HEALTH AND SAFETY CODE

TITLE 2. HEALTH

SUBTITLE C. PROGRAMS PROVIDING HEALTH CARE BENEFITS AND SERVICES

CHAPTER 62. CHILD HEALTH PLAN FOR CERTAIN LOW-INCOME CHILDREN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 62.001. OBJECTIVE OF THE STATE CHILD HEALTH PLAN. The principal objective of the state child health plan is to provide primary and preventative health care to low-income, uninsured children of this state, including children with special health care needs, who are not served by or eligible for other state assisted health insurance programs.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.002. DEFINITIONS. In this chapter:

(1) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 3.1639(22), eff. April 2, 2015.

(2) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 3.1639(22), eff. April 2, 2015.

(3) "Health plan provider" means an insurance company, health maintenance organization, or other entity that provides health benefits coverage under the child health plan program. The term includes a primary care case management provider network.

(4) "Household income" means the sum of the individual incomes of each individual in an applicant's or enrollee's household, minus the standard income disregard prescribed by federal law.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.45, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1353 (H.B. 109), Sec. 1, eff. June 15, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0190, eff. April 2, 2015.

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

3.1639(22), eff. April 2, 2015.

Sec. 62.003. NOT AN ENTITLEMENT; TERMINATION OF PROGRAM. (a) This chapter does not establish an entitlement to assistance in obtaining health benefits for a child.

(b) The program established under this chapter terminates at the time that federal funding terminates under Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, unless a successor program providing federal funding for a state-designed child health plan program is created.

(c) Unless the legislature authorizes the expenditure of other revenue for the program established under this chapter, the program terminates on the date that money obtained by the state as a result of the Comprehensive Settlement Agreement and Release filed in the case styled The State of Texas v. The American Tobacco Co., et al., No. 5-96CV-91, in the United States District Court, Eastern District of Texas, is no longer available to provide state funding for the program.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.004. FEDERAL LAW AND REGULATIONS. The executive commissioner shall monitor federal legislation affecting Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.) and changes to the federal regulations implementing that law. If the executive commissioner determines that a change to Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.) or the federal regulations implementing that law conflicts with this chapter, the executive commissioner shall report the changes to the governor, lieutenant governor, and speaker of the house of representatives, with recommendations for legislation necessary to implement the federal law or regulations, seek a waiver, or withdraw from participation.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0191, eff. April 2, 2015.

Sec. 62.051. DUTIES OF EXECUTIVE COMMISSIONER AND COMMISSION IN GENERAL. (a) The executive commissioner shall administer a state-designed child health plan program to obtain health benefits coverage for children in low-income families. The executive commissioner shall ensure that the child health plan program is designed and administered in a manner that qualifies for federal funding under Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations.

(b) The executive commissioner is responsible for making policy for the child health plan program, including policy related to covered benefits provided under the child health plan. The executive commissioner may not delegate this duty to another agency or entity.

(c) The executive commissioner shall oversee the implementation of the child health plan program and coordinate the activities of each agency necessary to the implementation of the program, including the Texas Department of Insurance.

(d) The executive commissioner shall adopt rules as necessary to implement this chapter.

(e) The commission shall conduct a review of each entity that enters into a contract under Section 62.055 or 62.155 to ensure that the entity is available, prepared, and able to fulfill the entity's obligations under the contract in compliance with the contract, this chapter, and rules adopted under this chapter.

(f) The commission shall ensure that the amounts spent for administration of the child health plan program do not exceed any limit on those expenditures imposed by federal law.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0192, eff. April 2, 2015.

Sec. 62.052. AUTHORITY OF COMMISSION RELATING TO HEALTH PLAN PROVIDER CONTRACTS. The commission may:

(1) implement contracts with health plan providers under Section 62.155;

(2) monitor the health plan providers, through reporting requirements and other means, to ensure performance under the contracts and quality delivery of services;

(3) monitor the quality of services delivered to enrollees through outcome measurements including:

(A) rate of hospitalization for ambulatory sensitive conditions, including asthma, diabetes, epilepsy, dehydration, gastroenteritis, pneumonia, and UTI/kidney infection;

(B) rate of hospitalization for injuries;

(C) percent of enrolled adolescents reporting risky health behavior such as injuries, tobacco use, alcohol/drug use, dietary behavior, physical activity, or other health related behaviors; and

(D) percent of adolescents reporting attempted suicide; and

(4) provide payment under the contracts to the health plan providers.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0192, eff. April 2, 2015.

Sec. 62.053. AUTHORITY OF COMMISSION RELATING TO ELIGIBILITY AND MEDICAID COORDINATION. The commission may:

(1) accept applications for coverage under the child health plan and implement the child health plan program eligibility screening and enrollment procedures;

(2) resolve grievances relating to eligibility determinations; and

(3) coordinate the child health plan program with the Medicaid program.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0193, eff. April 2, 2015.

Sec. 62.0531. AUTHORITY OF COMMISSION RELATING TO THIRD PARTY ADMINISTRATOR. If the commission contracts with a third party administrator under Section 62.055, the commission may:

(1) implement the contract;

(2) monitor the third party administrator, through reporting requirements and other means, to ensure performance under the contract and quality delivery of services; and

(3) provide payment under the contract to the third party administrator.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0193, eff. April 2, 2015.

Sec. 62.054. DUTIES OF TEXAS DEPARTMENT OF INSURANCE. (a) At the request of the commission, the Texas Department of Insurance shall provide any necessary assistance with the child health plan. The department shall monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers.

(b) The commission and the Texas Department of Insurance may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the plan.

(c) The Texas Department of Insurance, in consultation with the commission, shall adopt rules as necessary to implement this section.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0194, eff. April 2, 2015.

Sec. 62.055. CONTRACTS FOR IMPLEMENTATION OF CHILD HEALTH PLAN. (a) It is the intent of the legislature that the commission maximize the use of private resources in administering the child health plan created under this chapter. In administering the child health plan, the commission may contract with a third party administrator to provide enrollment and related services under the state child health plan.

(b), (c) Repealed by Acts 2003, 78th Leg., ch. 198, Sec. 2.156(a)(1).

(d) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 3.1639(23), eff. April 2, 2015.

(e) The executive commissioner shall retain all policymaking authority over the state child health plan.

(f) The commission shall:

(1) procure all contracts with a third party administrator through a competitive procurement process in compliance with all applicable federal and state laws or regulations; and

(2) ensure that all contracts with child health plan providers under Section 62.155 are procured through a competitive procurement process in compliance with all applicable federal and state laws or regulations.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.43, 2.156(a)(1), eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0195, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.1639(23), eff. April 2, 2015.

Sec. 62.056. COMMUNITY OUTREACH CAMPAIGN; TOLL-FREE HOTLINE. (a) The commission shall conduct a community outreach and education campaign to provide information relating to the availability of health benefits for children under this chapter. The commission shall conduct the campaign in a manner that promotes enrollment in, and minimizes duplication of effort among, all state-administered child health programs.

(b) The community outreach campaign must include:

(1) outreach efforts that involve school-based health clinics;

(2) a toll-free telephone number through which families may obtain information about health benefits coverage for children; and

(3) information regarding the importance of each conservator of a child promptly informing the other conservator of the child about the child's health benefits coverage.

(c) The commission shall contract with community-based organizations or coalitions of community-based organizations to implement the community outreach campaign and shall also promote and encourage voluntary efforts to implement the community outreach campaign. The commission shall procure the contracts through a process designed by the commission to encourage broad participation of organizations, including organizations that target population groups with high levels of uninsured children.

(d) The commission may direct that the Department of State Health Services perform all or part of the community outreach campaign.

(e) The commission shall ensure that information provided under this section is available in both English and Spanish.

Added by Acts 2007, 80th Leg., R.S., Ch. 1353 (H.B. 109), Sec. 2, eff. June 15, 2007.

Sec. 62.058. FRAUD PREVENTION. The commission shall develop and implement rules for the prevention and detection of fraud in the child health plan program.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.0582. THIRD-PARTY BILLING VENDORS. (a) A third-party billing vendor may not submit a claim with the commission for payment on behalf of a health plan provider under the 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 health plan providers, with an emphasis on provisions designed to prevent fraud or abuse under the 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 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 include detailed information regarding the claim submitted on behalf of the provider.

(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 payment under the 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 program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.44(a), eff. Jan. 1, 2006.

Sec. 62.060. 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 child health plan program conforms to standards required under federal law.

Added by Acts 2009, 81st Leg., R.S., Ch. 1120 (H.B. 1218), Sec. 2, eff. September 1, 2009.

SUBCHAPTER C. ELIGIBILITY FOR COVERAGE UNDER CHILD HEALTH PLAN

Sec. 62.101. ELIGIBILITY. (a) A child is eligible for health benefits coverage under the child health plan if the child:

(1) is younger than 19 years of age;

(2) is not eligible for medical assistance under the Medicaid program;

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

(4) has a household income that is less than or equal to the income eligibility level established under Subsection (b); and

(5) satisfies any other eligibility standard imposed under the child health plan program in accordance with 42 U.S.C. Section 1397bb, as amended, and any other applicable law or regulations.

(a-1) A child who is the dependent of an employee of an agency of this state and who meets the requirements of Subsection (a) may be eligible for health benefits coverage in accordance with 42 U.S.C. Section 1397jj(b)(6) and any other applicable law or regulations.

(b) The executive commissioner shall establish income eligibility levels consistent with Title XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other

applicable law or regulations, and subject to the availability of appropriated money, so that a child who is younger than 19 years of age and whose household income is at or below 200 percent of the federal poverty level is eligible for health benefits coverage under the program.

(b-1) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 3.1639(25), eff. April 2, 2015.

(c) The executive commissioner shall evaluate enrollment levels and program impact at least annually and shall submit a finding of fact to the Legislative Budget Board and the Governor's Office of Budget, Planning, and Policy as to the adequacy of funding and the ability of the program to sustain enrollment at the eligibility level established by Subsection (b). In the event that appropriated money is insufficient to sustain enrollment at the authorized eligibility level, the executive commissioner shall:

(1) suspend enrollment in the child health plan;

(2) establish a waiting list for applicants for coverage; and

(3) establish a process for periodic or continued enrollment of applicants in the child health plan program as the availability of money allows.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.46, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1353 (H.B. 109), Sec. 3, eff. June 15, 2007.

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.03(a), eff. September 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0196, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.1639(25), eff. April 2, 2015.

Sec. 62.1011. VERIFICATION OF INCOME. The commission shall continue employing methods of verifying the individual incomes of the individuals considered in the calculation of an applicant's

household income. The commission shall verify income under this section unless the applicant reports a household income that exceeds the income eligibility level established under Section 62.101(b).

Added by Acts 2007, 80th Leg., R.S., Ch. 1353 (H.B. 109), Sec. 4, eff. June 15, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0197, eff. April 2, 2015.

Sec. 62.1015. ELIGIBILITY OF CERTAIN CHILDREN; DISALLOWANCE OF MATCHING FUNDS. (a) In this section:

(1) "Charter school" and "regional education service center" have the meanings assigned by Section 1579.002, Insurance Code.

(2) "Employee" has the meaning assigned by Section 1579.003, Insurance Code.

(b) A child of an employee of a charter school, school district, other educational district whose employees are members of the Teacher Retirement System of Texas, or regional education service center may be enrolled in health benefits coverage under the child health plan. A child enrolled in the child health plan under this section:

(1) participates in the same manner as any other child enrolled in the child health plan; and

(2) is subject to the same requirements and restrictions relating to income eligibility, continuous coverage, and enrollment, including applicable waiting periods, as any other child enrolled in the child health plan.

(c) The cost of health benefits coverage for children enrolled in the child health plan under this section shall be paid as provided in the General Appropriations Act. Expenditures made to provide health benefits coverage under this section may not be included for the purpose of determining the state children's health insurance expenditures, as that term is defined by 42 U.S.C. Section 1397ee(d)(2)(B), as amended, unless the commission, after consultation with the appropriate federal agencies, determines

that the expenditures may be included without adversely affecting federal matching funding for the child health plan provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1187, Sec. 1.04, eff. Sept. 1, 2001. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.47, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0198, eff. April 2, 2015.

Sec. 62.102. CONTINUOUS COVERAGE. (a) Subject to a review under Subsection (b), the commission shall provide that an individual who is determined to be eligible for coverage under the child health plan remains eligible for those benefits until the earlier of:

(1) the end of a period not to exceed 12 months, beginning the first day of the month following the date of the eligibility determination; or

(2) the individual's 19th birthday.

(b) During the sixth month following the date of initial enrollment or reenrollment of an individual whose household income exceeds 185 percent of the federal poverty level, the commission shall:

(1) review the individual's household income and may use electronic technology if available and appropriate; and

(2) continue to provide coverage if the individual's household income does not exceed the income eligibility limits prescribed by this chapter.

(c) If, during the review required under Subsection (b), the commission determines that the individual's household income exceeds the income eligibility limits prescribed by this chapter, the commission may not disenroll the individual until:

(1) the commission has provided the family an opportunity to demonstrate that the family's household income is within the income eligibility limits prescribed by this chapter; and

(2) the family fails to demonstrate such eligibility.

(d) The commission shall provide written notice of termination of eligibility to the individual not later than the 30th day before the date the individual's eligibility terminates.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.48, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 3.01, eff. August 29, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1353 (H.B. 109), Sec. 5, eff. June 15, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0199, eff. April 2, 2015.

Sec. 62.103. APPLICATION FORM AND PROCEDURES. (a) The executive commissioner shall adopt an application form and application procedures for requesting child health plan coverage under this chapter.

(b) The form and procedures must be coordinated with forms and procedures under the Medicaid program to ensure that there is a single consolidated application to seek assistance under this chapter or the Medicaid program.

(c) To the extent possible, the application form shall be made available in languages other than English.

(d) The executive commissioner may permit application to be made by mail, over the telephone, or through the Internet.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2001, 77th Leg., ch. 584, Sec. 1.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0200, eff. April 2, 2015.

Sec. 62.104. ELIGIBILITY SCREENING AND ENROLLMENT. (a) The executive commissioner shall develop eligibility screening and enrollment procedures for children that comply with the requirements of 42 U.S.C. Section 1397bb, as amended, and any other applicable law or regulations. The procedures shall ensure

that Medicaid-eligible children are identified and referred to the Medicaid program.

(b) The Texas Integrated Enrollment Services eligibility determination system or a compatible system may be used to screen and enroll children under the child health plan.

(c) The eligibility screening and enrollment procedures shall ensure that children who appear to be Medicaid-eligible are identified and that their families are assisted in applying for Medicaid coverage.

(d) A child who applies for enrollment in the child health plan, who is denied Medicaid coverage after completion of a Medicaid application under Subsection (c), but who is eligible for enrollment in the child health plan, shall be enrolled in the child health plan without further application or qualification.

(e) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(81), eff. June 17, 2011.

(f) A determination of whether a child is eligible for child health plan coverage under the program and the enrollment of an eligible child with a health plan provider must be completed, and information on the family's available choice of health plan providers must be provided, in a timely manner, as determined by the commission. The commission must require that the determination be made and the information be provided not later than the 30th day after the date a complete application is submitted on behalf of the child, unless the child is referred for Medicaid application under this section.

(g) The executive commissioner may establish enrollment periods for the child health plan.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1050 (S.B. 71), Sec. 22(3), eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1083 (S.B. 1179), Sec. 25(81), eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0201, eff. April 2, 2015.

Sec. 62.105. COVERAGE FOR QUALIFIED ALIENS. The commission shall provide coverage under the state Medicaid program and under the program established under this chapter to a child who is a qualified alien, as that term is defined by 8 U.S.C. Section 1641(b), if the federal government authorizes the state to provide that coverage. The commission shall comply with any prerequisite imposed under the federal law to providing that coverage.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.106. SUSPENSION AND AUTOMATIC 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 health benefits coverage under the child health plan during the period the child is placed in the facility.

(c) Not later than 48 hours after the commission is notified of the release from a juvenile facility of a child whose eligibility for health benefits coverage under the child health plan 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. 1, eff. June 18, 2015.

Sec. 62.107. 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 62.106.

(b) A juvenile facility may notify the commission on the placement in the facility of a child who is enrolled in the child health plan.

(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 enrolled in the child health plan.

(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 health benefits coverage under the child health plan.

(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, enrolled in the child health plan 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. 1, eff. June 18, 2015.

SUBCHAPTER D. CHILD HEALTH PLAN

Sec. 62.151. CHILD HEALTH PLAN COVERAGE. (a) The child health plan must comply with this chapter and the coverage requirements prescribed by 42 U.S.C. Section 1397cc, as amended, and any other applicable law or regulations.

(b) In modifying the covered benefits, the executive

commissioner shall consider the health care needs of healthy children and children with special health care needs.

(c) In modifying the plan, the executive commissioner shall ensure that primary and preventive health benefits do not include reproductive services, other than prenatal care and care related to diseases, illnesses, or abnormalities related to the reproductive system.

(d) The child health plan must allow an enrolled child with a chronic, disabling, or life-threatening illness to select an appropriate specialist as a primary care physician.

(e) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(b)(2), and Ch. 946 (S.B. 277), Sec. 2.37(c)(2), eff. January 1, 2016.

(f) If the executive commissioner determines the policy to be cost-effective, the executive commissioner may ensure that an enrolled child does not, unless authorized by the commission in consultation with the child's attending physician or advanced practice nurse, receive under the child health plan:

(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.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.49, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0202, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(b)(2), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(c)(2), eff. January 1, 2016.

Sec. 62.1511. COVERAGE FOR MATERNAL DEPRESSION SCREENING. (a) In this section, "maternal depression" means depression of any severity with postpartum onset.

(b) The covered services under the child health plan must

include a maternal depression screening for an enrollee's mother, regardless of whether the mother is also an enrollee, that is performed during a covered well-child or other office visit for the enrollee that occurs before the enrollee'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. 1, eff. September 1, 2017.

Sec. 62.152. APPLICATION OF INSURANCE LAW. To provide the flexibility necessary to satisfy the requirements of Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, the child health plan is not subject to a law that requires:

(1) coverage or the offer of coverage of a health care service or benefit;

(2) coverage or the offer of coverage for the provision of services by a particular health care services provider, except as provided by Section 62.155(b); or

(3) the use of a particular policy or contract form or of particular language in a policy or contract form.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.153. COST SHARING. (a) To the extent permitted under 42 U.S.C. Section 1397cc, as amended, and any other applicable law or regulations, the executive commissioner shall require enrollees to share the cost of the child health plan, including provisions requiring enrollees under the child health

plan to pay:

(1) a copayment for services provided under the plan;

(2) an enrollment fee; or

(3) a portion of the plan premium.

(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 plan.

(c) If cost-sharing provisions imposed under Subsection (a) include requirements that enrollees pay a portion of the plan premium, the executive commissioner shall specify the manner in which the premium is paid. The commission may require that the premium be paid to the health plan provider.

(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 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.50, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0203, eff. April 2, 2015.

Sec. 62.154. WAITING PERIOD; CROWD OUT. (a) To the extent permitted under Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, the child health plan must include a waiting period and may include copayments and other provisions intended to discourage:

(1) employers and other persons from electing to discontinue offering coverage for children under employee or other group health benefit plans; and

(2) individuals with access to adequate health benefit plan coverage, other than coverage under the child health plan, from electing not to obtain or to discontinue that coverage for a child.

(b) A child is not subject to a waiting period adopted under Subsection (a) if:

(1) the family lost coverage for the child as a result of:

(A) termination of employment because of a layoff or business closing;

(B) termination of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272);

(C) change in marital status of a parent of the child;

(D) termination of the child's Medicaid eligibility because:

(i) the child's family's earnings or resources increased; or

(ii) the child reached an age at which Medicaid coverage is not available; or

(E) a similar circumstance resulting in the involuntary loss of coverage;

(2) the family terminated health benefits plan coverage for the child because the cost to the child's family for the coverage exceeded 9.5 percent of the family's household income;

(3) the child has access to group-based health benefits plan coverage and is required to participate in the health insurance premium payment reimbursement program administered by the commission;

(4) the commission has determined that other grounds exist for a good cause exception; or

(5) federal law provides that the child is not subject to a waiting period adopted under Subsection (a).

(c) A child described by Subsection (b) may enroll in the child health plan program at any time, without regard to any open enrollment period established under the enrollment procedures.

(d) The waiting period required by Subsection (a) must:

(1) extend for a period of 90 days after the last date on which the applicant was covered under a health benefits plan; and

(2) apply to a child who was covered by a health

benefits plan at any time during the 90 days before the date of application for coverage under the child health plan.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.51(a), (b), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1353 (H.B. 109), Sec. 6, eff. June 15, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0204, eff. April 2, 2015.

Sec. 62.155. HEALTH PLAN PROVIDERS. (a) The commission shall select the health plan providers under the program through a competitive procurement process. A health plan provider, other than a state administered primary care case management network, must hold a certificate of authority or other appropriate license issued by the Texas Department of Insurance that authorizes the health plan provider to provide the type of child health plan offered and must satisfy, except as provided by this chapter, any applicable requirement of the Insurance Code or another insurance law of this state.

(b) A managed care organization or other entity shall seek to obtain, in the organization's or entity's provider network, the participation of significant traditional providers, as defined by commission rule, if that organization or entity:

(1) contracts with the commission or with another agency or entity to operate a part of the child health plan under this chapter; and

(2) uses a provider network to provide or arrange for health care services under the child health plan.

(c) In selecting a health plan provider, the commission:

(1) may give preference to a person who provides similar coverage under the Medicaid program; and

(2) shall provide for a choice of at least two health plan providers in each service area.

(d) The executive commissioner may authorize an exception to Subsection (c)(2) if there is only one acceptable applicant to

become a health plan provider in the service area.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.52, eff. Sept. 1, 2003.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0205, eff. April 2, 2015.

Sec. 62.1551. INCLUSION OF CERTAIN HEALTH CARE PROVIDERS IN PROVIDER NETWORKS. (a) Notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the executive commissioner shall adopt rules to require a managed care organization or other entity to ensure that advanced practice registered nurses and physician assistants are available as primary care providers in the organization's or entity's provider network. The rules must require advanced practice registered nurses and physician assistants to be treated in the same manner as primary care physicians with regard to:

(1) selection and assignment as primary care providers;

(2) inclusion as primary care providers in the provider network; and

(3) inclusion as primary care providers in any provider network directory maintained by the organization or entity.

(b) For purposes of Subsection (a), an advanced practice registered nurse may be included as a primary care provider in a managed care organization's or entity's provider network regardless of whether the physician supervising the advanced practice registered nurse is in the provider network.

(c) This section may not be construed as authorizing a managed care organization or other entity to supervise or control the practice of medicine as prohibited by Subtitle B, Title 3, Occupations Code.

Added by Acts 2013, 83rd Leg., R.S., Ch. 418 (S.B. 406), Sec. 22, eff. November 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0206, eff. April 2, 2015.

Acts 2017, 85th Leg., R.S., Ch. 302 (S.B. 654), Sec. 2, eff. September 1, 2017.

Sec. 62.156. HEALTH CARE PROVIDERS. Health care providers who provide health care services under the child health plan must satisfy certification and licensure requirements, as required by commission rules and consistent with other law.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0207, eff. April 2, 2015.

Sec. 62.1561. PROHIBITION OF CERTAIN HEALTH CARE PROVIDERS. The executive commissioner shall adopt rules for prohibiting a person from participating in the child health plan 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 2011, 82nd Leg., R.S., Ch. 980 (H.B. 1720), Sec. 8, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0208, eff. April 2, 2015.

Sec. 62.157. TELEMEDICINE MEDICAL SERVICES, TELEDENTISTRY DENTAL SERVICES, AND TELEHEALTH SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS. (a) In providing covered benefits to a child with special health care needs, a health plan provider must permit benefits to be provided through telemedicine medical services, teledentistry dental services, and telehealth services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services, teledentistry dental services, and telehealth services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services, teledentistry dental services, and telehealth services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single session of telemedicine medical services, teledentistry dental services, telehealth services, or any combination of those services, if the executive commissioner determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services, teledentistry dental services, and telehealth services, including the costs of transportation and lodging and other direct costs.

(c) In developing the policies required by Subsection (a), the executive commissioner shall consult with:

(1) The University of Texas Medical Branch at Galveston;

(2) Texas Tech University Health Sciences Center;

(3) the Department of State Health Services;

(4) providers of telemedicine hub sites in this state;

(5) providers of services to children with special health care needs; and

(6) representatives of consumer or disability groups affected by changes to services for children with special health care needs.

Added by Acts 2001, 77th Leg., ch. 959, Sec. 5, eff. June 14, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0209, eff. April 2, 2015.

Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. 2056), Sec. 22, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. 2056), Sec. 23, eff. September 1, 2021.

Text of section as amended by Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. 2056), Sec. 24

For text of section as amended by Acts 2021, 87th Leg., R.S., Ch. 624 (H.B. 4), Sec. 7, see other Sec. 62.1571.

Sec. 62.1571. TELEMEDICINE MEDICAL SERVICES AND TELEDENTISTRY DENTAL SERVICES. (a) In providing covered benefits to a child, a health plan provider must permit benefits to be provided through telemedicine medical services and teledentistry dental services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services and teledentistry dental services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services and teledentistry dental services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single session of telemedicine medical services, teledentistry dental services, or both services, if the executive commissioner determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services or teledentistry dental services, including the costs of transportation and lodging and other direct costs.

(c) In this section, "teledentistry dental service" and "telemedicine medical service" have the meanings assigned by Section 531.001, Government Code.

Added by Acts 2001, 77th Leg., ch. 1255, Sec. 4, eff. June 15, 2001. Redesignated and amended from Health and Safety Code, Section 62.157 by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0210, eff. April 2, 2015.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(b)(3), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(c)(3), eff. January 1, 2016.

Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. 2056), Sec. 24, eff. September 1, 2021.

Text of section as amended by Acts 2021, 87th Leg., R.S., Ch. 624 (H.B. 4), Sec. 7

For text of section as amended by Acts 2021, 87th Leg., R.S., Ch. 811 (H.B. 2056), Sec. 24, see other Sec. 62.1571.

Sec. 62.1571. TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES. (a) In providing covered benefits to a child, a health plan provider must permit benefits to be provided through telemedicine medical services and telehealth services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services or telehealth services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services or telehealth services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single session of telemedicine medical services or telehealth services, if the executive commissioner determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services or telehealth services, including the costs of transportation and lodging and other direct costs.

(d) In this section, "telehealth service" and "telemedicine medical service" have the meanings assigned by Section 531.001, Government Code.

Added by Acts 2001, 77th Leg., ch. 1255, Sec. 4, eff. June 15, 2001. Redesignated and amended from Health and Safety Code, Section 62.157 by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0210, eff. April 2, 2015.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(b)(3), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(c)(3), eff. January 1, 2016.

Acts 2021, 87th Leg., R.S., Ch. 624 (H.B. 4), Sec. 7, eff. June 15, 2021.

Sec. 62.158. STATE TAXES. The commission shall ensure that any experience rebate or profit-sharing for health plan providers under the child health plan is calculated by treating premium, maintenance, and other taxes under the Insurance Code and any other taxes payable to this state as allowable expenses for purposes of determining the amount of the experience rebate or profit-sharing. Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.53, eff. Sept. 1, 2003.

Sec. 62.159. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist a child manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the executive commissioner identifies populations for which disease management would be cost-effective.

(b) The child health plan must provide disease management services or coverage for disease management services in the manner required by the executive commissioner, including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care. Added by Acts 2003, 78th Leg., ch. 589, Sec. 1, eff. June 20, 2003. Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0211, eff. April 2, 2015.