioner shall ensure, to the extent allowed by federal law, that forms and procedures used in conducting a recertification review of the eligibility and need for medical assistance of a child under 19 years of age, including documentation and verification procedures, are the same as the forms and procedures used to determine and certify a child's renewal of coverage under Chapter 62, Health and Safety Code.

(g) Notwithstanding any other provision of this code, the commission may use information obtained from a third party to verify the assets and resources of a person for purposes of determining the person's eligibility and need for medical assistance to the extent that verification is applicable under federal law. Third-party information includes information obtained from:

(1) a consumer reporting agency, as defined by Section 20.01, Business & Commerce Code;

(2) an appraisal district; or

(3) the Texas Department of Motor Vehicles vehicle registration record database.

Acts 1979, 66th Leg., p. 2350, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1989, 71st Leg., ch. 1215, Sec. 1, eff. Sept. 1, 1989; Acts 2001, 77th Leg., ch. 584, Sec. 3; Acts 2003, 78th Leg., ch. 198, Sec. 2.99(a), eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 376, Sec. 3, eff. June 18, 2003; Acts 2003, 78th Leg., ch. 1251, Sec. 8, eff. June 20, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1028 (H.B. 1633), Sec. 1, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 933 (H.B. 3097), Sec. 3G.02, eff. September 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.090, eff. April 2, 2015.

Sec. 32.0261. CONTINUOUS ELIGIBILITY. (a) This section applies only to a child younger than 19 years of age who is

determined eligible for medical assistance under this chapter.

(b) The executive commissioner shall adopt rules in accordance with 42 U.S.C. Section 1396a(e)(12), as amended, to provide for two consecutive periods of eligibility for a child between each certification and recertification of the child's eligibility, subject to Subsections (f) and (h).

(c) The first of the two consecutive periods of eligibility described by Subsection (b) must be continuous in accordance with Subsection (d). The second of the two consecutive periods of eligibility is not continuous and may be affected by changes in a child's household income, regardless of whether those changes occurred or whether the commission became aware of the changes during the first or second of the two consecutive periods of eligibility.

(d) A child remains eligible for medical assistance during the first of the two consecutive periods of eligibility, without additional review by the commission and regardless of changes in the child's household income, until the end of the six-month period following the date on which the child's eligibility was determined, except as provided by Subsections (f)(1) and (h).

(e) During the sixth month following the date on which a child's eligibility for medical assistance is certified or recertified, the commission shall, in a manner that complies with federal law, including verification plan requirements under 42 C.F.R. Section 435.945(j), review the child's household income using electronic income data available to the commission. The commission may conduct this review only once during the child's two consecutive periods of eligibility. Based on the review:

(1) the commission shall, if the review indicates that the child's household income does not exceed the maximum income for eligibility for the medical assistance program, provide for a second consecutive period of eligibility for the child until the child's required annual recertification, except as provided by Subsection (h) and subject to Subsection (c); or

(2) the commission may, if the review indicates that the child's household income exceeds the maximum income for eligibility for the medical assistance program, request additional

documentation to verify the child's household income in a manner that complies with federal law.

(f) If, after reviewing a child's household income under Subsection (e), the commission determines that the household income exceeds the maximum income for eligibility for the medical assistance program, the commission shall continue to provide medical assistance to the child until:

(1) the commission provides the child's parent or guardian with a period of not less than 30 days to provide documentation demonstrating that the child's household income does not exceed the maximum income for eligibility; and

(2) the child's parent or guardian fails to provide the documentation during the period described by Subdivision (1).

(g) If a child's parent or guardian provides to the commission within the period described by Subsection (f) documentation demonstrating that the child's household income does not exceed the maximum income for eligibility for the medical assistance program, the commission shall provide for a second consecutive period of eligibility for the child until the child's required annual recertification, except as provided by Subsection (h) and subject to Subsection (c).

(h) Notwithstanding any other period prescribed by this section, a child's eligibility for medical assistance ends on the child's 19th birthday.

(i) The commission may not recertify a child's eligibility for medical assistance more frequently than every 12 months as required by federal law.

(j) If a child's parent or guardian fails to provide to the commission within the period described by Subsection (f) documentation demonstrating that the child's household income does not exceed the maximum income for eligibility for the medical assistance program, the commission shall provide the child's parent or guardian with written notice of termination following that period. The notice must include a statement that the child may be eligible for enrollment in the child health plan under Chapter 62, Health and Safety Code.

(k) In developing the notice, the commission shall consult

with health care providers, children's health care advocates, family members of children enrolled in the medical assistance program, and other stakeholders to determine the most user-friendly method to provide the notice to a child's parent or guardian.

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

Added by Acts 2001, 77th Leg., ch. 584, Sec. 4, eff. Sept. 1, 2002.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 23, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 3.02, eff. August 29, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.090, eff. April 2, 2015.

Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 8, eff. September 1, 2021.

Sec. 32.026101. DETERMINATION OF ELIGIBILITY BY HEALTH CARE EXCHANGES PROHIBITED. (a) The commission may not accept Medicaid eligibility determinations from an exchange established under 42 U.S.C. Section 18041(c).

(b) The commission may accept eligibility assessments from an exchange, but the commission must determine the eligibility of an individual for Medicaid.

Added by Acts 2021, 87th Leg., R.S., Ch. 879 (S.B. 1341), Sec. 3, eff. September 1, 2021.

Sec. 32.02611. EXCLUSION OF ASSETS IN PREPAID TUITION PROGRAMS AND HIGHER EDUCATION SAVINGS PLANS. (a) Except as provided by Subsection (b), in determining eligibility and need for medical assistance, the commission may not consider as assets or resources, to the extent applicable under federal law, a right to assets held in or a right to receive payments or benefits under:

(1) any fund or plan established under Subchapter G, H, or I, Chapter 54, Education Code, including an interest in a savings trust account, prepaid tuition contract, or related matching account;

(2) any qualified tuition program of any state that meets the requirements of Section 529, Internal Revenue Code of 1986; or

(3) any school-based account or bond described by Section 28.0024(b)(2), Education Code.

(a-1) The amount of exclusion under Subsection (a)(3) of assets held in or the right to receive payments or benefits under a school-based account or bond described by Section 28.0024(b)(2)(C), (D), or (E), Education Code, is limited to the amount of the cost of undergraduate resident tuition and required fees for one academic year consisting of 30 semester credit hours charged by the general academic teaching institution with the highest such tuition and fee costs for the most recent academic year, as determined by the Texas Higher Education Coordinating Board under Section 54.753, Education Code.

(b) In determining eligibility and need for medical assistance for an applicant who may be eligible on the basis of the applicant's eligibility for medical assistance for the aged, blind, or disabled under 42 U.S.C. Section 1396a(a)(10), the commission may consider as assets or resources, to the extent applicable under federal law, a right to assets held in or a right to receive payments or benefits under any fund, account, bond, plan, or tuition program described by Subsection (a).

(c) Notwithstanding Subsection (b), the commission shall seek a federal waiver authorizing the commission to exclude, for purposes of determining the eligibility of an applicant described by that subsection and to the extent included under federal law, the right to assets held in or a right to receive payments or benefits under any fund, account, bond, plan, or tuition program described by Subsection (a) if the fund, account, bond, plan, or tuition program was established before the 21st birthday of the beneficiary of the fund, account, bond, plan, or tuition program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1186 (H.B. 3708), Sec. 9, eff. June 17, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.090, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1265 (H.B. 3987), Sec. 4, eff. June 20, 2015.

Sec. 32.02613. LIFE INSURANCE ASSETS; LIFE INSURANCE POLICY CONVERSION. (a) For purposes of this section, "long-term care services and support" includes home health care, assisted living, and nursing facility services.

(b) The owner of a life insurance policy with a face amount of more than $10,000 may enter into a life settlement contract under Chapter 1111A, Insurance Code, for the benefit of a recipient of long-term care services and support in exchange for direct payments to:

(1) a health care provider for the provision of those services to that recipient; or

(2) the state to offset the costs of providing those services to that recipient under the medical assistance program.

(c) The proceeds of a life settlement contract entered into under this section must be used for the payment of long-term care services and support, except for the amount specified in Subsection (d)(1). To the extent feasible and allowed under federal law, the medical assistance program may act only as the secondary payor for long-term care services and support provided to a person who is eligible for medical assistance and for whose benefit an owner of a life insurance policy has entered into a life settlement contract under this section.

(d) In addition to the requirements under Chapter 1111A, Insurance Code, a life settlement contract entered into under this section must:

(1) provide that the lesser of five percent of the face amount of the life insurance policy or $5,000 is reserved and is payable to the owner's estate or a named beneficiary for funeral expenses;

(2) provide that the balance of proceeds under the life settlement contract that are unpaid on the death of the owner must be paid to the owner's estate or a named beneficiary; and

(3) specify the total amount payable for the benefit of the recipient of long-term care services and support under the

life settlement contract.

(e) All proceeds of a life settlement contract entered into under this section must be held in an irrevocable state or federally insured account for the benefit of the recipient of long-term care services and support or for payment as otherwise required by this section.

(f) Only a recipient of long-term care services and support for whose benefit an owner enters into a life settlement contract under this section may choose the provider and type of services provided to the recipient and paid for out of an account described by Subsection (e). Any attempt by a person to require the recipient to choose a specific provider is strictly prohibited and constitutes an unfair method of competition or an unfair or deceptive act or practice under the Insurance Code.

(g) A person who enters into a life settlement contract with an owner of a life insurance policy under this section must maintain:

(1) a surety bond executed and issued by an insurer authorized to issue surety bonds in this state;

(2) a policy of errors and omissions insurance; or

(3) a deposit in the amount of $500,000 in any combination of cash, certificates of deposit, or securities.

(h) In accordance with the requirements of Chapter 1111A, Insurance Code, a life settlement contract provider who enters into life settlement contracts with owners of life insurance policies under this section must file with the Texas Department of Insurance:

(1) all life settlement contract forms used by the provider; and

(2) all advertising and marketing materials used by the provider.

(i) Section 1111A.022(a)(2)(A), Insurance Code, does not apply to a life insurance policy that is the subject of a life settlement contract entered into under this section if the contract has been in force at least five years.

(j) A claim against a life settlement contract provider with whom an owner of a life insurance policy enters into a life

settlement contract under this section by the owner, the owner's estate, a named beneficiary, or any other person with respect to the contract may not exceed the face amount of the policy, less the proceeds paid under the contract, plus the total amount of premiums paid by the owner since entering into the contract. A life settlement contract provider must pay a claim under this subsection from the funds in an account described by Subsection (e).

(k) In accordance with Chapter 1111A, Insurance Code, the Texas Department of Insurance may conduct periodic market examinations of each life settlement contract provider who enters into a life settlement contract with an owner of a life insurance policy under this section.

(l) The commission shall educate applicants for long-term care services and support under the medical assistance program about options for life insurance policies, including options that do not allow a life insurance policy to be considered as an asset or resource in determining eligibility for medical assistance.

(m) The executive commissioner, in consultation with the commissioner of insurance, shall adopt rules necessary to implement this section. The rules must ensure that:

(1) proceeds from a life settlement contract are used to reimburse a provider of long-term care services and support or the state to offset the cost of medical assistance long-term care services and support;

(2) eligibility and need for medical assistance are determined without considering the balance of proceeds from a life settlement contract as provided in this section; and

(3) payments to a provider of long-term care services and support and applied income payments are made in accordance with this chapter.

(n) The entry into a life settlement contract by an owner of a life insurance policy under this section is not the only method by which the owner may avoid having the policy considered as an asset or resource in determining the eligibility of the owner for medical assistance.

(o) Notwithstanding the provisions of this section, the commission may not implement a provision of this section if the

commission determines that implementation of the provision is not cost-effective or feasible.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1001 (H.B. 2383), Sec. 1, eff. June 14, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.091, eff. April 2, 2015.

Sec. 32.0262. ELIGIBILITY TRANSITION. (a) The executive commissioner shall develop procedures to ensure that all necessary information regarding a child who will be denied continued medical assistance under this chapter because of an increase in income, assets, or resources but who is eligible for enrollment in the child health plan under Chapter 62, Health and Safety Code, is promptly transmitted to the child health plan in accordance with the standards established under Section 62.104(d), Health and Safety Code.

(b) The executive commissioner shall develop procedures to ensure that the parent or caretaker of a child who will be denied continued medical assistance under this chapter because of a failure to keep an appointment, including an appointment for recertification of eligibility, a failure to provide information, or for another procedural reason, is promptly contacted and informed of:

(1) the need to recertify eligibility for continued medical assistance under this chapter; and

(2) the availability of medical coverage under the child health plan under Chapter 62, Health and Safety Code.

(c) The commission shall develop materials under this section in consultation with the appropriate agencies administering all or part of the child health plan under Chapter 62, Health and Safety Code.

(d) The executive commissioner by rule shall adopt procedures to assist a family whose child loses eligibility for medical assistance under this chapter in making a transition to the child health plan under Chapter 62, Health and Safety Code, with no interruption in coverage.

Added by Acts 2001, 77th Leg., ch. 584, Sec. 4.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.092, eff. April 2, 2015.

Sec. 32.0263. HEALTH CARE ORIENTATION. (a) The commission shall require that the parent or guardian of a child under 19 years of age who originally establishes eligibility for medical assistance must:

(1) attend an in-person counseling session with a commission representative not later than the 31st day after the date the child originally establishes eligibility; or

(2) accompany the child to an appointment with a health care provider for a comprehensive health care orientation not later than the 61st day after the date the child originally establishes eligibility.

(b) The executive commissioner by rule shall develop procedures to verify that:

(1) the parent or guardian of the child who originally establishes eligibility complies with the requirement of Subsection (a)(2), if applicable; and

(2) the child is provided a comprehensive health care orientation at the appointment with the health care provider.

Added by Acts 2001, 77th Leg., ch. 584, Sec. 4.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.092, eff. April 2, 2015.

Sec. 32.0264. SUSPENSION AND REINSTATEMENT OF ELIGIBILITY FOR CHILDREN IN JUVENILE FACILITIES. (a) In this section, "juvenile facility" means a facility for the placement, detention, or commitment of a child under Title 3, Family Code.

(b) To the extent allowed under federal law, if a child is placed in a juvenile facility, the commission shall suspend the child's eligibility for medical assistance during the period the child is placed in the facility.

(b-1) Notwithstanding Subsection (b), if, during the period

a child is placed in a juvenile facility, the child is hospitalized or becomes an inpatient in another type of medical facility, the commission shall reinstate the child's eligibility for medical assistance during the period of the child's inpatient stay. The executive commissioner shall adopt rules necessary to implement this subsection, including rules governing the procedure for reinstating a child's eligibility for medical assistance under this subsection.

(c) Not later than 48 hours after the commission is notified of the release from a juvenile facility of a child whose eligibility for medical assistance has been suspended under this section, the commission shall reinstate the child's eligibility. Following the reinstatement, the child remains eligible until the expiration of the period for which the child was certified as eligible, excluding the period during which the child's eligibility was suspended.

Added by Acts 2015, 84th Leg., R.S., Ch. 862 (H.B. 839), Sec. 2, eff. June 18, 2015.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 667 (H.B. 1664), Sec. 1, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 667 (H.B. 1664), Sec. 2, eff. September 1, 2021.

Sec. 32.0265. NOTICE OF CERTAIN PLACEMENTS IN JUVENILE FACILITIES. (a) In this section:

(1) "Custodian" and "guardian" have the meanings assigned by Section 51.02, Family Code.

(2) "Juvenile facility" has the meaning assigned by Section 32.0264.

(b) A juvenile facility may notify the commission on the placement in the facility of a child who is receiving medical assistance benefits.

(c) If a juvenile facility chooses to provide the notice described by Subsection (b), the facility shall provide the notice electronically or by other appropriate means as soon as possible, but not later than the 30th day, after the date of the child's placement.

(d) A juvenile facility may notify the commission of the release of a child who, immediately before the child's placement in the facility, was receiving medical assistance benefits.

(e) If a juvenile facility chooses to provide the notice described by Subsection (d), the facility shall provide the notice electronically or by other appropriate means not later than 48 hours after the child's release from the facility.

(f) If a juvenile facility chooses to provide the notice described by Subsection (d), at the time of the child's release, the facility shall provide the child's guardian or custodian, as appropriate, with a written copy of the notice and a telephone number at which the commission may be contacted regarding confirmation of or assistance relating to reinstatement of the child's eligibility for medical assistance benefits.

(g) The commission shall establish a means by which a juvenile facility, or an employee of the facility, may determine whether a child placed in the facility is or was, as appropriate, receiving medical assistance benefits for purposes of this section.

(h) A juvenile facility, or an employee of the facility, is not liable in a civil action for damages resulting from a failure to comply with this section.

Added by Acts 2015, 84th Leg., R.S., Ch. 862 (H.B. 839), Sec. 2, eff. June 18, 2015.

Sec. 32.0266. SUSPENSION, TERMINATION, AND AUTOMATIC REINSTATEMENT OF ELIGIBILITY FOR INDIVIDUALS CONFINED IN COUNTY JAILS. (a) In this section, "county jail" means a facility operated by or for a county for the confinement of persons accused or convicted of an offense.

(b) To the extent allowed by federal law, if an individual is confined in a county jail and the sheriff of the county has notified the commission of the confinement under Section 351.046, Local Government Code, the commission shall suspend or terminate, as appropriate, the individual's eligibility for medical assistance during the period the individual is confined in the county jail.

(c) Not later than 48 hours after the commission is notified

under Section 351.046, Local Government Code, of the release from a county jail of an individual whose eligibility for medical assistance has been suspended under this section, the commission shall reinstate the individual's eligibility, provided the individual's eligibility certification period has not elapsed. To the extent allowed by federal law, following the reinstatement, the individual remains eligible until the expiration of the period for which the individual was certified as eligible.

Added by Acts 2017, 85th Leg., R.S., Ch. 778 (H.B. 337), Sec. 1, eff. September 1, 2017.

Sec. 32.027. SELECTION OF PROVIDER OF MEDICAL ASSISTANCE. (a) Except as provided by Subsections (f) and (g), a recipient of medical assistance authorized in this chapter may select any provider authorized by the commission to provide medical assistance.

(b) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(38), eff. April 2, 2015.

(c) Repealed by Acts 2003, 78th Leg., ch. 1167, Sec. 4.

(d) The commission shall permit a recipient of medical assistance under this chapter to receive services relating to physical therapy from any person authorized to practice physical therapy under Chapter 453, Occupations Code.

(e) Repealed by Acts 2003, 78th Leg., ch. 198, Sec. 2.156(a)(2).

(e) Repealed by Acts 2005, 79th Leg., Ch. 349, Sec. 7(b), eff. September 1, 2005.

(f) The executive commissioner by rule may develop a system of selective contracting with health care providers for the provision of nonemergency inpatient hospital services to a recipient of medical assistance under this chapter. In implementing this subsection, the executive commissioner shall:

(1) seek input from consumer representatives and from representatives of hospitals licensed under Chapter 241, Health and Safety Code, and from organizations representing those hospitals; and

(2) ensure that providers selected under the system

meet the needs of a recipient of medical assistance under this chapter.

(g) The process to select a hospital must afford each disproportionate share hospital an opportunity to negotiate for a contract. The process will take into account the special circumstances of disproportionate share hospitals when evaluating proposals.

(h) A proposal or bid submitted by a hospital and any work papers, cost reports, or other financial data used to prepare the proposal or bid shall be confidential and not subject to required disclosure by the commission or the hospital under any other statute until the executed contracts have been awarded.

(i) In its establishment of provider criteria for hospitals, home health providers, or hospice providers, the commission shall accept licensure by the Department of Aging and Disability Services or the Department of State Health Services, as appropriate, or certification by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.).

(j) The commission shall assure that a recipient of medical assistance under this chapter may select a nurse first assistant, as defined by Section 301.354, Occupations Code, to perform any health care service or procedure covered under the medical assistance program if:

(1) the selected nurse first assistant is authorized by law to perform the service or procedure; and

(2) the physician requests that the service or procedure be performed by the nurse first assistant.

(k) The commission shall assure that a recipient of medical assistance under this chapter may select a surgical assistant licensed under Chapter 206, Occupations Code, to perform any health care service or procedure covered under the medical assistance program if:

(1) the selected surgical assistant is authorized by law to perform the service or procedure; and

(2) the physician requests that the service or procedure be performed by the surgical assistant.

(l) Subject to appropriations, the commission shall assure

that a recipient of medical assistance under this chapter may select a licensed psychologist, a licensed marriage and family therapist, as defined by Section 502.002, Occupations Code, a licensed professional counselor, as defined by Section 503.002, Occupations Code, or a licensed master social worker, as defined by Section 505.002, Occupations Code, to perform any health care service or procedure covered under the medical assistance program if the selected person is authorized by law to perform the service or procedure. This subsection shall be liberally construed.

Acts 1979, 66th Leg., p. 2351, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1989, 71st Leg., ch. 1085, Sec. 4, eff. Sept. 1, 1989; Acts 1989, 71st Leg., ch. 1173, Sec. 1, eff. Aug. 28, 1989; Acts 1990, 71st Leg., 6th C.S., ch. 12, Sec. 2(14), eff. Sept. 6, 1990; Acts 1993, 73rd Leg., ch. 390, Sec. 1, 2, eff. Sept. 1, 1993; Acts 1995, 74th Leg., ch. 965, Sec. 57, eff. June 16, 1995; Acts 1999, 76th Leg., ch. 930, Sec. 1, eff. Jan. 1, 2000; Acts 2001, 77th Leg., ch. 812, Sec. 4, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1014, Sec. 6, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1420, Sec. 14.813, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 198, Sec. 2.156(a)(2), eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1167, Sec. 4, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1251, Sec. 9, eff. June 20, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 7(a), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 7(b), eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.093, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.094, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.095, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.465(a)(38), eff. April 2, 2015.

Sec. 32.0275. MILITARY MEDICAL TREATMENT FACILITIES AND

AFFILIATED HEALTH CARE PROVIDERS; REIMBURSEMENT. (a) In this section, "military medical treatment facility" means a military medical treatment facility described by 10 U.S.C. Section 1073d(b), (c), or (d).

(b) This section applies only to a military medical treatment facility located in this state that has been verified as a Level 1 trauma center by the American College of Surgeons or an equivalent organization.

(c) A military medical treatment facility or a health care provider providing services at a military medical treatment facility is considered a provider under Medicaid for purposes of providing and receiving reimbursement for:

(1) inpatient emergency services; and

(2) related outpatient services to the extent those services are not available from an enrolled Medicaid provider at the time the services are needed.

Added by Acts 2021, 87th Leg., R.S., Ch. 696 (H.B. 2365), Sec. 1, eff. September 1, 2021.

Sec. 32.028. FEES, CHARGES, AND RATES. (a) The executive commissioner shall adopt reasonable rules and standards governing the determination of fees, charges, and rates for medical assistance payments.

(b) The fee, charge, or rate for a professional service is the usual and customary fee, charge, or rate that prevails in the community.

(c) The fee, charge, or rate for other medical assistance is the usual and customary fee, charge, or rate that prevails in the community unless the payment is limited by state or federal law.

(d) The executive commissioner in the adoption of reasonable rules and standards governing the determination of rates paid for inpatient hospital services on a prospective payment basis shall:

(1) assure that the payment rates are reasonable and adequate to meet the costs incurred by the hospital in rendering services to Medicaid recipients;

(2) assure that the prospective payment methodology

for hospital services sets the hospital-specific standardized amount at a minimum level of $1,600; and

(3) assure that the adjustment in payment rates for hospital services furnished by disproportionate share hospitals takes into account the essential role of rural hospitals in providing access to hospital services to medically indigent persons in rural areas of the state.

(e) The executive commissioner in the adoption of reasonable rules and standards governing the determination of rates paid for services provided by a federally qualified health center, as defined by 42 U.S.C. Section 1396d(l)(2)(B), shall assure that a center is reimbursed for 100 percent of reasonable costs incurred by the center in rendering services to Medicaid recipients.

(f) The executive commissioner in the adoption of reasonable rules and standards governing the determination of rates paid for services provided by a rural health clinic, as defined by 42 U.S.C. Section 1396d(l)(1), shall assure that a clinic is reimbursed for 100 percent of reasonable costs incurred by the clinic in rendering services to Medicaid recipients.

(g) Subject to Subsection (i), the executive commissioner shall ensure that the rules governing the determination of rates paid for nursing facility services improve the quality of care by:

(1) providing a program offering incentives for increasing direct care staff and direct care wages and benefits, but only to the extent that appropriated funds are available after money is allocated to base rate reimbursements as determined by the commission's nursing facility rate setting methodologies; and

(2) if appropriated funds are available after money is allocated for payment of incentive-based rates under Subdivision (1), providing incentives that incorporate the use of a quality of care index, a customer satisfaction index, and a resolved complaints index developed by the commission.

(h) The executive commissioner shall ensure that the rules governing the determination of rates paid for nursing facility services provide for the rate component derived from reported liability insurance costs to be paid only to those facilities that purchase liability insurance acceptable to the commission.

(i) The executive commissioner shall ensure that rules governing the incentives program described by Subsection (g)(1):

(1) provide that participation in the program by a nursing facility is voluntary;

(2) do not impose on a nursing facility not participating in the program a minimum spending requirement for direct care staff wages and benefits;

(3) do not set a base rate for a nursing facility participating in the program that is more than the base rate for a nursing facility not participating in the program; and

(4) establish a funding process to provide incentives for increasing direct care staff and direct care wages and benefits in accordance with appropriations provided.

(j) The executive commissioner shall adopt rules governing the determination of the amount of reimbursement or credit for restocking drugs under Section 562.1085, Occupations Code, that recognize the costs of processing the drugs, including the cost of:

(1) reporting the drug's prescription number and date of original issue;

(2) verifying whether the drug's expiration date or the drug's recommended shelf life exceeds 120 days;

(3) determining the source of payment; and

(4) preparing credit records.

(k) The commission shall provide an electronic system for the issuance of credit for returned drugs that complies with the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended. To ensure a cost-effective system, only drugs for which the credit exceeds the cost of the restocking fee by at least 100 percent are eligible for credit.

(l) The executive commissioner shall establish a task force to develop the rules necessary to implement Subsections (j) and (k). The task force must include representatives of nursing facilities and pharmacists.

(m) The commission may not fund an incentive program under Subsection (g)(1) using money appropriated for base rate reimbursements for nursing facilities.

(n) The executive commissioner shall ensure that rules

governing the determination of rates paid for nursing facility services provide for the reporting of all revenue and costs, without regard to whether a cost is an allowable cost for reimbursement under the medical assistance program, except:

(1) as provided by Subsection (h); and

(2) a penalty imposed under this chapter or Chapter 242, Health and Safety Code.

Acts 1979, 66th Leg., p. 2351, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1989, 71st Leg., ch. 1219, Sec. 2, eff. Sept. 1, 1989; Acts 1999, 76th Leg., ch. 1411, Sec. 1.16, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 974, Sec. 31, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1284, Sec. 10.01, eff. June 15, 2001; Acts 2003, 78th Leg., ch. 198, Sec. 2.102(a), eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 321, Sec. 3, eff. June 18, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 667 (S.B. 48), Sec. 2, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.096, eff. April 2, 2015.

Sec. 32.0281. RULES AND NOTICE RELATING TO PAYMENT RATES. (a) The executive commissioner shall by rule describe the process used to determine payment rates for medical assistance and shall notify providers, consumers, the Legislative Budget Board, and the Governor's Office of Budget, Planning, and Policy of that process.

(b) The executive commissioner shall adopt rules relating to payment rates that include:

(1) a description of the process used to determine payment rates;

(2) a description of each cost of living index used in calculating inflation rates and the procedure for determining the level of inflation used in the executive commissioner's calculations;

(3) the criteria for desk audits;

(4) the procedure for notifying providers of exclusions and adjustments to reported expenses, if notification is requested; and

(5) a method of adjusting rates if new legislation, regulations, or economic factors affect costs.

(c) The commission shall include in the Title XIX State Medicaid Plan submitted to the federal government for approval the procedures for making available to the public the data and methodology used in establishing payment rates.

(d) The procedures for adopting rules under this section shall be governed by Chapter 2001, Government Code.

(e) An interested party may appeal an action taken by the commission under this section, and an appeal of such action shall be governed by the procedures for a contested case hearing under Chapter 2001, Government Code. The filing of an appeal under this section shall not stay the implementation of payment rates adopted by the executive commissioner in accordance with commission rules.

Added by Acts 1989, 71st Leg., ch. 1085, Sec. 2, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49), eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.097, eff. April 2, 2015.

Sec. 32.0282. PUBLIC HEARING ON RATES. (a) The commission shall hold a public hearing to allow interested persons to present comments relating to proposed payment rates for medical assistance.

(b) The commission shall provide notice of each hearing to the public.

Added by Acts 1989, 71st Leg., ch. 1085, Sec. 2, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.098, eff. April 2, 2015.

Sec. 32.0284. CALCULATION OF PAYMENTS UNDER CERTAIN SUPPLEMENTAL HOSPITAL PAYMENT PROGRAMS. (a) In this section, "supplemental hospital payment program" means:

(1) the disproportionate share hospitals supplemental payment program administered according to 42 U.S.C. Section 1396r-4; and

(2) the uncompensated care payment program established 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).

(b) For purposes of calculating the hospital-specific limit used to determine a hospital's uncompensated care payment under a supplemental hospital payment program, the commission shall ensure that to the extent a third-party commercial payment exceeds the Medicaid allowable cost for a service provided to a recipient and for which reimbursement was not paid under the medical assistance program, the payment is not considered a medical assistance payment.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 6.07, eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.099, eff. April 2, 2015.

Text of section effective on September 01, 2022

Sec. 32.0285. CALCULATION OF MEDICAL EDUCATION ADD-ON FOR REIMBURSEMENT OF TEACHING HOSPITALS THAT PROVIDE BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES. The commission shall, on request from a teaching hospital that provides behavioral health and physical health services, update on a biannual basis the education adjustment factor used to calculate the medical education add-on using the most current Medicare education adjustment factor data available under 42 C.F.R. Section 412.105 at the time the commission makes the update.

Added by Acts 2021, 87th Leg., R.S., Ch. 966 (S.B. 1921), Sec. 3, eff. September 1, 2022.

Sec. 32.029. METHODS OF PAYMENT. (a) The commission may prescribe a method of payment for medical assistance claims by establishing a direct vendor payment program that is administered by the commission, or by an insurance plan, a hospital or medical service plan, or any other health service plan authorized to do business in the state, or by a combination of those plans.

(b) The commission may use any fiscal intermediary, method of payment, or combination of methods it finds most satisfactory and economical. The commission may make whatever changes it finds necessary from time to time to administer the program in an economical and equitable manner consistent with simplicity of administration and the best interest of the recipients of medical assistance.

(c) If the commission elects to make direct vendor payments, the payments shall be made by vouchers and warrants drawn by the comptroller on the proper account. The commission shall furnish the comptroller with a list of those vendors entitled to payments and the amounts to which each is entitled. When the warrants are drawn, they must be delivered to the commission, which shall supervise the delivery to vendors.

(d) If at any time state funds are not available to fully pay all claims for medical assistance, the executive commissioner shall prorate the claims.

(e) The commission or its designee must notify providers of health care services in clear and concise language of the status of their claims on any claim not paid or denied within 30 days of receipt by the payor.

Acts 1979, 66th Leg., p. 2351, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1985, 69th Leg., ch. 264, Sec. 12, eff. Aug. 26, 1985; Acts 1993, 73rd Leg., ch. 390, Sec. 3, eff. Sept. 1, 1993; Acts 1995, 74th Leg., ch. 6, Sec. 4, eff. March 23, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.100, eff. April 2, 2015.

Sec. 32.0291. PREPAYMENT REVIEWS AND PAYMENT HOLDS. (a) Notwithstanding any other law, the commission may:

(1) perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse; and

(2) as necessary to perform that review, withhold payment of the claim for not more than five working days without notice to the person submitting the claim.

(b) Subject to Section 531.102, Government Code, and notwithstanding any other law, the commission may impose a payment hold on future claims submitted by a provider.

(c) A payment hold authorized by this section is governed by the requirements and procedures specified for a payment hold under Section 531.102, Government Code, including the notice requirements under Subsection (g) of that section.

(d) Repealed by Acts 2013, 83rd Leg., R.S., Ch. 622, Sec. 6, eff. September 1, 2013.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.103, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 4, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 5, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 622 (S.B. 1803), Sec. 6, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.101, eff. April 2, 2015.

Sec. 32.031. RECEIPT AND EXPENDITURE OF FUNDS. (a) The commission may accept federal funds for the support of the medical assistance program and may expend the funds in the manner prescribed by this chapter or other laws. The expenditures must be made in accordance with appropriate agreements between the state and the federal government.

(b) The commission may administer and expend state funds appropriated for the program in accordance with commission rules and the provisions of this chapter.

(c) The amount of state funds spent for medical assistance on behalf of a qualified individual may not exceed the amount that is matchable with federal funds, and the total amount of state funds spent for all medical assistance on behalf of all qualified individuals may not exceed the amount that is matchable with federal funds.

(d) The executive commissioner is empowered and authorized

to pursue the use of local funds as part of the state share under the Medicaid program as provided by federal law and regulation.

(e) Public hospitals, including hospitals owned, operated, or leased by a governmental entity, including a municipality, county, hospital district, or this state, and specifically including a state teaching hospital, may transfer funds to the commission for use as the state share under the Medicaid disproportionate share program.

Acts 1979, 66th Leg., p. 2352, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1989, 71st Leg., ch. 1215, Sec. 4, eff. Sept. 1, 1989; Acts 1995, 74th Leg., ch. 6, Sec. 6, eff. March 23, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.102, eff. April 2, 2015.

Sec. 32.0311. DRUG REIMBURSEMENT UNDER CERTAIN PROGRAMS. The commission shall require a recipient of medical assistance to exhaust drug benefits available under the medical assistance program before reimbursing the recipient, pharmacist, or other health care provider for drugs purchased by or on behalf of the recipient under the Kidney Health Care Program or the Children with Special Health Care Needs Services Program.

Added by Acts 1999, 76th Leg., ch. 669, Sec. 1, eff. June 18, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.103, eff. April 2, 2015.

For expiration of this section, see Subsection (e).

Sec. 32.03115. REIMBURSEMENT FOR MEDICATION-ASSISTED TREATMENT FOR OPIOID OR SUBSTANCE USE DISORDER. (a) In this section, "medication-assisted opioid or substance use disorder treatment" means the use of methadone, buprenorphine, oral buprenorphine/naloxone, or naltrexone to treat opioid or substance use disorder.

Text of subsection as added by Acts 2019, 86th Leg., R.S., Ch. 640 (S.B. 1564), Sec. 2, and Ch. 1167 (H.B. 3285), Sec. 9

(b) Notwithstanding Sections 531.072 and 531.073, Government Code, or any other law and subject to Subsections (c) and (d), the commission shall provide medical assistance reimbursement for medication-assisted opioid or substance use disorder treatment without requiring a recipient of medical assistance or health care provider to obtain prior authorization or precertification for the treatment.

Text of subsection as added by Acts 2019, 86th Leg., R.S., Ch. 1105 (H.B. 2174), Sec. 13

(b) Notwithstanding Sections 531.072 and 531.073, Government Code, or any other law and subject to Subsections (c) and (d), the commission shall provide medical assistance reimbursement for medication-assisted opioid or substance use disorder treatment without requiring a recipient of medical assistance or health care provider to obtain prior authorization or precertification for the treatment, except as needed to minimize the opportunity for fraud, waste, or abuse.

(c) The duty to provide medical assistance reimbursement for medication-assisted opioid or substance use disorder treatment under Subsection (b) does not apply with respect to:

(1) a prescription for methadone;

(2) a recipient for whom medication-assisted opioid or substance use disorder treatment is determined to be medically contraindicated by the recipient's physician; or

(3) a recipient who is subject to an age-related restriction applicable to medication-assisted opioid or substance use disorder treatment.

(d) The commission may provide medical assistance reimbursement for medication-assisted opioid or substance use disorder treatment only if the treatment is prescribed to a recipient of medical assistance by a licensed health care provider who is authorized to prescribe methadone, buprenorphine, oral buprenorphine/naloxone, or naltrexone.

(e) This section expires August 31, 2023.

Added by Acts 2019, 86th Leg., R.S., Ch. 640 (S.B. 1564), Sec. 2, eff. June 10, 2019.

Added by Acts 2019, 86th Leg., R.S., Ch. 1105 (H.B. 2174), Sec. 13, eff. September 1, 2019.

Added by Acts 2019, 86th Leg., R.S., Ch. 1167 (H.B. 3285), Sec. 9, eff. September 1, 2019.

Sec. 32.0312. REIMBURSEMENT FOR SERVICES ASSOCIATED WITH PREVENTABLE ADVERSE EVENTS. The executive commissioner shall adopt rules regarding the denial or reduction of reimbursement under the medical assistance program for preventable adverse events that occur in a hospital setting. In adopting the rules, the executive commissioner:

(1) shall ensure that the commission imposes the same reimbursement denials or reductions for preventable adverse events as the Medicare program imposes for the same types of health care-associated adverse conditions and the same types of health care providers and facilities under a policy adopted by the federal Centers for Medicare and Medicaid Services;

(2) shall consult an advisory committee on health care quality, if established by the executive commissioner, to obtain the advice of that committee regarding denial or reduction of reimbursement claims for any other preventable adverse events that cause patient death or serious disability in health care settings, including events on the list of adverse events identified by the National Quality Forum; and

(3) may allow the commission to impose reimbursement denials or reductions for preventable adverse events described by Subdivision (2).

Added by Acts 2009, 81st Leg., R.S., Ch. 724 (S.B. 203), Sec. 3(a), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.104, eff. April 2, 2015.

Sec. 32.0313. INDUCED DELIVERIES OR CESAREAN SECTIONS BEFORE 39TH WEEK. (a) The commission shall achieve cost savings

with improved outcomes by adopting and implementing quality initiatives that are evidence-based, tested, and fully consistent with established standards of clinical care and that are designed to reduce the number of elective or nonmedically indicated induced deliveries or cesarean sections performed at a hospital on a medical assistance recipient before the 39th week of gestation.

(b) The commission shall coordinate with physicians, hospitals, managed care organizations, and the commission's billing contractor for the medical assistance program to develop a process for collecting information regarding the number of induced deliveries and cesarean sections described by Subsection (a) that occur during prescribed periods.

Added by Acts 2011, 82nd Leg., R.S., Ch. 299 (H.B. 1983), Sec. 1, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.105, eff. April 2, 2015.

Sec. 32.0314. REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES. The executive commissioner shall adopt rules requiring the electronic submission of any claim for reimbursement for durable medical equipment and supplies under the medical assistance program.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.18, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.105, eff. April 2, 2015.

Sec. 32.03141. AUTHORITY OF ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS REGARDING DURABLE MEDICAL EQUIPMENT AND SUPPLIES. To the extent allowed by federal law, an advanced practice registered nurse or physician assistant acting under adequate physician supervision and to whom a physician has delegated the authority to prescribe and order drugs and devices under Chapter 157, Occupations Code, may order and prescribe durable medical equipment and supplies under the medical assistance

program.

Added by Acts 2013, 83rd Leg., R.S., Ch. 418 (S.B. 406), Sec. 26, eff. November 1, 2013.

Sec. 32.0315. FUNDS FOR GRADUATE MEDICAL EDUCATION. (a) Subject to appropriated state funds, the executive commissioner shall establish procedures and formulas for the allocation of federal medical assistance funds that are directed to be used to support graduate medical education in connection with the medical assistance program.

(b) The executive commissioner shall allocate the funds in the manner the executive commissioner determines most effectively and equitably achieves the purposes for which those federal funds are received, consistent with the needs of this state for graduate medical education and the training of resident physicians in accredited residency programs in appropriate fields and specialties, taking into account other money available to support graduate medical education. In determining the needs of this state for graduate medical education, the executive commissioner shall give primary emphasis to graduate medical education in primary care specialties and shall also recognize the growth in residency training slots since 1997 in the Lower Rio Grande Valley and other health care shortage areas of this state.

(c) The executive commissioner shall consult with the Texas Higher Education Coordinating Board before adopting or revising a formula under this section. At the request of the executive commissioner, the coordinating board shall provide the executive commissioner with any information the board possesses to assist the executive commissioner in administering this section.

Added by Acts 1997, 75th Leg., ch. 252, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.100(a), (b), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 733 (H.B. 2420), Sec. 1, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.106, eff. April 2, 2015.

Sec. 32.0316. ELECTRONIC TRANSACTIONS; MEDICAID. The executive commissioner shall adopt and the commission shall implement policies that encourage the use of electronic transactions in Medicaid. The policies shall require payment to Medicaid providers by electronic funds transfer, including electronic remittance and status reports. The policies shall also include the establishment of incentives to submit claims electronically and of disincentives to submit claims on paper that are reasonably based on the higher administrative costs to process claims submitted on paper.

Added by Acts 1999, 76th Leg., ch. 1411, Sec. 1.10, eff. Sept. 1, 1999.

Transferred, redesignated and amended from Health and Safety Code, Section 12.0124 by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0017, eff. April 2, 2015.

Sec. 32.0317. REIMBURSEMENT FOR SERVICES PROVIDED UNDER SCHOOL HEALTH AND RELATED SERVICES PROGRAM. The executive commissioner shall adopt rules requiring parental consent for services provided under the school health and related services program in order for a school district to receive reimbursement for the services. The rules must allow a school district to seek a waiver to receive reimbursement for services provided to a student who does not have a parent or legal guardian who can provide consent.

Added by Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 7, eff. September 1, 2021.

Sec. 32.032. PREVENTION AND DETECTION OF FRAUD AND ABUSE. The executive commissioner shall adopt reasonable rules for minimizing the opportunity for fraud and abuse, for establishing and maintaining methods for detecting and identifying situations in which a question of fraud or abuse in the program may exist, and for referring cases where fraud or abuse appears to exist to the appropriate law enforcement agencies for prosecution.

Acts 1979, 66th Leg., p. 2352, ch. 842, art. 1, Sec. 1, eff. Sept. 1,

1979. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.104, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 257, Sec. 2, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.106, eff. April 2, 2015.

Sec. 32.0321. SURETY BOND. (a) The executive commissioner by rule may require each provider of medical assistance in a provider type that has demonstrated significant potential for fraud or abuse to file with the commission a surety bond in a reasonable amount. The executive commissioner by rule shall require a provider of medical assistance to file with the commission a surety bond in a reasonable amount if the commission identifies a pattern of suspected fraud or abuse involving criminal conduct relating to the provider's services under the medical assistance program that indicates the need for protection against potential future acts of fraud or abuse.

(b) The bond under Subsection (a) must be payable to the commission to compensate the commission for damages resulting from or penalties or fines imposed in connection with an act of fraud or abuse committed by the provider under the medical assistance program.

(c) Subject to Subsection (d) or (e), the executive commissioner by rule may require each provider of medical assistance that establishes a resident's trust fund account to post a surety bond to secure the account. The bond must be payable to the commission to compensate residents of the bonded provider for trust funds that are lost, stolen, or otherwise unaccounted for if the provider does not repay any deficiency in a resident's trust fund account to the person legally entitled to receive the funds.

(d) The executive commissioner may not require the amount of a surety bond posted for a single facility provider under Subsection (c) to exceed the average of the total average monthly balance of all the provider's resident trust fund accounts for the 12-month period preceding the bond issuance or renewal date.

(e) If an employee of a provider of medical assistance is

responsible for the loss of funds in a resident's trust fund account, the resident, the resident's family, and the resident's legal representative are not obligated to make any payments to the provider that would have been made out of the trust fund had the loss not occurred.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 2.03, eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.105, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 257, Sec. 3, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.107, eff. April 2, 2015.

Sec. 32.0322. CRIMINAL HISTORY RECORD INFORMATION; ENROLLMENT OF PROVIDERS. (a) The commission or the office of inspector general established under Chapter 531, Government Code, may obtain from any law enforcement or criminal justice agency the criminal history record information that relates to a provider under the medical assistance program or a person applying to enroll as a provider under the medical assistance program.

(a-1) The criminal history record information the commission and the office of inspector general are authorized to obtain under Subsection (a) includes criminal history record information relating to:

(1) a person with a direct or indirect ownership or control interest, as defined by 42 C.F.R. Section 455.101, in a provider of five percent or more; and

(2) a person whose information is required to be disclosed in accordance with 42 C.F.R. Part 1001.

(b) Subject to Subsections (b-1) and (e), the executive commissioner by rule shall establish criteria for the commission or the commission's office of inspector general to suspend a provider's billing privileges under the medical assistance program, revoke a provider's enrollment under the program, or deny a person's application to enroll as a provider under the program based on:

(1) the results of a criminal history check;

(2) any exclusion or debarment of the provider from participation in a state or federally funded health care program;

(3) the provider's failure to bill for medical assistance or refer clients for medical assistance within a 12-month period; or

(4) any of the provider screening or enrollment provisions contained in 42 C.F.R. Part 455, Subpart E.

(b-1) In adopting rules under this section, the executive commissioner shall require revocation of a provider's enrollment or denial of a person's application for enrollment as a provider under the medical assistance program if the person has been excluded or debarred from participation in a state or federally funded health care program as a result of:

(1) a criminal conviction or finding of civil or administrative liability for committing a fraudulent act, theft, embezzlement, or other financial misconduct under a state or federally funded health care program; or

(2) a criminal conviction for committing an act under a state or federally funded health care program that caused bodily injury to:

(A) a person who is 65 years of age or older;

(B) a person with a disability; or

(C) a person under 18 years of age.

(c) As a condition of eligibility to participate as a provider in the medical assistance program, the executive commissioner by rule shall:

(1) require a provider or a person applying to enroll as a provider to disclose:

(A) all persons described by Subsection (a-1)(1);

(B) any managing employees of the provider; and

(C) an agent or subcontractor of the provider if:

(i) the provider or a person described by Subsection (a-1)(1) has a direct or indirect ownership interest of at least five percent in the agent or subcontractor; or

(ii) the provider engages in a business transaction with the agent or subcontractor that meets the criteria

specified by 42 C.F.R. Section 455.105; and

(2) require disclosure by persons applying for enrollment as providers and provide for screening of applicants for enrollment in conformity and compliance with the requirements of 42 C.F.R. Part 455, Subparts B and E.

(d) In adopting rules under this section, the executive commissioner shall adopt rules as authorized by and in conformity with 42 C.F.R. Section 455.470 for the imposition of a temporary moratorium on enrollment of new providers, or to impose numerical caps or other limits on the enrollment of providers, that the commission or the commission's office of inspector general determines have a significant potential for fraud, waste, or abuse.

(e) The commission may reinstate a provider's enrollment under the medical assistance program or grant a person's previously denied application to enroll as a provider, including a person described by Subsection (b-1), if the commission finds:

(1) good cause to determine that it is in the best interest of the medical assistance program; and

(2) the person has not committed an act that would require revocation of a provider's enrollment or denial of a person's application to enroll since the person's enrollment was revoked or application was denied, as appropriate.

(f) The commission must support a determination made under Subsection (e) with written findings of good cause for the determination.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 2.04(a), eff. Sept. 1, 1997.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.15, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 28, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 10, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.108, eff. April 2, 2015.

Sec. 32.033. SUBROGATION. (a) The filing of an application for or receipt of medical assistance constitutes an assignment of the applicant's or recipient's right of recovery from:

(1) personal insurance;

(2) other sources; or

(3) another person for personal injury caused by the other person's negligence or wrong.

(b) A person who applies for or receives medical assistance shall inform the commission, at the time of application or at any time during eligibility and receipt of services, of any unsettled tort claim which may affect medical needs and of any private accident or sickness insurance coverage that is or may become available. A recipient shall inform the commission of any injury requiring medical attention that is caused by the act or failure to act of some other person. An applicant or a recipient shall inform the commission as required by this subsection within 60 days of the date the person learns of his or her insurance coverage, tort claim, or potential cause of action. An applicant or recipient who knowingly and intentionally fails to disclose the information required by this subsection commits a Class C misdemeanor.

(c) A claim for damages for personal injury does not constitute grounds for denying or discontinuing assistance under this chapter.

(d) A separate and distinct cause of action in favor of the state is hereby created, and the commission may, without written consent, take direct civil action in any court of competent jurisdiction. A suit brought under this section need not be ancillary to or dependent upon any other action.

(e) The commission's right of recovery is limited to the amount of the cost of medical care services paid by the commission. Other subrogation rights granted under this section are limited to the cost of the services provided.

(f) The executive commissioner may waive the commission's right of recovery in whole or in part when the executive commissioner finds that enforcement would tend to defeat the purpose of public assistance.

(g) The commission may designate an agent to collect funds

the commission has a right to recover from third parties under this section. The commission shall use any funds collected to pay costs of administering the medical assistance program.

(h) The executive commissioner may adopt rules for the enforcement of the commission's right of recovery.

Acts 1979, 66th Leg., p. 2352, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1979, 66th Leg., p. 2436, ch. 842, art. 2, Sec. 10, eff. Sept. 1, 1979.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.109, eff. April 2, 2015.

Sec. 32.034. CONTRACT CANCELLATION; NOTICE AND HEARING. (a) The commission has authority to adjudicate claims of contested cases in accordance with Chapter 2001, Government Code. When the commission intends to cancel its contract or impose monetary penalties under a contract with a person providing medical assistance, the commission shall give reasonable notice and an opportunity for hearing if one is requested. The executive commissioner shall adopt rules consistent with Chapter 2001, Government Code, to implement this section, and hearings under this section are contested cases under that act.

(b) The commission may not terminate a contract during the pendency of a hearing under this section. The commission may withhold payments during the pendency of a hearing, but the commission shall pay the withheld payments and resume contract payments if the final determination is favorable to the contractor. The commission's authority to withhold payments shall be established by contract.

(c) The section does not apply if federal matching funds are not available to pay the facility whose contract is being cancelled. If federal matching funds cannot be used, no state funds may be used to pay the facility.

Acts 1979, 66th Leg., p. 2352, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1987, 70th Leg., ch. 1052, Sec. 2.02, eff. Sept. 1, 1987; Acts 1991, 72nd Leg., 1st C.S., ch. 15, Sec. 5.22, eff. Sept. 1, 1991; Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49),

eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 1159, Sec. 2.03, eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.110, eff. April 2, 2015.

Sec. 32.035. APPEALS. The provisions of Section 31.034 governing the right of appeal of an applicant for or recipient of financial assistance authorized under Chapter 31 also apply to applicants for medical assistance authorized in this chapter.

Acts 1979, 66th Leg., p. 2353, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.111, eff. April 2, 2015.

Sec. 32.036. PROGRAM PAYMENTS NONASSIGNABLE AND EXEMPT FROM LEGAL PROCESS. (a) Neither medical assistance nor payments to providers of medical assistance under this chapter are transferable or assignable at law or in equity.

(b) No money paid or payable under the provisions of this chapter is subject to execution, levy, attachment, garnishment, or any other legal process, or the operation of any insolvency law.

(c) This section does not apply to the extent that it conflicts with the Social Security Act (42 U.S.C. Section 1396a(a)(32)).

Acts 1979, 66th Leg., p. 2353, ch. 842, art. 1, Sec. 1, eff. Sept. 1, 1979. Amended by Acts 1997, 75th Leg., ch. 216, Sec. 1, eff. May 23, 1997.

Sec. 32.038. COLLECTION OF INSURANCE PAYMENTS. (a) The commission may receive directly from an insurance company any payments to which the commission is entitled under Section 1204.153, Insurance Code.

(b) The executive commissioner shall adopt rules to implement this section, including rules establishing procedures relating to:

(1) notification to the commission that a child receiving benefits under Chapter 31 or this chapter is covered by an insurance policy under which the commission is eligible to receive direct payments;

(2) claims made by the commission to receive payments under Subsection (a);

(3) notification to the commission of any change in the status of the child or the parent; and

(4) notification to the insurance company that the commission is to receive payments under Subsection (a).

(c) Commission rules relating to the notice prescribed by Subsection (b)(4) must require the notice to be attached to the claim for insurance benefits when the claim is first submitted to the insurance company.

Added by Acts 1987, 70th Leg., ch. 1052, Sec. 2.03, eff. Sept. 1, 1987.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.128, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.112, eff. April 2, 2015.

Sec. 32.0381. ICF-IID PAYMENT RATES. (a) The executive commissioner shall set the payment rates for ICF-IID facilities at least annually.

(b) The executive commissioner shall adopt by rule the methodology used by the executive commissioner in setting payment rates for ICF-IID facilities. The methodology shall clearly define the procedures and methods used in projecting the costs of economic and efficient facilities and the procedures and methods used in setting payment rates that reasonably reimburse facilities at each level of care and in each class of providers, including size categories.

(c) The executive commissioner shall ensure that the methodology used in projecting costs and setting payment rates and its implementation is the same for state-operated ICF-IID facilities and for private ICF-IID facilities. Methods used to

project costs, including those involving the handling of gifts, grants, and donations, upper limits on facility and administrative costs, occupancy adjustments, and in assessing the cost impact of new or revised requirements, must be the same for state-operated and private facilities.

(d) To the extent allowed by federal law, any differences in methodology or its implementation between state-operated facilities and private facilities must be stated explicitly in the rule, must be related to actual differences in the nature of the expenses incurred by the class of providers, including size categories, and must not favor state-operated facilities in setting payment rates. When the proposed rule or amendments to the rule are published for public comment, the executive commissioner must certify that any differences in methodology between classes of providers, including size categories, are necessitated by cost structure and will not favor state-operated facilities in the setting of payment rates.

Added by Acts 1989, 71st Leg., ch. 1141, Sec. 11(a), eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.112, eff. April 2, 2015.

Sec. 32.039. DAMAGES AND PENALTIES. (a) In this section:

(1) "Claim" means an application for payment of health care services under Title XIX of the federal Social Security Act (42 U.S.C. Section 1396 et seq.) that is submitted by a person who is under a contract or provider agreement with the commission.

(1-a) "Inducement" includes a service, cash in any amount, entertainment, or any item of value.

(2) "Managed care organization" means any entity or person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

(3) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as

distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(4) A person "should know" or "should have known" information to be false if the person acts in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information, and proof of the person's specific intent to defraud is not required.

(b) A person commits a violation if the person:

(1) presents or causes to be presented to the commission a claim that contains a statement or representation the person knows or should know to be false;

(1-a) engages in conduct that violates Section 102.001, Occupations Code;

(1-b) solicits or receives, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind for referring an individual to a person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program, provided that this subdivision does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;

(1-c) solicits or receives, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind for purchasing, leasing, or ordering, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program;

(1-d) offers or pays, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to refer an individual to another person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in

whole or in part, under the medical assistance program, provided that this subdivision does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;

(1-e) offers or pays, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to purchase, lease, or order, or arrange for or recommend the purchase, lease, or order of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program;

(1-f) provides, offers, or receives an inducement in a manner or for a purpose not otherwise prohibited by this section or Section 102.001, Occupations Code, to or from a person, including a recipient, provider, employee or agent of a provider, third-party vendor, or public servant, for the purpose of influencing or being influenced in a decision regarding:

(A) selection of a provider or receipt of a good or service under the medical assistance program;

(B) the use of goods or services provided under the medical assistance program; or

(C) the inclusion or exclusion of goods or services available under the medical assistance program;

(2) is a managed care organization that contracts with the commission to provide or arrange to provide health care benefits or services to individuals eligible for medical assistance and:

(A) fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract with the commission;

(B) fails to provide to the commission information required to be provided by law, commission rule, or contractual provision;

(C) engages in a fraudulent activity in connection with the enrollment in the organization's managed care plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an

individual eligible for medical assistance; or

(D) engages in actions that indicate a pattern of:

(i) wrongful denial of payment for a health care benefit or service that the organization is required to provide under the contract with the commission; or

(ii) wrongful delay of at least 45 days or a longer period specified in the contract with the commission, not to exceed 60 days, in making payment for a health care benefit or service that the organization is required to provide under the contract with the commission; or

(3) fails to maintain documentation to support a claim for payment in accordance with the requirements specified by commission rule or medical assistance program policy or engages in any other conduct that a commission rule has defined as a violation of the medical assistance program.

(b-1) A person who commits a violation described by Subsection (b)(3) is liable to the commission for either the amount paid in response to the claim for payment or the payment of an administrative penalty in an amount not to exceed $500 for each violation, as determined by the commission.

(c) A person who commits a violation under Subsection (b) is liable to the commission for:

(1) the amount paid, if any, as a result of the violation and interest on that amount determined at the rate provided by law for legal judgments and accruing from the date on which the payment was made; and

(2) payment of an administrative penalty of an amount not to exceed twice the amount paid, if any, as a result of the violation, plus an amount:

(A) not less than $5,000 or more than $15,000 for each violation that results in injury to an elderly person, as defined by Section 48.002(a)(1), a person with a disability, as defined by Section 48.002(a)(8)(A), or a person younger than 18 years of age; or

(B) not more than $10,000 for each violation that does not result in injury to a person described by Paragraph (A).

(d) Unless the provider submitted information to the commission for use in preparing a voucher that the provider knew or should have known was false or failed to correct information that the provider knew or should have known was false when provided an opportunity to do so, this section does not apply to a claim based on the voucher if the commission calculated and printed the amount of the claim on the voucher and then submitted the voucher to the provider for the provider's signature. In addition, the provider's signature on the voucher does not constitute fraud. The executive commissioner shall adopt rules that establish a grace period during which errors contained in a voucher prepared by the commission may be corrected without penalty to the provider.

(e) In determining the amount of the penalty to be assessed under Subsection (c)(2), the commission shall consider:

(1) the seriousness of the violation;

(2) whether the person had previously committed a violation; and

(3) the amount necessary to deter the person from committing future violations.

(f) If after an examination of the facts the commission concludes that the person committed a violation, the commission may issue a preliminary report stating the facts on which it based its conclusion, recommending that an administrative penalty under this section be imposed and recommending the amount of the proposed penalty.

(g) The commission shall give written notice of the report to the person charged with committing the violation. The notice must include a brief summary of the facts, a statement of the amount of the recommended penalty, and a statement of the person's right to an informal review of the alleged violation, the amount of the penalty, or both the alleged violation and the amount of the penalty.

(h) Not later than the 10th day after the date on which the person charged with committing the violation receives the notice, the person may either give the commission written consent to the report, including the recommended penalty, or make a written request for an informal review by the commission.

(i) If the person charged with committing the violation consents to the penalty recommended by the commission or fails to timely request an informal review, the commission shall assess the penalty. The commission shall give the person written notice of its action. The person shall pay the penalty not later than the 30th day after the date on which the person receives the notice.

(j) If the person charged with committing the violation requests an informal review as provided by Subsection (h), the commission shall conduct the review. The commission shall give the person written notice of the results of the review.

(k) Not later than the 10th day after the date on which the person charged with committing the violation receives the notice prescribed by Subsection (j), the person may make to the commission a written request for a hearing. The hearing must be conducted in accordance with Chapter 2001, Government Code.

(l) If, after informal review, a person who has been ordered to pay a penalty fails to request a formal hearing in a timely manner, the commission shall assess the penalty. The commission shall give the person written notice of its action. The person shall pay the penalty not later than the 30th day after the date on which the person receives the notice.

(m) Within 30 days after the date on which the commission's order issued after a hearing under Subsection (k) becomes final as provided by Section 2001.144, Government Code, the person shall:

(1) pay the amount of the penalty;

(2) pay the amount of the penalty and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty; 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 the occurrence of the violation and the amount of the penalty.

(n) A person who acts under Subsection (m)(3) within the 30-day period may:

(1) stay enforcement of the penalty by:

(A) paying the amount of the penalty to the court

for placement in an escrow account; or

(B) giving to the court a supersedeas bond that is approved by the court for the amount of the penalty and that is effective until all judicial review of the commission's order is final; or

(2) request the court to stay enforcement of the penalty by:

(A) filing with the court a sworn affidavit of the person stating that the person is financially unable to pay the amount of the penalty and is financially unable to give the supersedeas bond; and

(B) giving a copy of the affidavit to the executive commissioner by certified mail.

(o) If the executive commissioner receives a copy of an affidavit under Subsection (n)(2), the executive commissioner may file with the court, within five days after the date the copy is received, a contest to the affidavit. The court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person who files an affidavit has the burden of proving that the person is financially unable to pay the amount of the penalty and to give a supersedeas bond.

(p) If the person charged does not pay the amount of the penalty and the enforcement of the penalty is not stayed, the commission may forward the matter to the attorney general for enforcement of the penalty and interest as provided by law for legal judgments. An action to enforce a penalty order under this section must be initiated in a court of competent jurisdiction in Travis County or in the county in which the violation was committed.

(q) Judicial review of a commission order or review under this section assessing a penalty is under the substantial evidence rule. A suit may be initiated by filing a petition with a district court in Travis County, as provided by Subchapter G, Chapter 2001, Government Code.

(r) If a penalty is reduced or not assessed, the commission shall remit to the person the appropriate amount plus accrued interest if the penalty has been paid or shall execute a release of

the bond if a supersedeas bond has been posted. The accrued interest on amounts remitted by the commission under this subsection shall be paid at a rate equal to the rate provided by law for legal judgments and shall be paid for the period beginning on the date the penalty is paid to the commission under this section and ending on the date the penalty is remitted.

(s) A damage, cost, or penalty collected under this section is not an allowable expense in a claim or cost report that is or could be used to determine a rate or payment under the medical assistance program.

(t) All funds collected under this section shall be deposited in the State Treasury to the credit of the General Revenue Fund.

(u) Except as provided by Subsection (w), a person found liable for a violation under Subsection (c) that resulted in injury to an elderly person, as defined by Section 48.002(a)(1), a person with a disability, as defined by Section 48.002(a)(8)(A), or a person younger than 18 years of age may not provide or arrange to provide health care services under the medical assistance program for a period of 10 years. The executive commissioner by rule may provide for a period of ineligibility longer than 10 years. The period of ineligibility begins on the date on which the determination that the person is liable becomes final.

(v) Except as provided by Subsection (w), a person found liable for a violation under Subsection (c) that did not result in injury to an elderly person, as defined by Section 48.002(a)(1), a person with a disability, as defined by Section 48.002(a)(8)(A), or a person younger than 18 years of age may not provide or arrange to provide health care services under the medical assistance program for a period of three years. The executive commissioner by rule may provide for a period of ineligibility longer than three years. The period of ineligibility begins on the date on which the determination that the person is liable becomes final.

(w) The executive commissioner by rule may prescribe criteria under which a person described by Subsection (u) or (v) is not prohibited from providing or arranging to provide health care services under the medical assistance program. The criteria may

include consideration of:

(1) the person's knowledge of the violation;

(2) the likelihood that education provided to the person would be sufficient to prevent future violations;

(3) the potential impact on availability of services in the community served by the person; and

(4) any other reasonable factor identified by the executive commissioner.

(x) Subsections (b)(1-b) through (1-f) do not prohibit a person from engaging in:

(1) generally accepted business practices, as determined by commission rule, including:

(A) conducting a marketing campaign;

(B) providing token items of minimal value that advertise the person's trade name; and

(C) providing complimentary refreshments at an informational meeting promoting the person's goods or services;

(2) the provision of a value-added service if the person is a managed care organization; or

(3) other conduct specifically authorized by law, including conduct authorized by federal safe harbor regulations (42 C.F.R. Section 1001.952).

Added by Acts 1987, 70th Leg., ch. 1052, Sec. 2.04, eff. Sept. 1, 1987. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49), (53), eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 1153, Sec. 3.01(a), eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 12, Sec. 1, 2, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 257, Sec. 4, 5, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 127 (S.B. 1694), Sec. 2, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 879 (S.B. 223), Sec. 3.16, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 29, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.113, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.114, eff. April 2, 2015.

Sec. 32.0391. CRIMINAL OFFENSE. (a) A person commits an offense if the person intentionally or knowingly commits a violation under Section 32.039(b)(1-b), (1-c), (1-d), (1-e), or (1-f).

(b) An offense under this section is a state jail felony.

(c) If conduct constituting an offense under this section also constitutes an offense under another provision of law, including a provision in the Penal Code, the person may be prosecuted under either this section or the other provision.

(d) With the consent of the appropriate local county or district attorney, the attorney general has concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section.

Added by Acts 2003, 78th Leg., ch. 257, Sec. 6, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 127 (S.B. 1694), Sec. 3, eff. September 1, 2007.

Sec. 32.040. IDENTIFICATION OF HUSBAND OR ALLEGED FATHER. (a) A woman receiving medical assistance in the form of prenatal care, child delivery care, and obstetrical care related to prenatal care and child delivery care shall identify her husband, or, if unmarried, shall provide the name and last known address of the alleged father of the unborn child.

(b) If the woman receiving medical assistance is under 18 years of age and resides with one or both parents, the parents shall cooperate in identifying the husband or the alleged father.

Added by Acts 1989, 71st Leg., 1st C.S., ch. 25, Sec. 37, eff. Jan. 1, 1990.

Sec. 32.042. INFORMATION REQUIRED FROM HEALTH INSURERS. (a) An insurer shall maintain a file system that contains:

(1) the name, address, including claim submission address, group policy number, employer's mailing address, social

security number, and date of birth of each enrollee, beneficiary, subscriber, or policyholder covered by the insurer; and

(2) the name, address, including claim submission address, and date of birth of each dependent of each enrollee, beneficiary, subscriber, or policyholder covered by the insurer.

(b) The state's Medicaid third-party recovery division shall identify state medical assistance recipients who have third-party health coverage or insurance as provided by this subsection. The commission may:

(1) provide to an insurer Medicaid data tapes that identify medical assistance recipients and request that the insurer identify each enrollee, beneficiary, subscriber, or policyholder of the insurer whose name also appears on the Medicaid data tape; or

(2) request that an insurer provide to the commission identifying information for each enrollee, beneficiary, subscriber, or policyholder of the insurer.

(b-1) An insurer from which the commission requests information under Subsection (b) shall provide that information, except that the insurer is only required to provide the commission with the information maintained under Subsection (a) by the insurer or made available to the insurer from the plan. A plan administrator is subject to Subsection (b) and shall provide information under that subsection to the extent the information is made available to the plan administrator from the insurer or plan.

(c) An insurer may not be required to provide information in response to a request under this section more than once every six months.

(d) An insurer shall provide the information required under Subsection (b)(1) only if the commission certifies that the identified individuals are applicants for or recipients of services under Medicaid or are legally responsible for an applicant for or recipient of Medicaid services.

(e) The commission shall enter into an agreement to reimburse an insurer or plan administrator for necessary and reasonable costs incurred in providing information requested under Subsection (b)(1), not to exceed $5,000 for each data match made under that subdivision. If the commission makes a data match using

information provided under Subsection (b)(2), the commission shall reimburse the insurer or plan administrator for reasonable administrative expenses incurred in providing the information. The reimbursement for information under Subsection (b)(2) may not exceed $5,000 for initially producing information with respect to a person, or $200 for each subsequent production of information with respect to the person. The commission may enter into an agreement with an insurer or plan administrator that provides procedures for requesting and providing information under this section. An agreement under this subsection may not be inconsistent with any law relating to the confidentiality or privacy of personal information or medical records. The procedures agreed to under this subsection must state the time and manner the procedures take effect.

(f) Information required to be furnished to the commission under this section is limited to information necessary to determine whether health benefits have been or should have been claimed and paid under a health insurance policy or plan for medical care or services received by an individual for whom Medicaid coverage would otherwise be available.

(g) Information regarding an individual certified to an insurer as an applicant for or recipient of medical assistance may only be used to identify the records or information requested and may not violate the confidentiality of the applicant or recipient. The commission shall establish guidelines not later than the date on which the procedures agreed to under Subsection (e) take effect.

(h) This section applies to a plan administrator in the same manner and to the same extent as an insurer if the plan administrator has the information necessary to comply with the applicable requirement.

(i) In this section:

(1) "Insurer" means a group hospital service corporation, a health maintenance organization, a self-funded or self-insured welfare or benefit plan or program to the extent the regulation of the plan or program is not preempted by federal law, and any other entity that provides health coverage in this state

through an employer, union, trade association, or other organization or other source.

(2) "Plan administrator" means a third-party administrator, prescription drug payer or administrator, pharmacy benefit manager, or dental payer or administrator.

Added by Acts 1993, 73rd Leg., ch. 816, Sec. 1.01, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 88, Sec. 1, eff. Sept. 1, 1999.

Amended by:

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

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.115, eff. April 2, 2015.

Sec. 32.0421. ADMINISTRATIVE PENALTY FOR FAILURE TO PROVIDE INFORMATION. (a) The commission may impose an administrative penalty on a person who does not comply with a request for information made under Section 32.042(b).

(b) The amount of the penalty may not exceed $10,000 for each day of noncompliance that occurs after the 180th day after the date of the request. The amount shall be based on:

(1) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation;

(2) the economic harm caused by the violation;

(3) the history of previous violations;

(4) the amount necessary to deter a future violation;

(5) efforts to correct the violation; and

(6) any other matter that justice may require.

(c) The enforcement of the penalty may be stayed during the time the order is under judicial review if the person pays the penalty to the clerk of the court or files a supersedeas bond with the court in the amount of the penalty. A person who cannot afford to pay the penalty or file the bond may stay the enforcement by filing an affidavit in the manner required by the Texas Rules of Civil Procedure for a party who cannot afford to file security for costs, subject to the right of the commission to contest the affidavit as provided by those rules.

(d) The attorney general may sue to collect the penalty.

(e) A proceeding to impose the penalty is considered to be a contested case under Chapter 2001, Government Code.

Added by Acts 1999, 76th Leg., ch. 88, Sec. 2, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.116, eff. April 2, 2015.

Sec. 32.0422. HEALTH INSURANCE PREMIUM PAYMENT REIMBURSEMENT PROGRAM FOR MEDICAL ASSISTANCE RECIPIENTS.

(a) In this section, "group health benefit plan" means a plan described by Section 1207.001, Insurance Code.

(b) The commission shall identify individuals, otherwise entitled to medical assistance, who are eligible to enroll in a group health benefit plan. The commission must include individuals eligible for or receiving health care services under a Medicaid managed care delivery system.

(b-1) To assist the commission in identifying individuals described by Subsection (b):

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

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

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

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

(c) The commission shall require an individual requesting medical assistance or a recipient, during the recipient's eligibility recertification review, to provide information as

necessary relating to any group health benefit plan that is available to the individual or recipient through an employer of the individual or recipient or an employer of the individual's or recipient's spouse or parent to assist the commission in making the determination required by Subsection (d).

(d) For an individual identified under Subsection (b), the commission shall determine whether it is cost-effective to enroll the individual in the group health benefit plan under this section.

(e) If the commission determines that it is cost-effective to enroll the individual in the group health benefit plan, the commission shall:

(1) require the individual to apply to enroll in the group health benefit plan as a condition for eligibility under the medical assistance program; and

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

(e-1) This subsection applies only to an individual who is identified under Subsection (b) as being eligible to enroll in a group health benefit plan offered by an employer. If the commission determines under Subsection (d) that enrolling the individual in the group health benefit plan is not cost-effective, but the individual prefers to enroll in that plan instead of receiving benefits and services under the medical assistance program, the commission, if authorized by a waiver obtained under federal law, shall:

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

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

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

(f) Except as provided by Subsection (f-1), the commission shall provide for payment of:

(1) the employee's share of required premiums for

coverage of an individual enrolled in the group health benefit plan; and

(2) any deductible, copayment, coinsurance, or other cost-sharing obligation imposed on the enrolled individual for an item or service otherwise covered under the medical assistance program.

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

(g) A payment made by the commission under Subsection (f) or (f-1) is considered to be a payment for medical assistance.

(h) A payment of a premium for an individual who is a member of the family of an individual enrolled in a group health benefit plan under Subsection (e) and who is not eligible for medical assistance is considered to be a payment for medical assistance for an eligible individual if:

(1) enrollment of the family members who are eligible for medical assistance is not possible under the plan without also enrolling members who are not eligible; and

(2) the commission determines it to be cost-effective.

(i) A payment of any deductible, copayment, coinsurance, or other cost-sharing obligation of a family member who is enrolled in a group health benefit plan in accordance with Subsection (h) and who is not eligible for medical assistance:

(1) may not be paid under this chapter; and

(2) is not considered to be a payment for medical assistance for an eligible individual.

(i-1) The commission shall make every effort to expedite payments made under this section, including by ensuring that those

payments are made through electronic transfers of money to the recipient's account at a financial institution, if possible. In lieu of reimbursing the individual enrolled in the group health benefit plan for required premium or cost-sharing payments made by the individual, the commission may, if feasible:

(1) make payments under this section for required premiums directly to the employer providing the group health benefit plan in which an individual is enrolled; or

(2) make payments under this section for required premiums and cost-sharing obligations directly to the group health benefit plan issuer.

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

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

(k) Repealed by Acts 2015, 84th Leg., R.S., Ch. 945 , Sec. 13(2), eff. September 1, 2015.

(l) The commission, in consultation with the Texas Department of Insurance, shall provide training to agents who hold a general life, accident, and health license under Chapter 4054, Insurance Code, regarding the health insurance premium payment

reimbursement program and the eligibility requirements for participation in the program. Participation in a training program established under this subsection is voluntary, and a general life, accident, and health agent who successfully completes the training is entitled to receive continuing education credit under Subchapter B, Chapter 4004, Insurance Code, in accordance with rules adopted by the commissioner of insurance.

(m) The commission may pay a referral fee, in an amount determined by the commission, to each general life, accident, and health agent who, after completion of the training program established under Subsection (l), successfully refers an eligible individual to the commission for enrollment in a group health benefit plan under this section.

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

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

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

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

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

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

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

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

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

Added by Acts 2001, 77th Leg., ch. 1165, Sec. 2, eff. Aug. 31, 2001. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.07(b), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.129, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.130, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 18, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.117, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 13(2), eff. September 1, 2015.

Sec. 32.0423. RECOVERY OF REIMBURSEMENTS FROM HEALTH COVERAGE PROVIDERS. To the extent allowed by federal law, a health care service provider must seek reimbursement from available third-party health coverage or insurance that the provider knows about or should know about before billing the medical assistance program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.106(a), eff. Sept. 1, 2003.

Sec. 32.0424. REQUIREMENTS OF THIRD-PARTY HEALTH INSURERS. (a) A third-party health insurer is required to provide to the commission, on the commission's request, information in a form prescribed by the executive commissioner necessary to determine:

(1) the period during which an individual entitled to medical assistance, the individual's spouse, or the individual's dependents may be, or may have been, covered by coverage issued by the health insurer;

(2) the nature of the coverage; and

(3) the name, address, and identifying number of the health plan under which the person may be, or may have been, covered.

(b) A third-party health insurer shall accept the state's right of recovery and the assignment under Section 32.033 to the state of any right of an individual or other entity to payment from the third-party health insurer for an item or service for which payment was made under the medical assistance program.

(c) A third-party health insurer shall respond to any inquiry by the commission regarding a claim for payment for any health care item or service reimbursed by the commission under the medical assistance program not later than the third anniversary of the date the health care item or service was provided.

(d) A third-party health insurer may not deny a claim submitted by the commission or the commission's designee for which payment was made under the medical assistance program solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of service that is the basis of the claim, if:

(1) the claim is submitted by the commission or the commission's designee not later than the third anniversary of the date the item or service was provided; and

(2) any action by the commission or the commission's designee to enforce the state's rights with respect to the claim is commenced not later than the sixth anniversary of the date the commission or the commission's designee submits the claim.

(e) This section does not limit the scope or amount of information required by Section 32.042.

Added by Acts 2009, 81st Leg., R.S., Ch. 745 (S.B. 531), Sec. 3, eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.118, eff.

April 2, 2015.

Sec. 32.04242. PAYOR OF LAST RESORT. The executive commissioner shall adopt rules to ensure, to the extent allowed by federal law, that the Medicaid program:

(1) is the payor of last resort; and

(2) provides reimbursement for services, including long-term care services, only if, and to the extent, other adequate public or private sources of payment are not available.

Added by Acts 2011, 82nd Leg., R.S., Ch. 821 (H.B. 2722), Sec. 1, eff. June 17, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.119, eff. April 2, 2015.

Sec. 32.0425. REIMBURSEMENT FOR WHEELED MOBILITY SYSTEMS. (a) In this section:

(1) "Qualified rehabilitation professional" means a person who:

(A) holds a certification as an assistive technology professional or a rehabilitation engineering technologist issued by, and is in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America, provided that the requirements for that certification are at least as stringent as the requirements in effect on January 1, 2009; or

(B) is otherwise qualified to conduct the professional activities of a person who holds a certification described by Paragraph (A), as determined by rules adopted by the executive commissioner.

(2) "Wheeled mobility system" means an item of durable medical equipment that is a customized powered or manual mobility device or a feature or component of the device, including the following features and components:

(A) seated positioning components;

(B) powered or manual seating options;

(C) specialty driving controls;

(D) multiple adjustment frame;

(E) nonstandard performance options; and

(F) other complex or specialized components.

(b) The commission may provide medical assistance reimbursement for the provision of, or the performance of a major modification to, a wheeled mobility system only if:

(1) the system is delivered to a recipient by a medical assistance provider that is, or directly employs or contracts with, a qualified rehabilitation professional and that professional was present and involved in any clinical assessment of the recipient that is required for obtaining the system; and

(2) at the time the wheeled mobility system is delivered to the recipient, the qualified rehabilitation professional:

(A) is present for and directs a fitting to ensure that the system is appropriate for the recipient; and

(B) verifies that the system functions relative to the recipient.

(c) The executive commissioner shall adopt rules specifying:

(1) the scope, including any required components, of the fitting and verification of functionality required by Subsection (b);

(2) documentation of the fitting and verification of functionality that must be submitted as part of a claim for reimbursement for the provision or modification of a wheeled mobility system; and

(3) the appropriate reimbursement methodology for compensating the evaluation and final fitting services provided by qualified rehabilitation professionals involved in the provision or modification of wheeled mobility systems.

Added by Acts 2009, 81st Leg., R.S., Ch. 832 (S.B. 1804), Sec. 1, eff. September 1, 2009.

Redesignated from Human Resources Code, Section 32.0424 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(32), eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.120, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.121, eff. April 2, 2015.

Sec. 32.043. PROCUREMENT RULES FOR PUBLIC DISPROPORTIONATE SHARE HOSPITALS. (a) A public hospital that is designated as a disproportionate share hospital during a fiscal year may acquire goods and services in accordance with this section during the succeeding fiscal year. A procurement of goods or services made in accordance with this section is considered to satisfy any state law requiring purchases by competitive bidding or competitive proposals.

(b) The public hospital shall acquire goods or services by any procurement method approved by the commission that provides the best value to the public hospital. The public hospital shall document that it considered all relevant factors under Subsection (c) in making the acquisition.

(c) The public hospital may consider all relevant factors in determining the best value, including:

(1) any installation costs;

(2) the delivery terms;

(3) the quality and reliability of the vendor's goods or services;

(4) the extent to which the goods or services meet the public hospital's needs;

(5) indicators of probable vendor performance under the contract such as past vendor performance, the vendor's financial resources and ability to perform, the vendor's experience and responsibility, and the vendor's ability to provide reliable maintenance agreements;

(6) the impact on the ability of the public hospital to comply with laws and rules relating to historically underutilized businesses or relating to the procurement of goods and services from persons with disabilities;

(7) the total long-term cost to the public hospital of acquiring the vendor's goods or services;

(8) the cost of any employee training associated with the acquisition;

(9) the effect of an acquisition on the public hospital's productivity;

(10) the acquisition price; and

(11) any other factor relevant to determining the best value for the public hospital in the context of a particular acquisition.

(d) The state auditor or the commission may audit the public hospital's acquisitions of goods and services to the extent that state money or federal money appropriated by the state is used to acquire the goods and services.

(e) The public hospital may adopt rules and procedures for the acquisition of goods and services under this section.

Added by Acts 1997, 75th Leg., ch. 1045, Sec. 2, eff. Sept. 1, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.122, eff. April 2, 2015.

Sec. 32.044. GROUP PURCHASING FOR DISPROPORTIONATE SHARE HOSPITALS. (a) A public or private hospital that is designated as a disproportionate share hospital during a fiscal year may purchase goods and services in accordance with this section during the succeeding fiscal year. A purchase of goods or services made in accordance with this section is considered to satisfy any state law requiring purchases by competitive bidding or competitive proposals.

(b) A state or local governmental entity may allow the public or private hospital to purchase goods or services by participating in one or more of the entity's contracts for the purchase of goods or services.

(c) The public or private hospital may purchase goods or services in accordance with this section through a group purchasing program that offers discount prices to hospitals or other providers of health care services.

(d) The executive commissioner with the assistance of the comptroller shall adopt rules under this section that allow the

public or private hospital to make purchases through group purchasing programs except when the commission has reason to believe that a better value is available through another procurement method.

(e) This section applies to private hospitals only to the extent it authorizes private hospitals to participate in purchasing contracts with governmental entities or to satisfy any state law that may require goods and services the hospital purchases to be competitively procured. This section does not impose new purchasing requirements on a private hospital, except to the extent that the private hospital agrees to be bound by the terms of a contract that is authorized by this section and that it chooses to enter. This section does not affect any explicit or implicit authority that a private hospital has under other law to participate in a group purchasing program or to participate in a purchasing contract with a public entity.

Added by Acts 1997, 75th Leg., ch. 1045, Sec. 2, eff. Sept. 1, 1997.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 937 (H.B. 3560), Sec. 1.95, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.123, eff. April 2, 2015.

Sec. 32.045. ENHANCED REIMBURSEMENT. The commission shall develop a procedure for:

(1) identifying each service provided under the medical assistance program for which the state is eligible to receive enhanced reimbursement of costs from the federal government; and

(2) ensuring that the state seeks the highest level of federal reimbursement available for each service provided.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.04(a), eff. June 20, 1997.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Sec. 32.046. SANCTIONS AND PENALTIES RELATED TO THE PROVISION OF PHARMACY PRODUCTS. (a) The executive commissioner shall adopt rules governing sanctions and penalties that apply to a provider who participates in the vendor drug program or is enrolled as a network pharmacy provider of a managed care organization contracting with the commission under Chapter 533, Government Code, or its subcontractor and who submits an improper claim for reimbursement under the program.

(b) The commission shall notify each provider in the vendor drug program that the provider is subject to sanctions and penalties for submitting an improper claim.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 3.02, eff. Sept. 1, 1997.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(k), eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Sec. 32.0461. VENDOR DRUG PROGRAM; COMPETITIVE BIDDING. (a) The commission shall seek competitive bids for the claims processing function of the vendor drug program.

(b) The commission shall require any person seeking to contract for services under this section to comply with competitive bidding procedures adopted by the executive commissioner.

(c) The commission may award a contract under this section to another person only if the commission determines that the provision of services under that contract would be more cost-effective and the time to process claims under the contract would be the same as or faster than having employees of the commission continue to process claims.

(d) The commission may consult with the comptroller in administering this section.

Added by Acts 1999, 76th Leg., ch. 103, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 24 (S.B. 706), Sec. 4, eff. September 1, 2017.

Sec. 32.0462. VENDOR DRUG PROGRAM; PRICING STANDARD. (a) Notwithstanding any other provision of state law, the commission shall:

(1) consider a nationally recognized, unbiased pricing standard for prescription drugs in determining reimbursement amounts under the vendor drug program; and

(2) update reimbursement amounts under the vendor drug program at least weekly.

(b) The executive commissioner shall adopt rules implementing this section. In adopting rules, the executive commissioner shall ensure that implementation of this section does not adversely affect the amount of federal funds available to the state for providing benefits under the vendor drug program.

Added by Acts 2003, 78th Leg., ch. 1251, Sec. 10, eff. June 20, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Sec. 32.0463. MEDICATIONS AND MEDICAL SUPPLIES. The executive commissioner may adopt rules establishing procedures for the purchase and distribution of medically necessary, over-the-counter medications and medical supplies under the medical assistance program that were previously being provided by prescription if the executive commissioner determines it is more cost-effective than obtaining those medications and medical supplies through a prescription.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.107(a), eff. Sept. 1, 2003.

Renumbered from Human Resources Code, Section 32.0462 by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(58), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Sec. 32.047. PROHIBITION OF CERTAIN HEALTH CARE SERVICE PROVIDERS. (a) A person is permanently prohibited from providing or arranging to provide health care services under the medical assistance program if:

(1) the person is convicted of an offense arising from a fraudulent act under the program; and

(2) the person's fraudulent act results in injury to an elderly person, as defined by Section 48.002(a)(1), a person with a disability, as defined by Section 48.002(a)(8)(A), or a person younger than 18 years of age.

(b) The executive commissioner shall adopt rules for prohibiting a person from participating in the medical assistance program as a health care provider for a reasonable period, as determined by the executive commissioner, if the person:

(1) fails to repay overpayments under the program; or

(2) owns, controls, manages, or is otherwise affiliated with and has financial, managerial, or administrative influence over a provider who has been suspended or prohibited from participating in the program.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 3.03, eff. Sept. 1, 1997.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 30, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Sec. 32.048. MANAGED CARE INFORMATION AND TRAINING PLAN. (a) Subject to the availability of funds, the commission shall develop a comprehensive plan to provide information and training about the requirements of a managed care plan to recipients of medical assistance, providers of medical assistance, local health and human services agencies, and other interested parties in each service area in which the commission provides medical assistance

through a managed care plan.

(b) The commission shall include in the comprehensive plan:

(1) information and training at regular intervals determined by the commission; and

(2) performance measures to evaluate the effectiveness of the information and training.

(c) In developing the comprehensive plan, the commission shall consult with the Medicaid medical care advisory committee.

Added by Acts 1997, 75th Leg., ch. 618, Sec. 1, eff. June 11, 1997. Renumbered from Sec. 32.043 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(74), eff. Sept. 1, 1999.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 23(6), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(108), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Sec. 32.049. MANAGED CARE CONTRACT COMPLIANCE. (a) The commission shall review each managed care organization that has contracted with the commission to provide medical assistance to medical assistance recipients through a managed care plan issued by the organization to determine whether the organization is prepared to meet its contractual obligations.

(b)(1) The commission shall require each managed care organization that has contracted with the commission to submit an implementation plan not later than the 90th day before the date on which the managed care organization plans to begin to provide medical assistance through a managed care plan in a service area. The implementation plan must include:

(A) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and enrollee training; and

(B) specific time frames for demonstrating preparedness for implementation before the date on which the

managed care organization plans to begin to provide medical assistance through a managed care plan in a service area.

(2) The commission shall respond within 10 working days if the implementation plan does not adequately meet preparedness guidelines.

(3) The commission shall require each managed care organization that has contracted with the commission to submit status reports on the implementation plan not later than the 60th day and the 30th day before the date on which the managed care organization plans to begin to provide medical assistance through a managed care plan in a service area and every 30th day after the managed care organization begins to provide medical assistance through a managed care plan in a service area until the 180th day of operations.

(c) The commission shall conduct a compliance and readiness review of each managed care organization that contracts with the state not later than the 15th day before the date on which the process of enrolling recipients in a managed care plan issued by the managed care organization is to begin in a service area and again not later than the 15th day before the date on which the managed care organization plans to begin to provide medical assistance through a managed care plan in that service area. The review shall include an on-site inspection and tests of service authorization and claims payment systems, complaint processing systems, and any other process or system required by the contract.

(d) The commission may delay enrollment of medical assistance recipients in a managed care plan if the review reveals that the managed care organization is not prepared to meet its contractual obligations.

Added by Acts 1997, 75th Leg., ch. 692, Sec. 1, eff. June 17, 1997. Renumbered from Sec. 32.043 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(75), eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.124, eff. April 2, 2015.

Sec. 32.050. DUAL MEDICAID AND MEDICARE COVERAGE. (a) At

least annually the commission shall identify each individual receiving medical assistance under the medical assistance program who is eligible to receive similar assistance under the Medicare program.

(b) The commission shall analyze claims submitted for payment for a service provided under the medical assistance program to an individual identified under Subsection (a) to ensure that payment is sought first under the Medicare program to the extent allowed by law.

(c) For an ambulance service provided to an individual who is eligible under the medical assistance program and Medicare, the medical assistance program shall pay the Medicare deductibles and coinsurance.

(d) Except as provided by Subsection (e), a nursing facility, a home health services provider, or any other similar long-term care services provider that is Medicare-certified and provides care to individuals who are eligible for Medicare must:

(1) seek reimbursement from Medicare before billing the medical assistance program for services provided to an individual identified under Subsection (a); and

(2) as directed by the commission, appeal Medicare claim denials for payment services provided to an individual identified under Subsection (a).

(e) A home health services provider is not required to seek reimbursement from Medicare before billing the medical assistance program for services provided to a person who is eligible for Medicare and who:

(1) has been determined as not being homebound; or

(2) meets other criteria determined by the executive commissioner.

(f) Repealed by Acts 2005, 79th Leg., Ch. 1067, Sec. 1, eff. June 18, 2005.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.03(a), eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 710, Sec. 1. Renumbered from Sec. 32.043 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(76), eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 2.108, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1067 (H.B. 1502), Sec. 1, eff. June 18, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.125, eff. April 2, 2015.

Sec. 32.051. MISDIRECTED BILLING. To the extent authorized by federal law, the commission shall develop a procedure for the state to:

(1) match claims for payment for medical assistance provided under the medical assistance program against data available from other entities, including the United States Department of Veterans Affairs and nursing facilities, to determine alternative responsibility for payment of the claims; and

(2) ensure that the appropriate entity bears the cost of a claim.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.03(a), eff. June 20, 1997. Renumbered from Sec. 32.044 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(77), eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.126, eff. April 2, 2015.

Sec. 32.052. WAIVER PROGRAMS FOR CHILDREN WITH DISABILITIES OR SPECIAL HEALTH CARE NEEDS. (a) This section applies to services under the medical assistance program provided to children younger than 23 years of age with disabilities or special health care needs under a waiver granted under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)).

(b) In this section, "permanency planning" means a philosophy and planning process designed to achieve family support through the facilitation of a permanent living arrangement that has as its primary feature an enduring and nurturing parental relationship.

(c) In developing and providing services subject to this section, the commission shall:

(1) fully assess a child at the time the child applies

for assistance to determine all appropriate services for the child under the medical assistance program, including both waiver and nonwaiver services;

(2) ensure that permanency planning is implemented to identify and establish the family support necessary to maintain a child's permanent living arrangement with a family;

(3) implement a transition and referral process to prevent breaks in services when a child is leaving a medical assistance waiver program or moving between service delivery systems due to a change in the child's disability status or needs, aging out of the current delivery system, or moving between geographic areas within the state;

(4) identify and provide core services addressing a child's developmental needs and the needs of the child's family to strengthen and maintain the child's family;

(5) provide for comprehensive coordination and use of available services and resources in a manner that ensures support for families in keeping their children at home;

(6) ensure that eligibility requirements, assessments for service needs, and other components of service delivery are designed to be fair and equitable for all families, including families with parents who work outside the home; and

(7) provide for a broad array of service options and a reasonable choice of service providers.

(d) To ensure that services subject to this section are cost neutral and not duplicative of other services provided under the medical assistance program, the commission shall coordinate the provision of services subject to this section with services provided under the Texas Health Steps Comprehensive Care Program.

(e) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(41), eff. April 2, 2015.

(f) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(41), eff. April 2, 2015.

Added by Acts 1999, 76th Leg., ch. 1012, Sec. 1, eff. June 18, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.127, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.465(a)(41), eff. April 2, 2015.

Sec. 32.053. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). (a) The commission, as an integral part of the medical assistance program, shall develop and implement a program of all-inclusive care for the elderly (PACE) in accordance with Section 4802 of the Balanced Budget Act of 1997 (Pub. L. No. 105-33), as amended. The commission shall provide medical assistance to a participant in the PACE program in the manner and to the extent authorized by federal law.

(b) The executive commissioner shall adopt rules as necessary to implement this section. In adopting rules, the executive commissioner shall:

(1) use the Bienvivir Senior Health Services of El Paso initiative as a model for the program;

(2) ensure that a person is not required to hold a certificate of authority as a health maintenance organization under Chapter 843, Insurance Code, to provide services under the PACE program;

(3) ensure that participation in the PACE program is available as an alternative to enrollment in a Medicaid managed care plan under Chapter 533, Government Code, for eligible recipients, including recipients eligible for assistance under both the medical assistance and Medicare programs;

(4) ensure that managed care organizations that contract under Chapter 533, Government Code, consider the availability of the PACE program when considering whether to refer a recipient to a nursing facility or other long-term care facility; and

(5) establish protocols for the referral of eligible persons to the PACE program.

(c) The commission may not contract with a person to provide services under the PACE program unless the person:

(1) purchases reinsurance in an amount determined by the commission that is sufficient to ensure the person's continued solvency; or

(2) has the financial resources sufficient to cover expenses in the event of the person's insolvency.

(d) To demonstrate sufficiency of financial resources for purposes of Subsection (c)(2), a person may use cash reserves, a letter of credit, a guarantee of a company affiliated with the person, or a combination of those arrangements. The amount of a person's financial arrangement must be at least equal to the sum of:

(1) the total capitation revenue for one month; and

(2) the average monthly payment of operating expenses.

(e) The Department of Aging and Disability Services and area agencies on aging shall develop and implement a coordinated plan to promote PACE program sites operating under this section. The executive commissioner shall adopt policies and procedures, including operating guidelines, to ensure that caseworkers and any other appropriate department staff discuss the benefits of participating in the PACE program with long-term care clients.

(f) The commission shall consider the PACE program as a community-based service option under any "Money Follows the Person" demonstration project or other initiative that is designed to eliminate barriers or mechanisms that prevent or restrict the flexible use of funds under the medical assistance program to enable a recipient to receive long-term services or supports in a setting of the recipient's choice.

(g) A PACE program site may coordinate with entities that are eligible to obtain discount prescription drug prices under Section 340B, Public Health Service Act (42 U.S.C. Section 256b), as necessary to enable the PACE program site to obtain those discounts.

(h) The executive commissioner shall adopt a standard reimbursement methodology for the payment of all PACE organizations for purposes of encouraging a natural increase in the number of PACE program sites throughout the state.

(i) To the extent allowed by the General Appropriations Act, the commission may transfer general revenue funds appropriated to the commission for the medical assistance program to the Department of Aging and Disability Services to provide PACE services in PACE program service areas to eligible recipients whose medical

assistance benefits would otherwise be delivered as home and community-based services through the STAR + PLUS Medicaid managed care program and whose personal incomes are at or below the level of income required to receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq.

Added by Acts 2001, 77th Leg., ch. 170, Sec. 1, eff. Sept. 1, 2001.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1168 (H.B. 2903), Sec. 1, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 6.08, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.128, eff. April 2, 2015.

Sec. 32.0531. PACE PROGRAM TEAM. (a) The Department of Aging and Disability Services shall establish a PACE program team composed of experienced personnel. The team is responsible for:

(1) increasing public attention and awareness of the availability of PACE program sites;

(2) increasing the number of PACE program sites operating in this state; and

(3) serving as a liaison with the state and federal agencies responsible for administering the PACE program, participants in the program, and PACE program sites.

(b) Expired.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1168 (H.B. 2903), Sec. 2, eff. September 1, 2011.

Sec. 32.0532. PACE PROGRAM REIMBURSEMENT METHODOLOGY. (a) In this section and Sections 32.0533 and 32.0534, "PACE program" means the program of all-inclusive care for the elderly (PACE) established under Section 32.053.

(b) In setting the reimbursement rates under the PACE program, the executive commissioner shall ensure that:

(1) reimbursement rates for providers under the program are adequate to sustain the program; and

(2) the program is cost-neutral or costs less when

compared to the cost to serve a population in the STAR + PLUS Medicaid managed care program that is comparable in:

(A) age;

(B) eligibility factors, including:

(i) income level;

(ii) health status; and

(iii) impairment level;

(C) geographic location;

(D) living environment; and

(E) other factors determined to be necessary.

(c) For purposes of Subsection (b)(2), the commission shall consider data on the cost of services provided to comparable recipients enrolled in the STAR + PLUS Medicaid managed care program to calculate the upper payment limit component of the PACE program reimbursement rates. The cost of those services includes the Medicaid capitation payment per recipient and Medicaid payments made on a fee-for-service basis for services not covered by the capitation payment.

Added by Acts 2015, 84th Leg., R.S., Ch. 823 (H.B. 3823), Sec. 1, eff. June 17, 2015.

Sec. 32.0533. DATA COLLECTION: PACE AND STAR + PLUS MEDICAID MANAGED CARE PROGRAMS. The commission, in collaboration with the Department of Aging and Disability Services and appropriate stakeholder groups, shall modify the methods by which the commission and the department collect data for evaluation of the PACE and STAR + PLUS Medicaid managed care programs to allow comparison of recipient outcomes between the programs. The modification to data collection methods must include changes to:

(1) survey instruments that measure recipient experience;

(2) compilation of the same or similar complaint, disenrollment, and appeals data; and

(3) compilation of the same or similar hospital admissions and readmissions data.

Added by Acts 2015, 84th Leg., R.S., Ch. 823 (H.B. 3823), Sec. 1, eff. June 17, 2015.

Sec. 32.054. DENTAL SERVICES. (a) For purposes of this section, the "dental necessity" for a dental service or product is based on whether a prudent dentist, acting in accordance with generally accepted practices of the professional dental community and within the American Dental Association's Parameters of Care for Dentistry and within the quality assurance criteria of the American Academy of Pediatric Dentistry, as applicable, would provide the service or product to a patient to diagnose, prevent, or treat orofacial pain, infection, disease, dysfunction, or disfiguration.

(b) A dental service or product may not be provided under the medical assistance program unless there is a dental necessity for the service or product.

(c) In providing dental services under the medical assistance program, the commission shall:

(1) ensure that a stainless steel crown is not used as a preventive measure;

(2) require a dentist participating in the medical assistance program to document, through x-rays or other methods established by commission rule, the dental necessity for a stainless steel crown before the crown is applied;

(3) require a dentist participating in the medical assistance program to comply with a minimum standard of documentation and recordkeeping for each of the dentist's patients, regardless of whether the patient's costs are paid privately or through the medical assistance program;

(4) replace the 15-point system used for determining the dental necessity for hospitalization and general anesthesia with a more objective and comprehensive system developed by the commission; and

(5) take all necessary action to eliminate unlawful acts described by Section 36.002 in the provision of dental services under the medical assistance program, including:

(A) aggressively investigating and prosecuting any dentist who abuses the system for reimbursement under the medical assistance program; and

(B) conducting targeted audits of dentists whose

billing activities under the medical assistance program are excessive or otherwise inconsistent with the billing activities of other similarly situated dentists.

(d) In setting reimbursement rates for dental services under the medical assistance program, the executive commissioner shall:

(1) provide for reimbursement of a behavior management fee only if:

(A) the patient receiving dental treatment has been previously diagnosed with an intellectual or developmental disability or a mental disability or disorder, and extraordinary behavior management techniques are necessary for therapeutic dental treatment because of the patient's uncooperative behavior; and

(B) the dentist includes in the patient's records and on the claim form for reimbursement a narrative description of:

(i) the specific behavior problem demonstrated by the patient that required the use of behavior management techniques;

(ii) the dentist's initial efforts to manage the patient's behavior through routine behavior management techniques; and

(iii) the dentist's extraordinary behavior management techniques subsequently required to manage the patient's behavior; and

(2) redistribute amounts made available through limitation of the behavior management fee under Subdivision (1) to other commonly billed dental services for which adequate accountability measures exist.

(e) The commission shall develop the minimum standard described by Subsection (c)(3) in cooperation with the State Board of Dental Examiners.

(f) To prevent serious medical conditions and reduce emergency room visits necessitated by complications resulting from a lack of access to dental care, the commission shall provide medical assistance reimbursement for preventive dental services, including reimbursement for one preventive dental care visit per

year, for an adult recipient with a disability who is enrolled in the STAR+PLUS Medicaid managed care program. This subsection does not apply to an adult recipient who is enrolled in the STAR+PLUS home and community-based services (HCBS) waiver program. This subsection may not be construed to reduce dental services available to persons with disabilities that are otherwise reimbursable under the medical assistance program.

Added by Acts 2001, 77th Leg., ch. 1470, Sec. 1.01, eff. Sept. 1, 2001. Renumbered from Human Resources Code Sec. 32.053 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(98), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.129, eff. April 2, 2015.

Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 6, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 954 (S.B. 1648), Sec. 6, eff. September 1, 2021.

Sec. 32.055. CATASTROPHIC CASE MANAGEMENT. (a) The commission shall develop and implement a catastrophic case management system to be used in providing medical assistance to persons with catastrophic health problems.

(b) The system must provide for the assignment of a case manager to a recipient of medical assistance with catastrophic health problems that are likely to:

(1) require the services of multiple, specialized health care providers; and

(2) result in major medical costs.

(c) The commission shall identify the services to be provided by a case manager assigned under the system. The services must include assessment of the recipient's needs and coordination of all available medical services and payment options. The services may include other support services such as:

(1) assistance with making arrangements to receive care from medical facilities;

(2) assistance with travel and lodging in connection with receipt of medical care;

(3) education of the recipient and the recipient's family members regarding the nature of the recipient's health problems;

(4) referral to appropriate support groups; and

(5) any other service likely to result in better care provided in a cost-effective manner.

(d) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(109), eff. June 17, 2011.

Added by Acts 2001, 77th Leg., ch. 408, Sec. 1, eff. Sept. 1, 2001. Renumbered from Human Resources Code Sec. 32.053 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(99), eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 23(7), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(109), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.130, eff. April 2, 2015.

Sec. 32.0551. OPTIMIZATION OF CASE MANAGEMENT SYSTEMS. The commission shall:

(1) create and coordinate staffing and other administrative efficiencies for case management initiatives across the commission and health and human services agencies; and

(2) optimize federal funding revenue sources and maximize the use of state funding resources for case management initiatives across the commission and health and human services agencies.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 8(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.131, eff. April 2, 2015.

Sec. 32.056. COMPLIANCE WITH TEXAS HEALTH STEPS COMPREHENSIVE CARE PROGRAM. The executive commissioner by rule shall develop procedures to ensure that recipients of medical

assistance who are eligible for Texas Health Steps Comprehensive Care Program comply with the regimen of care prescribed by the program.

Added by Acts 2001, 77th Leg., ch. 584, Sec. 5, eff. Jan. 1, 2002. Renumbered from Human Resources Code Sec. 32.053 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(100), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.131, eff. April 2, 2015.

Sec. 32.0561. MATERNAL DEPRESSION SCREENING. (a) In this section, "maternal depression" means depression of any severity with postpartum onset.

(b) The commission shall provide medical assistance reimbursement for a maternal depression screening for a recipient's mother, regardless of whether the mother is also a recipient, that is performed during a covered examination for the recipient under the Texas Health Steps Comprehensive Care Program that occurs before the recipient's first birthday.

(c) The executive commissioner shall adopt rules necessary to implement this section. The rules must be based on:

(1) clinical and empirical evidence concerning maternal depression; and

(2) information provided by relevant physicians and behavioral health organizations.

(d) The commission shall seek, accept, and spend any federal funds that are available for the purposes of this section, including priority funding authorized by Section 317L-1 of the Public Health Service Act (42 U.S.C. Section 201 et seq.), as added by the 21st Century Cures Act (Pub. L. No. 114-255).

Added by Acts 2017, 85th Leg., R.S., Ch. 852 (H.B. 2466), Sec. 3, eff. September 1, 2017.

Sec. 32.057. CONTRACTS FOR DISEASE MANAGEMENT PROGRAMS. (a) The commission shall request contract proposals from providers of disease management programs to provide program services to recipients of medical assistance who:

(1) have a disease or other chronic health condition, such as heart disease, hemophilia, chronic kidney disease and its medical complications, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, that the commission determines is a disease or condition that needs disease management; and

(2) are not eligible to receive those services under a Medicaid managed care plan.

(b) The commission may contract with a public or private entity to:

(1) write the requests for proposals;

(2) determine how savings will be measured;

(3) identify populations that need disease management;

(4) develop appropriate contracts; and

(5) assist the commission in:

(A) developing the content of disease management programs; and

(B) obtaining funding for those programs.

(c) The executive commissioner by rule shall prescribe the minimum requirements a provider of a disease management program must meet to be eligible to receive a contract under this section. The provider must, at a minimum, be required to:

(1) use disease management approaches that are based on evidence-supported models, standards of care in the medical community, and clinical outcomes; and

(2) ensure that a recipient's primary care physician and other appropriate specialty physicians, or registered nurses, advanced practice nurses, or physician assistants specified and directed or supervised in accordance with applicable law by the recipient's primary care physician or other appropriate specialty physicians, become directly involved in the disease management program through which the recipient receives services.

(c-1) A managed care health plan that develops and implements a disease management program under Section 533.009, Government Code, and a provider of a disease management program under this section shall coordinate during a transition period

beneficiary care for patients that move from one disease management program to another program.

(d) The commission may not award a contract for a disease management program under this section unless the contract includes a written guarantee of state savings on expenditures for the group of medical assistance recipients covered by the program.

(e) The commission may enter into a contract under this section with a comprehensive hemophilia diagnostic treatment center that receives funding through a maternal and child health services block grant under Section 501(a)(2), Social Security Act (42 U.S.C. Section 701(a)(2)), and the center shall be considered a disease management provider.

(f) Directly or through a provider of a disease management program that enters into a contract with the commission under this section, the commission shall, as appropriate and to the extent possible without cost to the state:

(1) identify recipients of medical assistance under this chapter or, at the discretion of the commission, enrollees in the child health plan under Chapter 62, Health and Safety Code, who are eligible to participate in federally funded disease management research programs operated by research-based disease management providers; and

(2) assist and refer eligible persons identified by the commission under Subdivision (1) to participate in the research programs described by Subdivision (1).

Added by Acts 2003, 78th Leg., ch. 208, Sec. 1, eff. June 16, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 19(b), eff. September 1, 2005.

Renumbered from Human Resources Code, Section 32.059 by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 23.001(59), eff. September 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 1047 (H.B. 1252), Sec. 2, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.132, eff. April 2, 2015.

Sec. 32.058. LIMITATION ON MEDICAL ASSISTANCE IN CERTAIN ALTERNATIVE COMMUNITY-BASED CARE SETTINGS. (a) In this section:

(1) "Department" means the Department of Aging and Disability Services.

(2) "Medical assistance waiver program" means a program operated by the Department of Aging and Disability Services, other than the Texas home living waiver program, that provides services under a waiver granted in accordance with 42 U.S.C. Section 1396n(c).

(b) Except as provided by Subsection (c), (d), (e), or (f), the department may not provide services under a medical assistance waiver program to a person if the projected cost of providing those services over a 12-month period exceeds the individual cost limit specified in the medical assistance waiver program.

(c) The department shall continue to provide services under a medical assistance waiver program to a person who was receiving those services on September 1, 2005, at a cost that exceeded the individual cost limit specified in the medical assistance waiver program, if continuation of those services:

(1) is necessary for the person to live in the most integrated setting appropriate to the needs of the person; and

(2) does not affect the department's compliance with the federal average per capita expenditure requirement of the medical assistance waiver program under 42 U.S.C. Section 1396n(c)(2)(D).

(d) The department may continue to provide services under a medical assistance waiver program, other than the home and community-based services program, to a person who is ineligible to receive those services under Subsection (b) and to whom Subsection (c) does not apply if:

(1) the projected cost of providing those services to the person under the medical assistance waiver program over a 12-month period does not exceed 133.3 percent of the individual cost limit specified in the medical assistance waiver program; and

(2) continuation of those services does not affect the department's compliance with the federal average per capita

expenditure requirement of the medical assistance waiver program under 42 U.S.C. Section 1396n(c)(2)(D).

(e) The department may exempt a person from the cost limit established under Subsection (d)(1) for a medical assistance waiver program if the department determines that:

(1) the person's health and safety cannot be protected by the services provided within the cost limit established for the program under that subdivision; and

(2) there is no available living arrangement, other than one provided through the program or another medical assistance waiver program, in which the person's health and safety can be protected, as evidenced by:

(A) an assessment conducted by clinical staff of the department; and

(B) supporting documentation, including the person's medical and service records.

(f) The department may continue to provide services under the home and community-based services program to a person who is ineligible to receive those services under Subsection (b) and to whom Subsection (c) does not apply if the department makes, with regard to the person's receipt of services under the home and community-based services program, the same determinations required by Subsections (e)(1) and (2) in the same manner provided by Subsection (e) and determines that continuation of those services does not affect:

(1) the department's compliance with the federal average per capita expenditure requirement of the home and community-based services program under 42 U.S.C. Section 1396n(c)(2)(D); and

(2) any cost-effectiveness requirements provided by the General Appropriations Act that limit expenditures for the home and community-based services program.

(g) The executive commissioner may adopt rules to implement Subsections (d), (e), and (f).

(h) If a federal agency determines that compliance with any provision in this section would make this state ineligible to receive federal funds to administer a program to which this section

applies, a state agency may, but is not required to, implement that provision.

Added by Acts 2005, 79th Leg., Ch. 317 (S.B. 626), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 19(a), eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.133, eff. April 2, 2015.

Sec. 32.059. USE OF RESPIRATORY THERAPISTS FOR RESPIRATORY THERAPY SERVICES. The executive commissioner by rule shall require that respiratory therapy services for ventilator-dependent persons furnished as part of a plan of care under this chapter be provided by a respiratory care practitioner authorized to practice respiratory care under Chapter 604, Occupations Code, when:

(1) respiratory therapy is determined by the recipient's treating physician to be the most effective method of treatment; and

(2) the use of a respiratory care practitioner is practicable and cost-neutral or cost-effective.

Acts 2003, 78th Leg., ch. 1167, Sec. 1, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.134, eff. April 2, 2015.

Sec. 32.061. COMMUNITY ATTENDANT SERVICES PROGRAM. (a) Any home and community-based services that the commission provides under Section 1929, Social Security Act (42 U.S.C. Section 1396t) and its subsequent amendments to functionally disabled individuals who have income that exceeds the limit established by federal law for Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) and its subsequent amendments shall be provided through the community attendant services program.

(b) In determining an applicant's eligibility for home and community-based services described by Subsection (a), the commission shall exclude $20 of unearned or earned income from the

applicant's monthly income.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.110, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 1(a), eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.135, eff. April 2, 2015.

Sec. 32.062. ADMISSIBILITY OF CERTAIN EVIDENCE RELATING TO NURSING INSTITUTIONS.

(a) The following are not admissible as evidence in a civil action:

(1) any finding by the Department of Aging and Disability Services that an institution licensed under Chapter 242, Health and Safety Code, has violated a standard for participation in the medical assistance program under this chapter; or

(2) the fact of the assessment of a monetary penalty against an institution under Section 32.021 or the payment of the penalty by an institution.

(b) This section does not apply in an enforcement action in which the state or an agency or political subdivision of the state is a party.

(c) Notwithstanding any other provision of this section, evidence described by Subsection (a) is admissible as evidence in a civil action only if:

(1) the evidence relates to a material violation of this chapter or a rule adopted under this chapter or assessment of a monetary penalty with respect to:

(A) the particular incident and the particular individual whose personal injury is the basis of the claim being brought in the civil action; or

(B) a finding by the Department of Aging and Disability Services that directly involves substantially similar conduct that occurred at the institution within a period of one year before the particular incident that is the basis of the claim being brought in the civil action;

(2) the evidence of a material violation has been affirmed by the entry of a final adjudicated and unappealable order of the Department of Aging and Disability Services after formal appeal; and

(3) the record is otherwise admissible under the Texas Rules of Evidence.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 16.01, eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 3, eff. September 1, 2009.

Redesignated from Human Resources Code, Section 32.060 by Acts 2011, 82nd Leg., R.S., Ch. 91 (S.B. 1303), Sec. 27.001(33), eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.136, eff. April 2, 2015.

Sec. 32.063. THIRD-PARTY BILLING VENDORS. (a) A third-party billing vendor may not submit a claim with the commission for reimbursement on behalf of a provider of medical services under the medical assistance program unless the vendor has entered into a contract with the commission authorizing that activity.

(b) To the extent practical, the contract shall contain provisions comparable to the provisions contained in contracts between the commission and providers of medical services, with an emphasis on provisions designed to prevent fraud or abuse under the medical assistance program. At a minimum, the contract must require the third-party billing vendor to:

(1) provide documentation of the vendor's authority to bill on behalf of each provider for whom the vendor submits claims;

(2) submit a claim in a manner that permits the commission to identify and verify the vendor, any computer or telephone line used in submitting the claim, any relevant user password used in submitting the claim, and any provider number referenced in the claim; and

(3) subject to any confidentiality requirements imposed by federal law, provide the commission, the office of the attorney general, or authorized representatives with:

(A) access to any records maintained by the vendor, including original records and records maintained by the vendor on behalf of a provider, relevant to an audit or investigation of the vendor's services or another function of the commission or office of the attorney general relating to the vendor; and

(B) if requested, copies of any records described by Paragraph (A) at no charge to the commission, the office of the attorney general, or authorized representatives.

(c) On receipt of a claim submitted by a third-party billing vendor, the commission shall send a remittance notice directly to the provider referenced in the claim. The notice must:

(1) include detailed information regarding the claim submitted on behalf of the provider; and

(2) require the provider to review the claim for accuracy and notify the commission promptly regarding any errors.

(d) The commission shall take all action necessary, including any modifications of the commission's claims processing system, to enable the commission to identify and verify a third-party billing vendor submitting a claim for reimbursement under the medical assistance program, including identification and verification of any computer or telephone line used in submitting the claim, any relevant user password used in submitting the claim, and any provider number referenced in the claim.

(e) The commission shall audit each third-party billing vendor subject to this section at least annually to prevent fraud and abuse under the medical assistance program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.111(a), eff. Jan. 1, 2004.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.137, eff. April 2, 2015.

Sec. 32.064. COST SHARING. (a) To the extent permitted

under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), as amended, and any other applicable law or regulations, the executive commissioner shall adopt provisions requiring recipients of medical assistance to share the cost of medical assistance, including provisions requiring recipients to pay:

(1) an enrollment fee;

(2) a deductible; or

(3) coinsurance or a portion of the plan premium, if the recipients receive medical assistance under the Medicaid managed care program under Chapter 533, Government Code.

(b) Subject to Subsection (d), cost-sharing provisions adopted under this section shall ensure that families with higher levels of income are required to pay progressively higher percentages of the cost of the medical assistance.

(c) If cost-sharing provisions imposed under Subsection (a) include requirements that recipients pay a portion of the plan premium, the commission shall specify the manner in which the premium is paid. The commission may require that the premium be paid to the commission, an agency operating part of the medical assistance program, or the Medicaid managed care plan.

(d) Cost-sharing provisions adopted under this section may be determined based on the maximum level authorized under federal law and applied to income levels in a manner that minimizes administrative costs.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.112(a), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.138, eff. April 2, 2015.

Sec. 32.0641. RECIPIENT ACCOUNTABILITY PROVISIONS; COST-SHARING REQUIREMENT TO IMPROVE APPROPRIATE UTILIZATION OF SERVICES. (a) To the extent permitted under and in a manner that is consistent with Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) and any other applicable law or regulation or under a federal waiver or other authorization, the executive commissioner shall adopt cost-sharing provisions that encourage

personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to a recipient who chooses to receive a nonemergency medical service through a hospital emergency room.

(b) The commission may not seek a federal waiver or other authorization under this section that would:

(1) prevent a Medicaid recipient who has a condition requiring emergency medical services from receiving care through a hospital emergency room; or

(2) waive any provision under Section 1867, Social Security Act (42 U.S.C. Section 1395dd).

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 20, eff. September 1, 2007.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.09(b), eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.139, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.37, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.34, eff. January 1, 2016.

Sec. 32.067. DELIVERY OF COMPREHENSIVE CARE SERVICES TO CERTAIN RECIPIENTS OF MEDICAL ASSISTANCE. (a) In this section, "certified agency" and "home health service" have the meanings assigned by Section 142.001, Health and Safety Code.

(b) The commission shall assure that any agency licensed to provide home health services under Chapter 142, Health and Safety Code, and not only a certified agency licensed under that chapter, may provide home health services to individuals enrolled in the Texas Health Steps Comprehensive Care Program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.204, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.140, eff. April 2, 2015.

Sec. 32.068. IN-PERSON EVALUATION REQUIRED FOR CERTAIN SERVICES. (a) A medical assistance provider may order or otherwise authorize the provision of home health services for a recipient only if the provider has conducted an in-person evaluation of the recipient within the 12-month period preceding the date the order or other authorization was issued.

(b) A physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife that orders or otherwise authorizes the provision of durable medical equipment for a recipient in accordance with Chapter 157, Occupations Code, and other applicable law, including rules, must certify on the order or other authorization that the person conducted an in-person evaluation of the recipient within the 12-month period preceding the date the order or other authorization was issued.

(c) The executive commissioner shall adopt rules necessary to implement this section. The executive commissioner may by rule adopt limited exceptions to the requirements of this section.

Added by Acts 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 31, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.141, eff. April 2, 2015.

Sec. 32.069. CHRONIC KIDNEY DISEASE MANAGEMENT INITIATIVE. A provider of disease management programs under Section 32.057 shall develop a program to provide screening for and diagnosis and treatment of chronic kidney disease and its medical complications under the medical assistance program. The program must use generally recognized clinical practice guidelines and laboratory assessments that identify chronic kidney disease on the basis of impaired kidney function or the presence of kidney damage.

Added by Acts 2005, 79th Leg., Ch. 1047 (H.B. 1252), Sec. 3, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.142, eff. April 2, 2015.

Sec. 32.070. AUDITS OF PROVIDERS. (a) In this section, "provider" means an individual, firm, partnership, corporation, agency, association, institution, or other entity that is or was approved by the commission to provide medical assistance under contract or provider agreement with the commission.

(b) The executive commissioner shall adopt rules governing the audit of providers in the medical assistance program.

(c) The rules must:

(1) provide that the agency conducting the audit must notify the provider, and the provider's corporate headquarters, if the provider is a pharmacy that is incorporated, of the impending audit not later than the seventh day before the date the field audit portion of the audit begins;

(2) limit the period covered by an audit to three years;

(3) provide that the agency conducting the audit must accommodate the provider's schedule to the greatest extent possible when scheduling the field audit portion of the audit;

(4) require the agency conducting the audit to conduct an entrance interview before beginning the field audit portion of the audit;

(5) provide that each provider must be audited under the same standards and parameters as other providers of the same type;

(6) provide that the audit must be conducted in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States or other appropriate standards;

(7) require the agency conducting the audit to conduct an exit interview at the close of the field audit portion of the audit with the provider to review the agency's initial findings;

(8) provide that, at the exit interview, the agency conducting the audit shall:

(A) allow the provider to:

(i) respond to questions by the agency;

(ii) comment, if the provider desires, on

the initial findings of the agency; and

(iii) correct a questioned cost by providing additional supporting documentation that meets the auditing standards required by Subdivision (6) if there is no indication that the error or omission that resulted in the questioned cost demonstrates intent to commit fraud; and

(B) provide to the provider a preliminary audit report and a copy of any document used to support a proposed adjustment to the provider's cost report;

(9) permit the provider to produce documentation to address any exception found during an audit not later than the 10th day after the date the field audit portion of the audit is completed;

(10) provide that the agency conducting the audit shall deliver a draft audit report to the provider not later than the 60th day after the date the field audit portion of the audit is completed;

(11) permit the provider to submit to the agency conducting the audit a written management response to the draft audit report or to appeal the findings in the draft audit report not later than the 30th day after the date the draft audit report is delivered to the provider;

(12) provide that the agency conducting the audit shall deliver the final audit report to the provider not later than the 180th day after the date the field audit portion of the audit is completed or the date on which a final decision is issued on an appeal made under Subdivision (13), whichever is later; and

(13) establish an ad hoc review panel, composed of providers practicing or doing business in this state appointed by the executive commissioner, to administer an informal process through which:

(A) a provider may obtain an early review of an audit report or an unfavorable audit finding without the need to obtain legal counsel; and

(B) a recommendation to revise or dismiss an unfavorable audit finding that is found to be unsubstantiated may be made by the review panel to the agency, provided that the

recommendation is not binding on the agency.

(d) This section does not apply to a computerized audit conducted using the Medicaid Fraud Detection System or an audit or investigation of fraud and abuse conducted by the Medicaid fraud control unit of the office of the attorney general, the office of the state auditor, the office of the inspector general, or the Office of Inspector General in the United States Department of Health and Human Services.

Added by Acts 2005, 79th Leg., Ch. 811 (S.B. 630), Sec. 1, eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.143, eff. April 2, 2015.

Sec. 32.0705. EXTERNAL AUDITS OF CERTAIN MEDICAID CONTRACTORS BASED ON RISK. (a) In this section, "Medicaid contractor" means an entity that:

(1) is not a health and human services agency as defined by Section 531.001, Government Code; and

(2) under a contract with the commission or otherwise on behalf of the commission, performs one or more administrative services in relation to the commission's operation of Medicaid, such as claims processing, utilization review, client enrollment, provider enrollment, quality monitoring, or payment of claims.

(b) The commission shall contract with an independent auditor to perform annual independent external financial and performance audits of any Medicaid contractor used in the commission's operation of Medicaid. The commission regularly shall review the Medicaid contracts and ensure that:

(1) the frequency and extent of audits of a Medicaid contractor under this section are based on the amount of risk to the state involved in the administrative services being performed by the contractor;

(2) audit procedures related to financial audits and performance audits are used consistently in audits under this section; and

(3) to the extent possible, audits under this section

are completed in a timely manner.

(c) If another state agency succeeds to the commission's operation of a part of Medicaid for which the commission used a Medicaid contractor, the successor agency shall comply with this section with regard to the Medicaid contractor, including the requirement to contract with an independent auditor to perform the external financial and performance audits required by this section.

(d) An audit required by this section must be completed before the end of the fiscal year immediately following the fiscal year for which the audit is performed.

Added by Acts 1999, 76th Leg., ch. 1411, Sec. 1.10, eff. Sept. 1, 1999.

Transferred, redesignated and amended from Health and Safety Code, Section 12.0123 by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0016, eff. April 2, 2015.

Sec. 32.071. RECIPIENT AND PROVIDER EDUCATION. (a) The commission shall develop and implement a comprehensive medical assistance education campaign for recipients and providers to ensure that care is provided in such a way as to improve patient outcomes and maximize cost-effectiveness. The commission shall ensure that educational information developed under this section is demographically relevant and appropriate for each recipient or provider to whom the information is provided.

(b) The comprehensive medical assistance education campaign must include elements designed to encourage recipients to obtain, maintain, and use a medical home and to reduce their use of high-cost emergency department services for conditions that can be treated through primary care or nonemergency physicians or other providers. The campaign must include the dissemination of educational information through newsletters and emergency department staff members and at local health fairs, unless the department determines that these methods of dissemination are not effective in increasing recipients' appropriate use of the health care system.

(c) The commission shall evaluate whether certain risk groups may disproportionately increase their appropriate use of the

health care system as a result of targeted elements of an education campaign. If the commission determines that certain risk groups will respond with more appropriate use of the system, the commission shall develop and implement the appropriate targeted educational elements.

(d) The commission shall develop a system for reviewing recipient prescription drug use and educating providers with respect to that drug use in a manner that emphasizes reducing inappropriate prescription drug use and the possibility of adverse drug interactions.

(e) The commission shall coordinate the medical assistance education campaign with area health education centers, federally qualified health centers, as defined by 42 U.S.C. Section 1396d(l)(2)(B), and other stakeholders who use public funds to educate recipients and providers about the health care system in this state. The commission shall make every effort to maximize state funds by working through these partners to maximize receipt of additional federal funding for administrative and other costs.

(f) The commission shall coordinate with other state and local agencies to ensure that community-based health workers, health educators, state eligibility determination employees who work in hospitals and other provider locations, and promoters are used in the medical assistance education campaign, as appropriate.

(g) The commission shall ensure that all state agencies that work with recipients, all administrative persons who provide eligibility determination and enrollment services, and all service providers use the same curriculum for recipient and provider education, as appropriate.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 9(a), eff. September 1, 2005.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.144, eff. April 2, 2015.

Sec. 32.072. DIRECT ACCESS TO EYE HEALTH CARE SERVICES. (a) Notwithstanding any other law, a recipient of medical assistance is entitled to:

(1) select an ophthalmologist or therapeutic optometrist who is a medical assistance provider to provide eye health care services, other than surgery, that are within the scope of:

(A) services provided under the medical assistance program; and

(B) the professional specialty practice for which the ophthalmologist or therapeutic optometrist is licensed; and

(2) have direct access to the selected ophthalmologist or therapeutic optometrist for the provision of the nonsurgical services without any requirement that the patient or ophthalmologist or therapeutic optometrist obtain:

(A) a referral from a primary care physician or other gatekeeper or health care coordinator; or

(B) any other prior authorization or precertification.

(b) The commission may require an ophthalmologist or therapeutic optometrist selected as provided by this section by a recipient of medical assistance who is otherwise required to have a primary care physician or other gatekeeper or health care coordinator to forward to the recipient's physician, gatekeeper, or health care coordinator information concerning the eye health care services provided to the recipient.

(c) This section may not be construed to expand the scope of eye health care services provided under the medical assistance program.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 21(a), eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.145, eff. April 2, 2015.

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

Sec. 32.073. HEALTH INFORMATION TECHNOLOGY STANDARDS. (a) In this section, "health information technology" means information

technology used to improve the quality, safety, or efficiency of clinical practice, including the core functionalities of an electronic health record, an electronic medical record, a computerized health care provider order entry, electronic prescribing, and clinical decision support technology.

(b) The commission shall ensure that any health information technology used by the commission or any entity acting on behalf of the commission in the medical assistance program conforms to standards required under federal law.

(c) Not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, the commission shall require a health benefit plan issuer participating in the medical assistance program or the agent of the health benefit plan issuer that manages or administers prescription drug benefits to exchange prior authorization requests electronically with a prescribing provider participating in the medical assistance program who has electronic prescribing capability and who initiates a request electronically.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 4, eff. September 1, 2009.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 11, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.146, eff. April 2, 2015.

Sec. 32.074. ACCESS TO PERSONAL EMERGENCY RESPONSE SYSTEM. (a) In this section, "personal emergency response system" has the meaning assigned by Section 1702.331, Occupations Code.

(b) The commission shall ensure that each Medicaid recipient enrolled in a home and community-based services waiver program that includes a personal emergency response system as a service has access to a personal emergency response system, if necessary, without regard to the recipient's access to a landline telephone.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.20, eff. September 28, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.147, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 838 (S.B. 202), Sec. 3.021, eff. September 1, 2015.

Sec. 32.075. EMPLOYMENT ASSISTANCE AND SUPPORTED EMPLOYMENT. (a) In this section:

(1) "Employment assistance" means assistance provided to an individual to help the individual locate paid employment in the community. Employment assistance includes:

(A) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

(B) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and

(C) contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

(2) "Supported employment" means assistance provided, in order to sustain paid employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported employment includes adaptations, supervision, and training related to an individual's diagnosis.

(b) This section applies only to the following medical assistance waiver programs:

(1) the community based alternatives program;

(2) the community living assistance and support services program;

(3) the deaf-blind with multiple disabilities program;

(4) the home and community-based services program;

(5) the medically dependent children program;

(6) the STAR + PLUS Medicaid managed care program;

(7) the Texas home living program; and

(8) the youth empowerment services program.

(c) The commission shall provide employment assistance and supported employment to participants in the waiver programs identified in Subsection (b).

Added by Acts 2013, 83rd Leg., R.S., Ch. 506 (S.B. 45), Sec. 1, eff. June 14, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.148, eff. April 2, 2015.

Sec. 32.076. SUBSTITUTE DENTISTS. To the extent allowed by federal law, the executive commissioner of the Health and Human Services Commission shall adopt rules ensuring that the same standards applying to a physician who bills the medical assistance program for services provided by a substitute physician apply also to a dentist who bills the medical assistance program for services provided by a substitute dentist.

Added by Acts 2015, 84th Leg., R.S., Ch. 739 (H.B. 1661), Sec. 1, eff. June 17, 2015.

## SUBCHAPTER C. MEDICAL ASSISTANCE PROGRAM PROVIDER DATABASE

Sec. 32.101. DEFINITIONS. In this subchapter:

(1) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1 , Sec. 4.465(a)(43), eff. April 2, 2015.

(2) "Health care provider" means a person, other than a physician, who:

(A) is licensed or otherwise authorized to provide a health care service in this state, including:

(i) a pharmacist, dentist, optometrist, mental health counselor, social worker, advanced practice nurse, physician assistant, or durable medical equipment supplier;

(ii) a pharmacy, hospital, or other institution or organization; or

(iii) a local public health entity;

(B) is wholly owned or controlled by:

(i) a health care provider or a group of

health care providers described by Paragraph (A); or

(ii) one or more hospitals and physicians, including a physician-hospital organization;

(C) is a professional association of physicians organized under the Texas Professional Association Law, as described by Section 1.008, Business Organizations Code;

(D) is an approved nonprofit health corporation certified under Chapter 162, Occupations Code;

(E) is a medical and dental unit, as defined by Section 61.003, Education Code, a medical school, as defined by Section 61.501, Education Code, or a health science center described by Subchapter K, Chapter 74, Education Code, that employs or contracts with physicians to teach or provide medical services, or employs physicians and contracts with physicians in a practice plan; or

(F) is another person wholly owned by physicians.

(3) "Managed care organization" has the meaning assigned by Section 533.001, Government Code.

(4) "Managed care plan" has the meaning assigned by Section 533.001, Government Code.

(5) "Participating provider" means a physician or health care provider who is a provider of medical assistance, including a physician or health care provider who contracts or otherwise agrees with a managed care organization to provide medical assistance under this chapter.

(6) "Physician" means an individual licensed to practice medicine in this state.

(7) "Recipient" means a recipient of medical assistance.

Added by Acts 2007, 80th Leg., R.S., Ch. 883 (H.B. 2042), Sec. 1, eff. June 15, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.465(a)(43), eff. April 2, 2015.

Acts 2021, 87th Leg., R.S., Ch. 535 (S.B. 73), Sec. 3, eff. September 1, 2021.

Sec. 32.102. DATABASE OF MEDICAL ASSISTANCE PROGRAM PROVIDERS. (a) The executive commissioner shall establish and administer an electronic, searchable, Internet-based database of all participating providers in the medical assistance program.

(b) The database must include, as applicable, at least the following information regarding each participating provider:

(1) the provider's:

(A) name;

(B) specialty;

(C) location;

(D) office hours, including any office hours outside of regular business hours; and

(E) telephone number;

(2) whether the provider:

(A) is accepting new recipients, and if the provider is accepting new recipients and if applicable, the managed care organization or managed care plan under which new recipients are being accepted;

(B) has any practice limitations, including specific age range limitations; and

(C) speaks any languages other than English;

(3) a list of the medical assistance program services offered by the provider; and

(4) any waiver program or other program within the medical assistance program in which the provider is a participant, including the Texas Health Steps program.

(c) In establishing the database, the executive commissioner shall ensure that the database:

(1) allows a person to search a managed care organization by name and by participating provider within each of the managed care plans offered by that managed care organization;

(2) allows a participating provider to electronically access and change or update the information required by Subsection (b)(1), (2), or (3); and

(3) is available and accessible to each participating provider and each recipient.

(d) The executive commissioner shall ensure that the

database is updated continually and at least once a month.
Added by Acts 2007, 80th Leg., R.S., Ch. 883 (H.B. 2042), Sec. 1, eff. June 15, 2007.

Sec. 32.103. CERTAIN FEES PROHIBITED. A person, including the executive commissioner, a person acting under a contract under Section 32.104, or a managed care organization, may not charge a participating provider or a recipient a fee, directly or indirectly, for making information available or for accessing information in the database established under this subchapter.
Added by Acts 2007, 80th Leg., R.S., Ch. 883 (H.B. 2042), Sec. 1, eff. June 15, 2007.

Sec. 32.104. AUTHORITY TO CONTRACT. (a) The executive commissioner may contract with a state agency or a private entity for the creation, operation, and maintenance of the database required by this subchapter.

(b) A contract entered into under this section must allow the executive commissioner to oversee and supervise the contractor and the database.
Added by Acts 2007, 80th Leg., R.S., Ch. 883 (H.B. 2042), Sec. 1, eff. June 15, 2007.

Sec. 32.105. RULES. The executive commissioner shall adopt rules to implement and administer this subchapter.
Added by Acts 2007, 80th Leg., R.S., Ch. 883 (H.B. 2042), Sec. 1, eff. June 15, 2007.

## SUBCHAPTER E. ELECTRONIC COMMUNICATIONS

Sec. 32.201. DEFINITIONS. In this subchapter:

(1) "Electronic health record" means electronically originated and maintained health and claims information regarding the health status of an individual that may be derived from multiple sources and includes the following core functionalities:

(A) a patient health and claims information or data entry function to aid with medical diagnosis, nursing

assessment, medication lists, allergy recognition, demographics, clinical narratives, and test results;

(B) a results management function that may include computerized laboratory test results, diagnostic imaging reports, interventional radiology reports, and automated displays of past and present medical or laboratory test results;

(C) a computerized physician order entry of medication, care orders, and ancillary services;

(D) clinical decision support that may include electronic reminders and prompts to improve prevention, diagnosis, and management; and

(E) electronic communication and connectivity that allows online communication:

(i) among physicians and health care providers; and

(ii) among the commission, the operating agencies, and participating providers.

(2) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(44), eff. April 2, 2015.

(3) "Health care provider" means a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state.

(4) "Health information technology" means information technology used to improve the quality, safety, or efficiency of clinical practice, including the core functionalities of an electronic health record, electronic medical record, computerized physician or health care provider order entry, electronic prescribing, and clinical decision support technology.

(5) "Operating agency" means a health and human services agency operating part of the medical assistance program.

(6) "Participating provider" means a physician or health care provider who is a provider of medical assistance, including a physician or health care provider who contracts or otherwise agrees with a managed care organization to provide medical assistance under this chapter.

(7) "Physician" means an individual licensed to practice medicine in this state under the authority of Subtitle B,

Title 3, Occupations Code, or a person that is:

(A) a professional association of physicians formed under the Texas Professional Association Law, as described by Section 1.008, Business Organizations Code;

(B) an approved nonprofit health corporation certified under Chapter 162, Occupations Code, that employs or contracts with physicians to provide medical services;

(C) a medical and dental unit, as defined by Section 61.003, Education Code, a medical school, as defined by Section 61.501, Education Code, or a health science center described by Subchapter K, Chapter 74, Education Code, that employs or contracts with physicians to teach or provide medical services, or employs physicians and contracts with physicians in a practice plan; or

(D) a person wholly owned by a person described by Paragraph (A), (B), or (C).

(8) "Recipient" means a recipient of medical assistance.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 22, eff. September 1, 2007.

Renumbered from Human Resources Code, Section 32.101 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(57), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.149, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.465(a)(44), eff. April 2, 2015.

Sec. 32.202. ELECTRONIC COMMUNICATIONS. (a) To the extent allowed by federal law, the executive commissioner may adopt rules allowing the commission to permit, facilitate, and implement the use of health information technology for the medical assistance program to allow for electronic communication among the commission, the operating agencies, and participating providers for:

(1) eligibility, enrollment, verification procedures, and prior authorization for health care services or procedures

covered by the medical assistance program, as determined by the executive commissioner, including diagnostic imaging;

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

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

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

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

(b) If the executive commissioner determines that a need exists for the use of health information technology in the medical assistance program and that the technology is cost-effective, the commission may, for the purposes prescribed by Subsection (a):

(1) acquire and implement the technology; or

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

(c) The commission:

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

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

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

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

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

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

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

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 22, eff. September 1, 2007.

Renumbered from Human Resources Code, Section 32.102 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(57), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.150, eff. April 2, 2015.

## SUBCHAPTER F. PARTNERSHIP FOR LONG-TERM CARE PROGRAM

Sec. 32.251. DEFINITIONS. In this subchapter:

(1) "Approved plan" means a long-term care benefit plan that is approved by the Texas Department of Insurance under Subchapter C, Chapter 1651, Insurance Code.

(2) "Asset disregard" means the total equity value of assets and resources not exempt under rules governing the medical assistance program that are disregarded in determining eligibility for the medical assistance program and in determining estate recovery obligations.

(3) "Asset protection" means the right extended to a plan holder of an approved plan to dollar-for-dollar asset disregard under the medical assistance program.

(4) "Dollar-for-dollar asset disregard" means an asset disregard in which the amount of the disregard is equal to the sum of qualifying benefit payments made on behalf of the qualified plan holder.

(5) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 4.465(a)(45), eff. April 2, 2015.

(6) "Partnership for long-term care program" means the program established under this subchapter and Subchapter C, Chapter 1651, Insurance Code.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 2, eff. March 1, 2008.

Renumbered from Human Resources Code, Section 32.101 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(58), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.465(a)(45), eff. April 2, 2015.

Sec. 32.252. PARTNERSHIP FOR LONG-TERM CARE PROGRAM. The partnership for long-term care program is administered as part of the medical assistance program by the commission with the assistance of the Texas Department of Insurance. The program must be consistent with provisions governing the expansion of a state long-term care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171).

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 2, eff. March 1, 2008.

Renumbered from Human Resources Code, Section 32.102 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(58), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.151, eff. April 2, 2015.

Sec. 32.253. ASSET DISREGARD. (a) To the extent allowed by the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171) and other federal law, the executive commissioner, in adopting rules

and standards governing the medical assistance program, shall allow for dollar-for-dollar asset disregard in determining eligibility for medical assistance for an individual receiving long-term care services if the individual is or was covered by a long-term care benefit plan providing coverage for long-term care that meets the applicable minimum benefit standards of the commissioner of the Texas Department of Insurance under Subchapter C, Chapter 1651, Insurance Code, and other requirements for approval under the partnership for long-term care program.

(b) The commission may not consider the resources of an individual who has used all or part of the individual's benefits under an approved plan to the extent those resources are the subject of a dollar-for-dollar asset disregard in determining:

(1) eligibility for medical assistance under the medical assistance program;

(2) the amount of medical assistance provided; or

(3) any subsequent recovery by this state from the individual's estate for medical assistance provided to the individual.

(c) The commission may not provide to an individual eligible for medical assistance under this section those medical assistance services covered under the medical assistance program that are also covered by the individual's benefits under the approved plan until the individual has fully exhausted the individual's benefits under the plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 2, eff. March 1, 2008.

Renumbered from Human Resources Code, Section 32.103 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(58), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.152, eff. April 2, 2015.

Sec. 32.254. RECIPROCAL AGREEMENTS. The commission may enter into reciprocal agreements with other states to extend asset protection to a resident of this state who purchased a long-term

care benefit plan in another state that has a substantially similar asset disregard program.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 2, eff. March 1, 2008.

Renumbered from Human Resources Code, Section 32.104 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(58), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.153, eff. April 2, 2015.

Sec. 32.255. TRAINING; INFORMATION AND TECHNICAL ASSISTANCE. The commission shall provide information and technical assistance to the Texas Department of Insurance regarding that department's role in ensuring that each individual who sells a long-term care benefit plan under the partnership for long-term care program receives training and demonstrates evidence of an understanding of these plans as required by Section 1651.105, Insurance Code. The training must satisfy the training requirements imposed under the provisions governing the expansion of a state long-term care partnership program established under the federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171).

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 2, eff. March 1, 2008.

Renumbered from Human Resources Code, Section 32.105 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(58), eff. September 1, 2009.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.153, eff. April 2, 2015.

Sec. 32.256. RULES. (a) The executive commissioner shall adopt rules as necessary to administer the partnership for long-term care program and to implement this subchapter.

(b) In adopting rules under this section, the executive commissioner shall:

(1) provide for dollar-for-dollar asset disregard and

asset protection for purchasers of an approved plan; and

(2) count benefits paid under the approved plan toward the dollar-for-dollar asset disregard to the extent the benefits are provided for covered services under the approved plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 795 (S.B. 22), Sec. 2, eff. March 1, 2008.

Renumbered from Human Resources Code, Section 32.106 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(58), eff. September 1, 2009.