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.

SECTION 6.09. LIMITATION ON PROVISION OF MEDICAL ASSISTANCE. Under this Act, the Health and Human Services Commission may only provide medical assistance to a person who would have been otherwise eligible for medical assistance or for whom federal matching funds were available under the eligibility criteria for medical assistance in effect on December 31, 2013.

ARTICLE 7. FEDERAL AUTHORIZATIONS, FUNDING, AND EFFECTIVE DATE

SECTION 7.01. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 7.02. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall apply for and actively seek a waiver or authorization from the appropriate federal agency to waive, with respect to a person who is dually eligible for Medicare and Medicaid, the requirement under 42 C.F.R. Section 409.30 that the person be hospitalized for at least three consecutive calendar days before Medicare covers posthospital skilled nursing facility care for the person.

SECTION 7.03. If the Health and Human Services Commission determines that it is cost-effective, the commission shall apply for and actively seek a waiver or authorization from the appropriate federal agency to allow the state to provide medical assistance under the waiver or authorization to medically fragile individuals:

1. who are at least 21 years of age; and
2. whose costs to receive care exceed cost limits under existing Medicaid waiver programs.

SECTION 7.04. The Health and Human Services Commission may use any available revenue, including legislative appropriations and available federal funds, for purposes of implementing any provision of this Act.

SECTION 7.05. (a) Except as provided by Subsection (b) of this section, this Act takes effect September 1, 2013.

(b) Section 533.0354, Health and Safety Code, as amended by this Act, takes effect January 1, 2014.

Passed the Senate on March 25, 2013: Yeas 31, Nays 0; May 22, 2013, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 23, 2013, House granted request of the Senate; May 26, 2013, Senate adopted Conference Committee Report by the following vote: Yeas 30, Nays 1; passed the House, with amendments, on May 21, 2013: Yeas 139, Nays 5; two present not voting; May 23, 2013, House granted request of the Senate for appointment of Conference Committee; May 26, 2013, House adopted Conference Committee Report by the following vote: Yeas 146, Nays 1, one present not voting.

Approved June 14, 2013.

Effective September 1, 2013, except as provided by § 7.05(b).

CHAPTER 1311

S.B. No. 8

AN ACT

relating to the provision and delivery of certain health and human services in this state, including the provision of those services through the Medicaid program and the prevention of fraud, waste, and abuse in that program and other programs.
Be it enacted by the Legislature of the State of Texas:

SECTION 1. Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.0082 to read as follows:

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

(1) improve contract management;
(2) detect data trends; and
(3) identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts.

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

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

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

SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02115 to read as follows:

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

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

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

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

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

(c) Nothing in this section prohibits:

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

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

(i) is conducted at a community-sponsored educational event, health fair, outreach activity, or other similar community or nonprofit event in which the provider participates and does not involve unsolicited personal contact or promotion of the provider’s practice; or

(ii) involves only the general dissemination of information, including by television, radio, newspaper, or billboard advertisement, and does not involve unsolicited personal contact.
(B) as permitted under the provider’s contract, engaging in the dissemination of material or another attempt to communicate with a Medicaid client or a parent whose child is enrolled in the Medicaid or child health plan program, including communication in person or by direct mail or telephone, for the purpose of:

(i) providing an appointment reminder;
(ii) distributing promotional health materials;
(iii) providing information about the types of services offered by the provider; or
(iv) coordinating patient care; or

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

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

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

(e) The executive commissioner shall adopt rules as necessary to implement this section, including rules relating to provider marketing activities that are exempt from the requirements of this section and, if applicable, Section 533.008.

SECTION 3. Section 531.02414, Government Code, is amended by amending Subsection (d) and adding Subsections (g) and (h) to read as follows:

(d) Subject to Section 533.00257, the commission may contract with a public transportation provider, as defined by Section 461.002, Transportation Code, a private transportation provider, or a regional transportation broker for the provision of public transportation services, as defined by Section 461.002, Transportation Code, under the medical transportation program.

(g) The commission shall enter into a memorandum of understanding with the Texas Department of Motor Vehicles and the Department of Public Safety for purposes of obtaining the motor vehicle registration and driver’s license information of a provider of medical transportation services, including a regional contracted broker and a subcontractor of the broker, to confirm that the provider complies with applicable requirements adopted under Subsection (e).

(h) The commission shall establish a process by which providers of medical transportation services, including providers under a managed transportation delivery model, that contract with the commission may request and obtain the information described under Subsection (g) for purposes of ensuring that subcontractors providing medical transportation services meet applicable requirements adopted under Subsection (e).

SECTION 4. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.076 to read as follows:

Sec. 531.076. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. (a) The commission shall periodically review in accordance with an established schedule the prior authorization and utilization review processes within the Medicaid fee-for-service delivery model to determine if those processes need modification to reduce authorizations of unnecessary services and inappropriate use of services. The commission shall also monitor the processes described in this subsection for anomalies and, on identification of an anomaly in a process, shall review the process for modification earlier than scheduled.

(b) The commission shall monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services.
SECTION 5. Section 531.102, Government Code, is amended by amending Subsection (a) and adding Subsection (l) to read as follows:

(a) The [commission, through the] commission's office of inspector general[,] is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and the enforcement of state law relating to the provision of those services. The commission may obtain any information or technology necessary to enable the office to meet its responsibilities under this subchapter or other law.

(l) Nothing in this section limits the authority of any other state agency or governmental entity.

SECTION 6. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1022 to read as follows:

Sec. 531.1022. PEACE OFFICERS. (a) The commission's office of inspector general shall employ and commission not more than five peace officers at any given time for the purpose of assisting the office in carrying out the duties of the office relating to the investigation of fraud, waste, and abuse in the Medicaid program.

(b) Peace officers employed under this section are administratively attached to the Department of Public Safety. The commission shall provide administrative support to the department necessary to support the assignment of peace officers employed under this section.

(c) A peace officer employed and commissioned by the office under this section is a peace officer for purposes of Article 2.12, Code of Criminal Procedure.

(d) A peace officer employed and commissioned under this section shall obtain prior approval from the office of attorney general before carrying out any duties requiring peace officer status.

SECTION 7. (a) Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00257 to read as follows:

Sec. 533.00257. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES. (a) In this section:

(1) "Managed transportation organization" means:

(A) a rural or urban transit district created under Chapter 458, Transportation Code;
(B) a public transportation provider defined by Section 461.002, Transportation Code;
(C) a regional contracted broker defined by Section 531.02414;
(D) a local private transportation provider approved by the commission to provide Medicaid nonemergency medical transportation services; or
(E) any other entity the commission determines meets the requirements of this section.

(2) "Medical transportation program" has the meaning assigned by Section 531.02414.

(3) "Transportation service area provider" means a for-profit or nonprofit entity or political subdivision of this state that provides demand response, curb-to-curb, nonemergency transportation under the medical transportation program.

(b) Subject to Subsection (i), the commission shall provide medical transportation program services on a regional basis through a managed transportation delivery model using managed transportation organizations and providers, as appropriate, that:

(1) operate under a capitated rate system;
(2) assume financial responsibility under a full-risk model;
(3) operate a call center;
(4) use fixed routes when available and appropriate; and
(5) agree to provide data to the commission if the commission determines that the data is required to receive federal matching funds.

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(c) The commission shall procure managed transportation organizations under the medical transportation program through a competitive bidding process for each managed transportation region as determined by the commission.

(d) A managed transportation organization that participates in the medical transportation program must attempt to contract with medical transportation providers that:

(1) are considered significant traditional providers, as defined by rule by the executive commissioner;

(2) meet the minimum quality and efficiency measures required under Subsection (g) and other requirements that may be imposed by the managed transportation organization; and

(3) agree to accept the prevailing contract rate of the managed transportation organization.

(e) To the extent allowed under federal law, a managed transportation organization may own, operate, and maintain a fleet of vehicles or contract with an entity that owns, operates, and maintains a fleet of vehicles. The commission shall seek appropriate federal waivers or other authorizations to implement this subsection as necessary.

(f) The commission shall consider the ownership, operation, and maintenance of a fleet of vehicles by a managed transportation organization to be a related-party transaction for purposes of applying experience rebates, administrative costs, and other administrative controls determined by the commission.

(g) The commission shall require that managed transportation organizations and providers participating in the medical transportation program meet minimum quality and efficiency measures as determined by the commission.

(h) The commission may contract with transportation service area providers providing services under the medical transportation program on September 1, 2013, in not more than three contiguous rural or small urban transit districts located within a managed transportation region to execute appropriate interlocal agreements to consolidate and coordinate medical transportation program service delivery activities within the area served by the providers for the evaluation of:

(1) cost-savings measures;

(2) efficiencies;

(3) best practices; and

(4) available matching funds.

(i) The commission may delay providing medical transportation program services through a managed transportation delivery model in areas of this state in which the commission on September 1, 2013, is operating a full-risk transportation broker model.

(j) Notwithstanding Subsection (i), the commission may not delay providing medical transportation program services through a managed transportation delivery model in:

(1) a county with a population of 750,000 or more:

(A) in which all or part of a municipality with a population of one million or more is located; and

(B) that is located adjacent to a county with a population of two million or more; or

(2) a county with a population of at least 55,000 but not more than 65,000 that is located adjacent to a county with a population of at least 500,000 but not more than 1.5 million.

(k) Subsection (h) and this subsection expire August 31, 2015.

(b) The Health and Human Services Commission shall begin providing medical transportation program services through the delivery model required by Section 533.00257, Government Code, as added by this section, not later than September 1, 2014, subject to Subsection (i), Section 533.00257, Government Code, as added by this section.

SECTION 8. Subsection (a-1), Section 533.005, Government Code, is amended to read as follows:

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(a-i) The requirements imposed by Subsections (a)(23)(A), (B), and (C) do not apply, and may not be enforced, on and after August 31, 2018.

SECTION 9. (a) Section 773.0571, Health and Safety Code, is amended to read as follows:

Sec. 773.0571. REQUIREMENTS FOR PROVIDER LICENSE. The department shall issue to an emergency medical services provider applicant a license that is valid for two years if the department is satisfied that:

(1) the applicant has adequate staff to meet the staffing standards prescribed by this chapter and the rules adopted under this chapter;

(2) each emergency medical services vehicle is adequately constructed, equipped, maintained, and operated to render basic or advanced life support services safely and efficiently;

(3) the applicant offers safe and efficient services for emergency prehospital care and transportation of patients; and

(4) the applicant:
   (A) possesses sufficient professional experience and qualifications to provide emergency medical services; and
   (B) has not been excluded from participation in the state Medicaid program;

(5) the applicant holds a letter of approval issued under Section 773.0573 by the governing body of the municipality or the commissioners court of the county in which the applicant is located and is applying to provide emergency medical services, as applicable;

(6) the applicant employs a medical director; and

(7) the applicant complies with the rules adopted under this chapter.

(b) Subchapter C, Chapter 773, Health and Safety Code, is amended by adding Sections 773.05711, 773.05712, and 773.05713 to read as follows:

Sec. 773.05711. ADDITIONAL EMERGENCY MEDICAL SERVICES PROVIDER LICENSE REQUIREMENTS. (a) In addition to the requirements for obtaining or renewing an emergency medical services provider license under this subchapter, a person who applies for a license or for a renewal of a license must:

(1) provide the department with a letter of credit issued by a federally insured bank or savings institution in the amount of:
   (A) $100,000 for the initial license and for renewal of the license on the second anniversary of the date the initial license is issued;
   (B) $75,000 for renewal of the license on the fourth anniversary of the date the initial license is issued;
   (C) $50,000 for renewal of the license on the sixth anniversary of the date the initial license is issued; and
   (D) $25,000 for renewal of the license on the eighth anniversary of the date the initial license is issued;

(2) if the applicant participates in the medical assistance program operated under Chapter 32, Human Resources Code, the Medicaid managed care program operated under Chapter 533, Government Code, or the child health plan program operated under Chapter 62 of this code, provide the Health and Human Services Commission with a surety bond in the amount of $50,000; and

(3) submit for approval by the department the name and contact information of the provider's administrator of record who satisfies the requirements under Section 773.05712.

(b) An emergency medical services provider that is directly operated by a governmental entity is exempt from this section.

Sec. 773.05712. ADMINISTRATOR OF RECORD. (a) The administrator of record for an emergency medical services provider licensed under this subchapter:

(1) may not be employed or otherwise compensated by another private for-profit emergency medical services provider;
(2) must meet the qualifications required for an emergency medical technician or other health care professional license or certification issued by this state; and

(3) must submit to a criminal history record check at the applicant's expense.

(b) Section 773.0415 does not apply to information an administrator of record is required to provide under this section.

(c) An administrator of record initially approved by the department may be required to complete an education course for new administrators of record. The executive commissioner shall recognize, prepare, or administer the education course for new administrators of record, which must include information about the laws and department rules that affect emergency medical services providers.

(d) An administrator of record approved by the department under Section 773.05711(a) annually must complete at least eight hours of continuing education following initial approval. The executive commissioner shall recognize, prepare, or administer continuing education programs for administrators of record, which must include information about changes in law and department rules that affect emergency medical services providers.

(e) Subsection (a)(2) does not apply to an emergency medical services provider that held a license on September 1, 2013, and has an administrator of record who has at least eight years of experience providing emergency medical services.

(f) An emergency medical services provider that is directly operated by a governmental entity is exempt from this section.

Sec. 773.05713. REPORT TO LEGISLATURE. Not later than December 1 of each even-numbered year, the department shall electronically submit a report to the lieutenant governor, the speaker of the house of representatives, and the standing committees of the house and senate with jurisdiction over the department on the effect of Sections 773.05711 and 773.05712 that includes:

(1) the total number of applications for emergency medical services provider licenses submitted to the department and the number of applications for which licenses were issued or licenses were denied by the department;

(2) the number of emergency medical services provider licenses that were suspended or revoked by the department for violations of those sections and a description of the types of violations that led to the license suspension or revocation;

(3) the number of occurrences and types of fraud committed by licensed emergency medical services providers related to those sections;

(4) the number of complaints made against licensed emergency medical services providers for violations of those sections and a description of the types of complaints; and

(5) the status of any coordination efforts of the department and the Texas Medical Board related to those sections.

(c) Subchapter C, Chapter 773, Health and Safety Code, is amended by adding Section 773.0573 to read as follows:

Sec. 773.0573. LETTER OF APPROVAL FROM LOCAL GOVERNMENTAL ENTITY. (a) An emergency medical services provider applicant must obtain a letter of approval from:

(1) the governing body of the municipality in which the applicant is located and is applying to provide emergency medical services; or

(2) if the applicant is not located in a municipality, the commissioners court of the county in which the applicant is located and is applying to provide emergency medical services.

(b) A governing body of a municipality or a commissioners court of a county may issue a letter of approval to an emergency medical services provider applicant who is applying to provide emergency medical services in the municipality or county only if the governing body or commissioners court determines that:

(1) the addition of another licensed emergency medical services provider will not interfere with or adversely affect the provision of emergency medical services by the licensed emergency medical services providers operating in the municipality or county;
(2) the addition of another licensed emergency medical services provider will remedy an existing provider shortage that cannot be resolved through the use of the licensed emergency medical services providers operating in the municipality or county; and

(3) the addition of another licensed emergency medical services provider will not cause an oversupply of licensed emergency medical services providers in the municipality or county.

(c) An emergency medical services provider is prohibited from expanding operations to or stationing any emergency medical services vehicles in a municipality or county other than the municipality or county from which the provider obtained the letter of approval under this section until after the second anniversary of the date the provider's initial license was issued, unless the expansion or stationing occurs in connection with:

(1) a contract awarded by another municipality or county for the provision of emergency medical services;

(2) an emergency response made in connection with an existing mutual aid agreement; or

(3) an activation of a statewide emergency or disaster response by the department.

(d) This section does not apply to:

(1) renewal of an emergency medical services provider license; or

(2) a municipality, county, emergency services district, hospital, or emergency medical services volunteer provider organization in this state that applies for an emergency medical services provider license.

(d) Subchapter C, Chapter 773, Health and Safety Code, is amended by adding Section 773.06141 to read as follows:

Sec. 773.06141. SUSPENSION, REVOCATION, OR DENIAL OF EMERGENCY MEDICAL SERVICES PROVIDER LICENSE. (a) The commissioner may suspend, revoke, or deny an emergency medical services provider license on the grounds that the provider's administrator of record, employee, or other representative:

(1) has been convicted of, or placed on deferred adjudication community supervision or deferred disposition for, an offense that directly relates to the duties and responsibilities of the administrator, employee, or representative, other than an offense for which points are assigned under Section 708.052, Transportation Code;

(2) has been convicted of or placed on deferred adjudication community supervision or deferred disposition for an offense, including:

(A) an offense listed in Sections 3g(a)(1)(A) through (H), Article 42.12, Code of Criminal Procedure; or

(B) an offense, other than an offense described by Subdivision (1), for which the person is subject to registration under Chapter 62, Code of Criminal Procedure; or

(3) has been convicted of Medicare or Medicaid fraud, has been excluded from participation in the state Medicaid program, or has a hold on payment for reimbursement under the state Medicaid program under Subchapter C, Chapter 531, Government Code.

(b) An emergency medical services provider that is directly operated by a governmental entity is exempt from this section.

(e) Notwithstanding Chapter 773, Health and Safety Code, as amended by this section, the Department of State Health Services may not issue any new emergency medical services provider licenses for the period beginning on September 1, 2013, and ending on August 31, 2014. The moratorium does not apply to the issuance of an emergency medical services provider license to a municipality, county, emergency services district, hospital, or emergency medical services volunteer provider organization in this state, or to an emergency medical services provider applicant who is applying to provide services in response to 911 calls and is located in a rural area, as that term is defined in Section 773.0045, Health and Safety Code.

(f) Section 773.0571, Health and Safety Code, as amended by this section, and Section 773.0573, Health and Safety Code, as added by this section, apply only to an application for approval of an emergency medical services provider license submitted to the Department of State Health Services on or after the effective date of this Act. An application submitted
before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(g) The changes in law made by this section apply only to an application for approval or renewal of an emergency medical services provider license submitted to the Department of State Health Services on or after the effective date of this Act. An application submitted before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 10. Section 32.022, Human Resources Code, is amended by amending Subsection (b) and adding Subsections (b-1), (e), and (f) to read as follows:

(b) Subject to Subsections (b-1) and (e), the executive commissioner of the Health and Human Services Commission by rule shall establish criteria for the department 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 of the Health and Human Services Commission 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.

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

SECTION 11. Section 32.073, Human Resources Code, is amended by adding Subsection (c) to read as follows:

(c) Not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, the Health and Human Services 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.
SECTION 12. Section 36.005, Human Resources Code, is amended by amending Subsection (b-1) and adding Subsections (e), (f), and (g) to read as follows:

(b-1) The period of ineligibility begins on the date on which the judgment finding the provider liable under Section 36.052 is entered by the trial court [after determination that the provider is liable becomes final].

(e) Notwithstanding Subsection (b-1), the period of ineligibility for an individual licensed by a health care regulatory agency or a physician begins on the date on which the determination that the individual or physician is liable becomes final.

(f) For purposes of Subsection (e), a "physician" includes a physician, a professional association composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code, or a partnership composed solely of physicians.

(g) For purposes of Subsection (e), "health care regulatory agency" has the meaning assigned by Section 774.001, Government Code.

SECTION 13. (a) The Health and Human Services Commission, in cooperation with the Department of State Health Services and the Texas Medical Board, shall:

(1) as soon as practicable after the effective date of this Act, conduct a thorough review of and solicit stakeholder input regarding the laws and policies related to the use of non-emergent services provided by ambulance providers under the medical assistance program established under Chapter 32, Human Resources Code;

(2) not later than January 1, 2014, make recommendations to the legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse with respect to the activities described by Subdivision (1) of this subsection; and

(3) amend the policies described by Subdivision (1) of this subsection as necessary to assist in accomplishing the goals described by Subdivision (2) of this subsection.

(b) This section expires September 1, 2015.

SECTION 14. (a) The Department of State Health Services, in cooperation with the Health and Human Services Commission and the Texas Medical Board, shall:

(1) as soon as practicable after the effective date of this Act, conduct a thorough review of and solicit stakeholder input regarding the laws and policies related to the licensure of nonemergency transportation providers;

(2) not later than January 1, 2014, make recommendations to the legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse with respect to the activities described by Subdivision (1) of this subsection; and

(3) amend the policies described by Subdivision (1) of this subsection as necessary to assist in accomplishing the goals described by Subdivision (2) of this subsection.

(b) This section expires September 1, 2015.

SECTION 15. (a) The Texas Medical Board, in cooperation with the Department of State Health Services and the Health and Human Services Commission, shall:

(1) as soon as practicable after the effective date of this Act, conduct a thorough review of and solicit stakeholder input regarding the laws and policies related to:

(A) the delegation of health care services by physicians or medical directors to qualified emergency medical services personnel; and

(B) physicians' assessment of patients' needs for purposes of ambulatory transfer or transport or other purposes;

(2) not later than January 1, 2014, make recommendations to the legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse with respect to the activities described by Subdivision (1) of this subsection; and
(3) amend the policies described by Subdivision (1) of this subsection as necessary to assist in accomplishing the goals described by Subdivision (2) of this subsection.

(b) This section expires September 1, 2015.

SECTION 16. (a) The Health and Human Services Commission shall study the feasibility of developing and implementing a single standard prior authorization form to be used for requesting prior authorization for prescription drugs in the medical assistance program by participating prescribers who do not have electronic prescribing capability and are not able to initiate electronic prior authorization requests. The commission shall complete the study not later than December 31, 2014.

(b) If the Health and Human Services Commission determines that developing and implementing the form described in Subsection (a) of this section is feasible, will reduce administrative burdens, and is cost-effective, the commission shall adjust contracts with participating health benefit plan issuers and participating health benefit plan administrators to require acceptance of the form.

SECTION 17. (a) The office of inspector general of the Health and Human Services Commission shall review the manner in which:

(1) the office investigates fraud, waste, and abuse in the supplemental nutrition assistance program under Chapter 33, Human Resources Code, including in the provision of benefits under that program; and

(2) the office coordinates with other state and federal agencies in conducting those investigations.

(b) Not later than September 1, 2014, and based on the review required by Subsection (a) of this section, the office of inspector general of the Health and Human Services Commission shall submit to the legislature a written report containing strategies for addressing fraud, waste, and abuse in the supplemental nutrition assistance program under Chapter 33, Human Resources Code, including in the provision of benefits under that program.

(c) This section expires January 1, 2015.

SECTION 18. (a) This section is a clarification of legislative intent regarding Subsection (s), Section 32.024, Human Resources Code, and a validation of certain Health and Human Services Commission acts and decisions.

(b) In 1999, the legislature became aware that certain children enrolled in the Medicaid program were receiving treatment under the program outside the presence of a parent or another responsible adult. The treatment of unaccompanied children under the Medicaid program resulted in the provision of unnecessary services to those children, the exposure of those children to unnecessary health and safety risks, and the submission of fraudulent claims by Medicaid providers.

(c) In addition, in 1999, the legislature became aware of allegations that certain Medicaid providers were offering money and other gifts in exchange for a parent's or child's consent to receive unnecessary services under the Medicaid program. In some cases, a child was offered money or gifts in exchange for the parent's or child's consent to have the child transported to a different location to receive unnecessary services. In some of those cases, once transported, the child received no treatment and was left unsupervised for hours before being transported home. The provision of money and other gifts by Medicaid providers in exchange for parents' or children's consent to services deprived those parents and children of the right to choose a Medicaid provider without improper inducement.

(d) In response, in 1999, the legislature enacted Chapter 766 (H.B. 1285), Acts of the 76th Legislature, Regular Session, 1999, which amended Section 32.024, Human Resources Code, by amending Subsection (s) and adding Subsection (s-1). As amended, Subsection (s), Section 32.024, Human Resources Code, requires that a child's parent or guardian or another adult authorized by the child's parent or guardian accompany the child at a visit or screening under the early and periodic screening, diagnosis, and treatment program in order for a Medicaid provider to be reimbursed for services provided at the visit or screening. As filed, the bill required a child's parent or guardian to accompany the child. The house committee report added the language allowing an adult authorized by the child's parent or guardian to
accompany the child in order to accommodate a parent or guardian for whom accompanying
the parent's or guardian's child to each visit or screening would be a hardship.

(e) The legislature finds that:
  (1) in amending Subsection (s), Section 32.024, Human Resources Code, in 1999, the
    legislature did not intend to:
    (A) create a hardship for families whose circumstances prevent a parent or guardian
        from accompanying the parent's or guardian's child to each visit or screening under the
        early and periodic screening, diagnosis, and treatment program; and
    (B) compromise a child's access to medically necessary services or to require a parent
        or guardian to jeopardize his or her employment or the health and safety of other
        children in the household;
  (2) in enacting and enforcing administrative rules and policies to implement the parental
      accompaniment requirement of Subsection (s), Section 32.024, Human Resources Code, the
      Health and Human Services Commission should give special consideration and should
      reasonably accommodate the circumstances of a child who lives in a single parent or
      guardian family and whose parent or guardian:
        (A) has a full-time job that does not allow the parent or guardian to take time off
            during a provider's regular business hours;
        (B) attends school or participates in a job training program that requires the parent's
            or guardian's full-time attendance and does not allow absences for medical or personal
            needs;
        (C) is the caretaker of two or more children and does not have access to child care;
        (D) has a disability or illness that prevents the parent or guardian from safely
            accompanying the child to a visit or screening; or
        (E) is the primary caregiver of a person who has a disability or illness and for whom
            no alternate caregiver is available; and
  (3) in developing reasonable accommodations described by this subsection, the Health
      and Human Services Commission should not allow the provider of a service or an affiliate of
      the provider to accompany the child as an authorized adult for purposes of Paragraph (B),
      Subdivision (2), Subsection (s), Section 32.024, Human Resources Code.

(f) The principal purposes of Chapter 766 (H.B. 1285), Acts of the 76th Legislature,
    Regular Session, 1999, were to prevent Medicaid providers from committing fraud, encourage
    parental involvement in and management of health care of children enrolled in the early and
    periodic screening, diagnosis, and treatment program, and ensure the safety of children
    receiving services under the Medicaid program. The addition of the language allowing an
    adult authorized by a child's parent or guardian to accompany the child furthered each of
    those purposes.

(g) The legislature, in amending Subsection (s), Section 32.024, Human Resources Code,
    understood that:
    (1) the effectiveness of medical, dental, and therapy services provided to a child improves
        when the child's parent or guardian actively participates in the delivery of those services;
    (2) a parent is responsible for the safety and well-being of the parent's child, and that a
        parent cannot casually delegate this responsibility to a stranger;
    (3) a parent may not always be available to accompany the parent's child at a visit to the
        child's doctor, dentist, or therapist; and
    (4) Medicaid providers and their employees and associates have a financial interest in the
        delivery of services under the Medicaid program and, accordingly, cannot fulfill the
        responsibilities of a parent or guardian when providing services to a child.

(h)(1) On March 15, 2012, the Health and Human Services Commission notified certain
    Medicaid providers that state law and commission policy require a child's parent or guardian
    or another properly authorized adult to accompany a child receiving services under the
    Medicaid program. This notice followed the commission's discovery that some providers
    were transporting children from schools to therapy clinics and other locations to receive
    therapy services. Although the children were not accompanied by a parent or guardian

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during these trips, the providers were obtaining reimbursement for the trips under the Medicaid medical transportation program. The commission clarified in the notice that, in order for a provider to be reimbursed for transportation services provided to a child under the Medicaid medical transportation program, the child must be accompanied by the child's parent or guardian or another adult who is not the provider and whom the child's parent or guardian has authorized to accompany the child by submitting signed, written consent to the provider.

(2) In May 2012, a lawsuit was filed to enjoin the Health and Human Services Commission from enforcing Subsection (a), Section 32.024, Human Resources Code, and 1 T.A.C. Section 380.207, as interpreted in certain notices issued by the commission. A state district court enjoined the commission from denying eligibility to a child for transportation services under the Medicaid medical transportation program if the child's parent or guardian does not accompany the child, provided that the child's parent or guardian authorizes any other adult to accompany the child. The court also enjoined the commission from requiring as a condition for a provider to be reimbursed for services provided to a child during a visit or screening under the early and periodic screening, diagnosis, and treatment program that the child be accompanied by the child's parent or guardian, provided that the child's parent or guardian authorizes another adult to accompany the child. The state has filed a notice of appeal of the court's order.

(3) The legislature declares that a rule or policy adopted by the Health and Human Services Commission before the effective date of this Act to require that, in order for a Medicaid provider to be reimbursed for services provided to a child under the early and periodic screening, diagnosis, and treatment program or the medical transportation program, the child must be accompanied by the child's parent or guardian or another adult whom the child's parent or guardian has authorized to accompany the child is conclusively presumed, as of the date the rule or policy was adopted, to be a valid exercise of the commission's authority and consistent with the intent of the legislature, provided that the rule or policy:

(A) was adopted pursuant to Subsection (a), Section 32.024, Human Resources Code; and

(B) prohibits the child's parent or guardian from authorizing the provider or the provider's employee or associate as an adult who may accompany the child.

(4) Subdivision (3) of this subsection does not apply to:

(A) an action or decision that was void at the time the action was taken or the decision was made;

(B) an action or decision that violates federal law or the terms of a federal waiver; or

(C) an action or decision that, under a statute of this state or the United States, was a misdemeanor or felony at the time the action was taken or the decision was made.

(5) This section does not apply to:

(A) an action or decision that was void at the time the action was taken or the decision was made;

(B) an action or decision that violates federal law or the terms of a federal waiver; or

(C) an action or decision that, under a statute of this state or the United States, was a misdemeanor or felony at the time the action was taken or the decision was made.

SECTION 19. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall establish the data analysis unit required under Section 531.0082, Government Code, as added by this Act. The data analysis unit shall provide the initial update required under Subsection (d), Section 531.0082, Government Code, as added by this Act, not later than the 30th day after the last day of the first complete calendar quarter occurring after the date the unit is established.

SECTION 20. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.
SECTION 21. This Act takes effect September 1, 2013.

Passed the Senate on April 15, 2013: Yeas 30, Nays 0, one present not voting; May 22, 2013, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 23, 2013, House granted request of the Senate; May 24, 2013, Senate adopted Conference Committee Report by the following vote: Yeas 27, Nays 4; passed the House, with amendments, on May 20, 2013: Yeas 144, Nays 0, two present not voting; May 23, 2013, House granted request of the Senate for appointment of Conference Committee; May 26, 2013, House adopted Conference Committee Report by the following vote: Yeas 105, Nays 38, one present not voting.

Approved June 14, 2013.
Effective September 1, 2013.

CHAPTER 1312

S.B. No. 59

AN ACT relating to required reports and other documents prepared by state agencies and institutions of higher education.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Section 15.006, Agriculture Code, is amended to read as follows:

Sec. 15.006. BIENNIAL [ANNUAL] REPORT. The department [and the Texas Department of Health] shall [jointly] prepare a biennial [an annual] report concerning the special nutrition program and submit a copy of the report to the governor, lieutenant governor, and speaker of the house of representatives. The report must include information on the condition of the program, persons served, amount of food coupons redeemed, and funds received and expended.

SECTION 2. Subsection (e), Section 102.167, Agriculture Code, is amended to read as follows:

(e) Not later than December 1 [the 30th day] before the first day of each regular session of the legislature, the department shall submit to the governor a full report of transactions under this subchapter during the preceding biennium. The report must include a complete statement of receipts and expenditures under this subchapter during the biennium.

SECTION 3. Section 201.028, Agriculture Code, is amended to read as follows:

Sec. 201.028. ANNUAL [SEMIANNUAL] REPORT. Not later than January 1 [and July 1] of each year, the state board shall prepare and deliver to the governor, the lieutenant governor, and the speaker of the house of representatives a report relating to the status of the budget areas of responsibility assigned to the board, including outreach programs, grants made and received, federal funding applied for and received, special projects, and oversight of water conservation district activities.

SECTION 4. Article 59.11, Code of Criminal Procedure, is amended to read as follows:

Art. 59.11. REPORT OF SEIZED AND FORFEITED AIRCRAFT. Not later than the 10th day after the last day of each quarter of the fiscal year, the Department of Public Safety shall report to the Texas Department of Transportation [State Aircraft Pooling Board]:

(1) a description of each aircraft that the Department of Public Safety [department] has received by forfeiture under this chapter during the preceding quarter and the purposes for which the Department of Public Safety [department] intends to use the aircraft; and

(2) a description of each aircraft the Department of Public Safety [department] knows to have been seized under this chapter during the preceding quarter and the purposes for which the Department of Public Safety [department] would use the aircraft if it were forfeited to the Department of Public Safety [department].