

GOVERNMENT CODE  
SUBTITLE I. HEALTH AND HUMAN SERVICES  
CHAPTER 531. HEALTH AND HUMAN SERVICES COMMISSION  
SUBCHAPTER A. GENERAL PROVISIONS; ORGANIZATION OF COMMISSION

Sec. 531.001. DEFINITIONS. In this subtitle:

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

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

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

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

(4) "Health and human services agencies" includes the:  
(A) Department of Aging and Disability Services;  
(B) Department of State Health Services;  
(C) Department of Assistive and Rehabilitative Services; and  
(D) Department of Family and Protective Services.

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

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

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.01, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 1022, Sec. 97, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 7, Sec. 2, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 899, Sec. 1, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 8.01, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 53, Sec. 1, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 957, Sec. 6, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1429, Sec. 9.007, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 198, Sec. 1.01(a) to 1.01(c), 2.01, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 9.009, eff. Sept. 1, 2003.

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) increasing the availability of health care services;

(C) improving the quality of health care services;

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

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

(F) improving knowledge of health care needs;

(G) reducing infant death and disease;

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

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

(J) increasing participation in nutrition programs;

(K) increasing nutritional education; and

(L) reducing substance abuse;

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

(A) improving workforce skills;

(B) increasing employment, earnings, and benefits;

(C) increasing housing opportunities;

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

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

(F) reducing school dropouts;

(G) reducing teen pregnancy;

(H) improving parental effectiveness;

(I) increasing support services for people with disabilities;

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

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

(L) improving services to juvenile offenders;

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

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

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

(C) increasing the availability and diversity of long-term care provided to support people with chronic conditions in settings that focus on community-based services with options ranging from their own homes to total-care facilities;

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

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

(B) reducing child abuse and neglect;

(C) reducing family violence;

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

(E) reducing crime and juvenile delinquency;

(F) reducing community health risks; and

(G) improving regulation of human services providers; and

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

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

Sec. 531.004. SUNSET PROVISION. The Health and Human Services Commission is subject to Chapter 325 (Texas Sunset Act). Unless continued in existence as provided by that chapter, the commission is abolished and this chapter expires September 1, 2009. Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 1.01, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 1.02, eff. Sept. 1, 2003.

Sec. 531.005. EXECUTIVE COMMISSIONER. (a) The commission is

governed by an executive commissioner appointed by the governor with the advice and consent of the senate.

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

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

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

(b) The commission shall:

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

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

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

(B) an emphasis on research and implementation on a demonstration or pilot basis of appropriate and efficient uses of new and existing technology to improve the operation of health and human services agencies and delivery of health and human services;

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

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

(A) the child health plan program;

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

(C) the medical assistance program under Chapter 32, Human Resources Code;

(D) the nutritional assistance programs under Chapter 33, Human Resources Code;

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

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

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

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

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

(d) After implementation of the commission's duties under Subsections (b) and (c), the commission shall implement the powers and duties given to the commission under Section 531.0248. Nothing in the priorities established by this section is intended to limit the authority of the commission to work simultaneously to achieve the multiple tasks assigned to the commission in this section, when such an approach is beneficial in the judgment of the commission. The commission shall plan and implement an efficient and effective centralized system of administrative support services for health and human services agencies. The performance of administrative support services for health and human services agencies is the responsibility of the commission. The term "administrative support services" includes, but is not limited to, strategic planning and evaluation, audit, legal, human resources, information resources, purchasing, contract management, financial management, and accounting services.

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

for an agency by the executive commissioner, shall:

(1) manage and direct the operations of each health and human services agency;

(2) supervise and direct the activities of each agency director; and

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

(A) selecting the director of internal audit;

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

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

(f) The operational authority and responsibility of the executive commissioner for purposes of Subsection (e) at each health and human services agency includes authority over and responsibility for the:

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

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

(3) personnel and employment policies;

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

(5) information resources systems used by the agency;

(6) location of agency facilities; and

(7) coordination of agency activities with activities of other state agencies, including other health and human services agencies.

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

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

(i) To facilitate the operations of a health and human services agency in accordance with this section, the executive commissioner may delegate a specific power or duty given under Subsection (f) or (g) to an agency director. The agency director shall, at the request of the executive commissioner, assist in the development of rules and policies for the operation and provision of health and human services by the agency. The agency director acts on behalf of the executive commissioner in performing the delegated function and reports to the executive commissioner regarding the delegated function and any matter affecting agency programs and operations.

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

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

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

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

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

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

(3) describes each delegation of a power or duty made under Subsection (i) or other law.

(l) Notwithstanding any other law, the executive commissioner has the authority to adopt policies and rules governing the delivery of services to persons who are served by each

health and human services agency and the rights and duties of persons who are served or regulated by each agency.

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

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

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

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

(d) The terms of the memorandum of understanding shall outline specific performance objectives, as defined by the executive commissioner, to be fulfilled by the agency director, including the performance objectives outlined in Section 531.0055(h).

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

(f) The executive commissioner shall submit the evaluation to the governor not later than January 1 of each even-numbered year. Added by Acts 1999, 76th Leg., ch. 1460, Sec. 2.01, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 1.04, eff. Sept. 1, 2003.

Sec. 531.006. ELIGIBILITY. (a) A person is not eligible for appointment as commissioner if the person or the person's spouse is an employee, officer, or paid consultant of a trade association in a field under the commission's jurisdiction.

(b) A person who is required to register as a lobbyist under Chapter 305 because of the person's activities for compensation in or on behalf of a profession related to a field under the commission's jurisdiction may not serve as commissioner.

(c) A person is not eligible for appointment as commissioner if the person has a financial interest in a corporation, organization, or association under contract with the Texas Department of Mental Health and Mental Retardation, a local mental health or mental retardation authority, or a community center. Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995.

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

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

Sec. 531.008. DIVISIONS OF COMMISSION. (a) Subject to Subsection (c), the executive commissioner may establish divisions within the commission as necessary for effective administration and for the discharge of the commission's functions.

(b) Subject to Subsection (c), the executive commissioner may allocate and reallocate functions among the commission's divisions.

(c) The executive commissioner shall establish the following divisions and offices within the commission:

(1) the eligibility services division to make eligibility determinations for services provided through the commission or a health and human services agency related to:

(A) the child health plan program;

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

(C) the medical assistance program under Chapter 32, Human Resources Code;

(D) the nutritional assistance programs under Chapter 33, Human Resources Code;

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

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

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

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

- (3) the office of the ombudsman to:
  - (A) provide dispute resolution services for the commission and the health and human services agencies; and
  - (B) perform consumer protection functions related to health and human services;
- (4) a purchasing division as provided by Section 531.017; and
- (5) an internal audit division to conduct a program of internal auditing in accordance with Government Code, Chapter 2102. Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 1.05, eff. Sept. 1, 2003.

Sec. 531.0081. OFFICE OF MEDICAL TECHNOLOGY. (a) In this section, "office" means the office of medical technology.

(b) The commission shall establish the office of medical technology within the commission. The office shall explore and evaluate new developments in medical technology and propose implementing the technology in the medical assistance program under Chapter 32, Human Resources Code, if appropriate and cost-effective.

(c) Office staff must have skills and experience in research regarding health care technology.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 10, eff. Sept. 1, 2005.

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

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

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

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

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

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

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

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

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

- (1) be updated annually;

- (2) be reviewed by the state Commission on Human Rights for compliance with Subsection (f)(1); and

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

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

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

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

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

Sec. 531.011. PUBLIC INPUT INFORMATION AND COMPLAINTS. (a) The commission shall develop and implement policies that provide

the public a reasonable opportunity to appear before the commission and to speak on any issue under the commission's jurisdiction.

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

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

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

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

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

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

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

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

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

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

(2) a service delivered by the commission.

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

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

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

Sec. 531.012. ADVISORY COMMITTEES. The commissioner may appoint advisory committees as needed.

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

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

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

(1) case management;

(2) contract management;

(3) financial management;

(4) performance measurement and evaluation;

(5) research; and

(6) other matters the commission considers appropriate.

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

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

(e) Expired.

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

Sec. 531.014. CONSOLIDATION OF REPORTS. The commission may

consolidate any annual or biennial reports required to be made under this chapter or another law if:

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

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

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

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

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

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

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

(2) appropriate alternative dispute resolution procedures under Chapter 2009 to assist in the resolution of internal and external disputes under the commission's or agency's jurisdiction.

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

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

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

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

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

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

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

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

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

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

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

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

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

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



Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.06, eff. Sept. 1, 2003. Amended by Acts 2005, 79th Leg., ch. 268, Sec. 2.17, eff. Sept. 1, 2005.

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

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

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

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

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

Sec. 531.017. PURCHASING DIVISION. (a) The commission shall establish a purchasing division for the management of administrative activities related to the purchasing functions of the commission and the health and human services agencies.

(b) The purchasing division shall:

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

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

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

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

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

(2) entered into by the person and:

(A) the commission;

(B) a health and human services agency; or

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

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

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

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

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

Added by Acts 2005, 79th Leg., ch. 1011, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.020. OFFICE OF COMMUNITY COLLABORATION. The executive commissioner shall establish within the commission an office of community collaboration. The office is responsible for:

(1) collaborating with community, state, and federal stakeholders to improve the elements of the health care system that

are involved in the delivery of Medicaid services; and

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

Added by Acts 2005, 79th Leg., ch. 349, Sec. 1, eff. Sept. 1, 2005.

#### SUBCHAPTER B. POWERS AND DUTIES

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

(b) The commission shall:

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

(2) adopt reasonable rules and standards governing the determination of fees, charges, and rates for medical assistance payments under Chapter 32, Human Resources Code, in consultation with the agencies that operate the Medicaid program; and

(3) establish requirements for and define the scope of the ongoing evaluation of the Medicaid managed care system conducted in conjunction with the Texas Health Care Information Council under Section 108.0065, Health and Safety Code.

(c) The commission in its adoption of reasonable rules and standards under Subsection (b)(2) shall include financial performance standards that, in the event of a proposed rate reduction, provide private ICF-MR facilities and home and community-based services providers with flexibility in determining how to use medical assistance payments to provide services in the most cost-effective manner while continuing to meet the state and federal requirements of the Medicaid program.

(d) In adopting rules and standards required by Subsection (b)(2), the commission may provide for payment of fees, charges, and rates in accordance with:

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

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

(3) economic conditions that substantially and materially affect provider participation in the Medicaid program, as determined by the commissioner; or

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

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

(f) In adopting rates for medical assistance payments under Subsection (b)(2), the executive commissioner may adopt reimbursement rates for appropriate nursing services provided to recipients with certain health conditions if those services are determined to provide a cost-effective alternative to hospitalization. A physician must certify that the nursing services are medically appropriate for the recipient for those services to qualify for reimbursement under this subsection.

(g) In adopting rates for medical assistance payments under Subsection (b)(2), the executive commissioner may adopt cost-effective reimbursement rates for group appointments with medical assistance providers for certain diseases and medical conditions specified by rules of the executive commissioner.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 1262, Sec. 1, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1460, Sec. 3.01, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 2.03, eff. Sept. 1, 2003; Acts 2005, 79th Leg., ch. 349, Sec. 11(a), eff. Sept. 1, 2005.

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

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

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

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

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

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

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

(2) how to access health care services;

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

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

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

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

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

Sec. 531.02111. BIENNIAL MEDICAID FINANCIAL REPORT. (a) The commission shall prepare a biennial Medicaid financial report covering each state agency that administers any part of the state Medicaid program and each of the Medicaid programs operated or administered by those agencies.

(b) The report must include:

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

(A) a description of each of the Medicaid programs administered or operated by the agency; and

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

(i) the amount of any federal medical assistance funds allocated to the agency for the support of each of the Medicaid programs operated or administered by the agency;

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

(iii) the amount of medical assistance payments and related expenditures made by or in connection with each of those programs; and

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

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

(B) the information required by Section 531.02112(b).

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

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

(e) Not later than December 1 of each even-numbered year, the commission shall submit the report to the governor, the lieutenant governor, the speaker of the house of representatives, the presiding officer of each standing committee of the senate and house of representatives having jurisdiction over health and human services issues, the state auditor, and the comptroller.

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

Sec. 531.02112. QUARTERLY REPORT OF MEDICAID EXPENDITURES. (a) The commission shall prepare a report, on a quarterly basis, regarding the Medicaid expenditures of each state agency that administers or operates a Medicaid program.

(b) The report must identify each agency's expenditures by Medicaid program and must include for each program:

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

(2) the amount spent on program operations, including

eligibility determination, claims processing, and case management; and

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

(c) The commission shall submit the report to the governor, legislature, state auditor, and comptroller.

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

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

- (1) maximize the state's receipt of federal funds;
- (2) create incentives for providers to use preventive care;
- (3) increase and retain providers in the system to maintain an adequate provider network;
- (4) more accurately reflect the costs borne by providers; and
- (5) encourage the improvement of the quality of care.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 2(a), eff. Sept. 1, 2005.

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

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

- (1) respect, dignity, privacy, confidentiality, and nondiscrimination;
- (2) a reasonable opportunity to choose a health care plan and primary care provider and to change to another plan or provider in a reasonable manner;
- (3) consent to or refuse treatment and actively participate in treatment decisions;
- (4) ask questions and receive complete information relating to the client's medical condition and treatment options, including specialty care;
- (5) access each available complaint process, receive a timely response to a complaint, and receive a fair hearing; and
- (6) timely access to care that does not have any communication or physical access barriers.

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

- (1) learn and understand each right the client has under the Medicaid program;
- (2) abide by the health plan and Medicaid policies and procedures;
- (3) share information relating to the client's health status with the primary care provider and become fully informed about service and treatment options; and
- (4) actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain the client's health.

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

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

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

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

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

- (1) operate a statewide toll-free assistance telephone number that includes TDD lines and assistance for persons who speak Spanish;
- (2) intervene promptly with the state Medicaid office, managed care organizations and providers, the Texas Department of Health, and any other appropriate entity on behalf of a person who has an urgent need for medical services;
- (3) assist a person who is experiencing barriers in

the Medicaid application and enrollment process and refer the person for further assistance if appropriate;

(4) educate persons so that they:  
(A) understand the concept of managed care;  
(B) understand their rights under the Medicaid program, including grievance and appeal procedures; and  
(C) are able to advocate for themselves;

(5) collect and maintain statistical information on a regional basis regarding calls received by the assistance lines and publish quarterly reports that:

(A) list the number of calls received by region;  
(B) identify trends in delivery and access problems;  
(C) identify recurring barriers in the Medicaid system; and

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

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

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

Sec. 531.02131. MEDICAID MEDICAL INFORMATION TELEPHONE HOTLINE PILOT PROGRAM. (a) In this section, "net cost-savings" means the total projected cost of Medicaid benefits for an area served under the pilot program minus the actual cost of Medicaid benefits for the area.

(b) The commission shall evaluate the cost-effectiveness, in regard to preventing unnecessary emergency room visits and ensuring that Medicaid recipients seek medical treatment in the most medically appropriate and cost-effective setting, of developing a Medicaid medical information telephone hotline pilot program under which physicians are available by telephone to answer medical questions and provide medical information for recipients. If the commission determines that the pilot program is likely to result in net cost-savings, the commission shall develop the pilot program.

(c) The commission shall select the area in which to implement the pilot program. The selected area must include:

(1) at least two counties; and  
(2) not more than 100,000 Medicaid recipients, with approximately 50 percent of the recipients enrolled in a managed care program in which the recipients receive services from a health maintenance organization.

(d) The commission shall request proposals from private vendors for the operation of a telephone hotline under the pilot program. The commission may not award a contract to a vendor unless the vendor agrees to contractual terms:

(1) requiring the vendor to answer medical questions and provide medical information by telephone to recipients using only physicians;

(2) providing that the value of the contract is contingent on achievement of net cost-savings in the area served by the vendor; and

(3) permitting the commission to terminate the contract after a reasonable period if the vendor's services do not result in net cost-savings in the area served by the vendor.

(e) The commission shall periodically determine whether the pilot program is resulting in net cost-savings. The commission shall discontinue the pilot program if the commission determines that the pilot program is not resulting in net cost-savings after a reasonable period.

(f) Notwithstanding any other provision of this section, including Subsection (b), the commission is not required to develop the pilot program if suitable private vendors are not available to operate the telephone hotline.

(g) The executive commissioner shall adopt rules necessary for implementation of this section.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 15(a), eff. Sept. 1, 2005.

Sec. 531.0214. MEDICAID DATA COLLECTION SYSTEM. (a) The commission and each health and human services agency that administers a part of the state Medicaid program shall jointly develop a system to coordinate and integrate state Medicaid

databases to:

(1) facilitate the comprehensive analysis of Medicaid data; and  
(2) detect fraud perpetrated by a program provider or client.

(b) To minimize cost and duplication of activities, the commission shall assist and coordinate:

(1) the efforts of the agencies that are participating in the development of the system required by Subsection (a); and

(2) the efforts of those agencies with the efforts of other agencies involved in a statewide health care data collection system provided for by Section 108.006, Health and Safety Code, including avoiding duplication of expenditure of state funds for computer hardware, staff, or services.

(c) On the request of the commissioner, a state agency that administers any part of the state Medicaid program shall assist the commission in developing the system required by this section.

(d) The commission shall develop the database system in a manner that will enable a complete analysis of the use of prescription medications, including information relating to:

(1) Medicaid clients for whom more than three medications have been prescribed; and

(2) the medical effect denial of Medicaid coverage for more than three medications has had on Medicaid clients.

(e) The commission shall ensure that the database system is used each month to match bureau of vital statistics death records with a list of persons eligible for medical assistance under Chapter 32, Human Resources Code, and that each person who is deceased is promptly removed from the list of persons eligible for medical assistance.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.03(a), eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 215, Sec. 1, eff. Sept. 1, 1999.

Sec. 531.02141. MEDICAID INFORMATION COLLECTION AND ANALYSIS. (a) The commission shall make every effort to improve data analysis and integrate available information associated with the Medicaid program. The commission shall use the decision support system in the commission's center for strategic decision support for this purpose and shall modify or redesign the system to allow for the data collected by the Medicaid program to be used more systematically and effectively for Medicaid program evaluation and policy development. The commission shall develop or redesign the system as necessary to ensure that the system:

(1) incorporates program enrollment, utilization, and provider data that are currently collected;

(2) allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within the program;

(3) is able to obtain consistent and accurate answers to questions;

(4) allows for analysis of multiple issues within the program to determine whether any programmatic or policy issues overlap or are in conflict;

(5) includes predefined data reports on utilization of high-cost services that allow program management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate;

(6) includes any encounter data with respect to recipients that a managed care organization that contracts with the commission under Chapter 533 receives from a health care provider under the organization's provider network; and

(7) links Medicaid and non-Medicaid data sets, including data sets related to the Medicaid program, the Temporary Assistance for Needy Families program, the Special Supplemental Nutrition Program for Women, Infants, and Children, vital statistics, and other public health programs.

(b) The commission shall ensure that all Medicaid data sets created or identified by the decision support system are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist or arise with respect to making the data sets available on the Internet, the system and the commission shall make every effort to make the data available through that means either by removing information by which particular individuals may be identified or by aggregating the data in a manner so that individual

records cannot be associated with particular individuals.  
Added by Acts 2005, 79th Leg., ch. 349, Sec. 3(a), eff. Sept. 1, 2005.

Sec. 531.0215. COMPILATION OF STATISTICS RELATING TO FRAUD. The commission and each health and human services agency that administers a part of the state Medicaid program shall maintain statistics on the number, type, and disposition of fraudulent claims for benefits submitted under the part of the program the agency administers.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 6.02(a), eff. Sept. 1, 1997.

Sec. 531.0216. PARTICIPATION AND REIMBURSEMENT OF TELEMEDICINE MEDICAL SERVICE PROVIDERS UNDER MEDICAID. (a) The commission by rule shall develop and implement a system to reimburse providers of services under the state Medicaid program for services performed using telemedicine medical services.

(b) In developing the system, the executive commissioner by rule shall:

(1) review programs and pilot projects in other states to determine the most effective method for reimbursement;

(2) establish billing codes and a fee schedule for services;

(3) provide for an approval process before a provider can receive reimbursement for services;

(4) consult with the Department of State Health Services and the telemedicine advisory committee to establish procedures to:

(A) identify clinical evidence supporting delivery of health care services using a telecommunications system;

(B) establish pilot studies for telemedicine medical service delivery; and

(C) annually review health care services, considering new clinical findings, to determine whether reimbursement for particular services should be denied or authorized;

(5) establish pilot programs in designated areas of this state under which the commission, in administering government-funded health programs, may reimburse a health professional participating in the pilot program for telehealth services authorized under the licensing law applicable to the health professional;

(6) establish a separate provider identifier for telemedicine medical services providers; and

(7) establish a separate modifier for telemedicine medical services eligible for reimbursement.

(c) The commission shall encourage physicians, teaching hospitals, small rural hospitals, federally qualified health centers, and state-owned health care facilities to participate as telemedicine medical service providers in the health care delivery system. The commission may not require that a service be provided to a patient through telemedicine medical services when the service can reasonably be provided by a physician through a face-to-face consultation with the patient in the community in which the patient resides or works. This subsection does not prohibit the authorization of the provision of any service to a patient through telemedicine medical services at the patient's request.

(d) Subject to Section 153.004, Occupations Code, the commission may adopt rules as necessary to implement this section.

(e) The commission may not reimburse a health care facility for telemedicine medical services provided to a Medicaid recipient unless the facility complies with the minimum standards adopted under Section 531.02161.

(f) Not later than December 1 of each even-numbered year, the commission shall report to the speaker of the house of representatives and the lieutenant governor on the effects of telemedicine medical services on the Medicaid program in the state, including the number of physicians and health professionals using telemedicine medical services, the geographic and demographic disposition of the physicians and health professionals, the number of patients receiving telemedicine medical services, the types of services being provided, and the cost of utilization of telemedicine medical services to the program.

(g) In this section:

(1) "Telehealth service" has the meaning assigned by Section 57.042, Utilities Code.

(2) "Telemedicine medical service" has the meaning assigned by Section 57.042, Utilities Code. Added by Acts 1997, 75th Leg., ch. 1244, Sec. 1, eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 62, Sec. 18.22, eff. Sept. 1, 1999. Renumbered from V.T.C.A., Government Code Sec. 531.0215 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(46), eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1255, Sec. 1, eff. June 15, 2001; Acts 2001, 77th Leg., ch. 1420, Sec. 14.765, eff. Sept. 1, 2001; Acts 2005, 79th Leg., ch. 370, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.02161. TELEMEDICINE TECHNOLOGY STANDARDS. (a) In this section, "telemedicine medical service" has the meaning assigned by Section 57.042, Utilities Code.

(b) The commission and the Telecommunications Infrastructure Fund Board by joint rule shall establish and adopt minimum standards for an operating system used in the provision of telemedicine medical services by a health care facility participating in the state Medicaid program, including standards for electronic transmission, software, and hardware.

(c) In developing standards under this section, the commission and the Telecommunications Infrastructure Fund Board shall address:

- (1) authentication and authorization of users;
- (2) authentication of the origin of information;
- (3) the prevention of unauthorized access to the system or information;
- (4) system security, including the integrity of information that is collected, program integrity, and system integrity;
- (5) maintenance of documentation about system and information usage;
- (6) information storage, maintenance, and transmission; and
- (7) synchronization and verification of patient profile data.

Added by Acts 2001, 77th Leg., ch. 1255, Sec. 2, eff. June 15, 2001.

Sec. 531.02162. MEDICAID SERVICES PROVIDED THROUGH TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS. (a) In this section, "child with special health care needs" has the meaning assigned by Section 35.0022, Health and Safety Code.

(b) The commission by rule shall establish policies that permit reimbursement under the state Medicaid and children's health insurance program for services provided through telemedicine medical services and telehealth services to children with special health care needs.

(c) The policies required under this section must:

- (1) be designed to:
  - (A) prevent unnecessary travel and encourage efficient use of telemedicine medical services and telehealth services for children with special health care needs in all suitable circumstances; and
  - (B) ensure in a cost-effective manner the availability to a child with special health care needs of services appropriately performed using telemedicine medical services and telehealth services that are comparable to the same types of services available to that child without the use of telemedicine medical services and telehealth services; and

(2) provide for reimbursement of multiple providers of different services who participate in a single telemedicine medical services and telehealth services session for a child with special health care needs, if the commission determines that reimbursing each provider for the session is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services and telehealth services, including the costs of transportation and lodging and other direct costs.

Added by Acts 2001, 77th Leg., ch. 959, Sec. 2, eff. June 14, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.02161 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(63), eff. Sept. 1, 2003.

Sec. 531.02163. TELEPRESENTERS. (a) In this section, "health professional" means an individual who:

- (1) is licensed or certified in this state to perform health care services; and
- (2) is not a physician, registered nurse, advanced practice nurse, or physician assistant.



(b) The executive commissioner by rule shall establish and adopt minimum standards to permit the use of trained health professionals in presenting patients who are Medicaid recipients for telemedicine medical services consultations to be conducted by physicians at distant sites.

(c) Notwithstanding Section 531.0217, the commission may provide reimbursement under the state Medicaid program for a telemedicine medical service initiated by a trained health professional who complies with the minimum standards adopted under this section.

(d) The commission shall provide reimbursement under the state Medicaid program to a physician for overseeing a telemedicine consultation at a telemedicine hub site if the telepresenter at the remote site is another physician or is an advanced practice nurse, registered nurse, or physician assistant acting under physician delegation and supervision throughout the consultation.

Added by Acts 2005, 79th Leg., ch. 370, Sec. 2, eff. Sept. 1, 2005.

Sec. 531.0217. REIMBURSEMENT FOR CERTAIN MEDICAL CONSULTATIONS. (a) In this section:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(3) "Telehealth service" has the meaning assigned by Section 57.042, Utilities Code.

(4) "Telemedicine medical service" has the meaning assigned by Section 57.042, Utilities Code.

(b) The commission by rule shall require each health and human services agency that administers a part of the Medicaid program to provide Medicaid reimbursement for a telemedicine medical service initiated or provided by a physician

(c) The commission shall ensure that reimbursement is provided only for a telemedicine medical service initiated or provided by a physician.

(d) The commission shall require reimbursement for a telemedicine medical service at the same rate as the Medicaid program reimburses for a comparable in-person medical service. A request for reimbursement may not be denied solely because an in-person medical service between a physician and a patient did not occur.

(e) A health care facility that receives reimbursement under this section for a telemedicine medical service provided by a physician who practices in that facility or a health professional who participates in a telemedicine medical service under this section shall establish quality of care protocols and patient confidentiality guidelines to ensure that the telemedicine medical service meets legal requirements and acceptable patient care standards.

(f) The commission may not require a telemedicine medical service if an in-person consultation with a physician is reasonably available where the patient resides or works. The commission shall require facilities and providers of telemedicine medical services to make a good faith effort to identify and coordinate with existing providers to preserve and protect existing health care systems and medical relationships in an area.

(g) If a patient receiving a telemedicine medical service has a primary care physician or provider and consents to the notification, the commission shall require that the primary care physician or provider be notified of the telemedicine medical service for the purpose of sharing medical information.

(h) The commission in consultation with the Texas State Board of Medical Examiners shall monitor and regulate the use of telemedicine medical services to ensure compliance with this section. In addition to any other method of enforcement, the commission may use a corrective action plan to ensure compliance with this section.

(i) The Texas State Board of Medical Examiners, in consultation with the commission, as appropriate, may adopt rules as necessary to:

(1) ensure that appropriate care, including quality of care, is provided to patients who receive telemedicine medical services;

(2) prevent abuse and fraud through the use of telemedicine medical services, including rules relating to filing of claims and records required to be maintained in connection with telemedicine; and

(3) define those situations when a face-to-face consultation with a physician is required after a telemedicine medical service.

(i-1) The Texas State Board of Medical Examiners, in consultation with the commission and the Department of State Health Services, as appropriate, shall adopt rules to establish supervisory requirements for a physician delegating a service to be performed by an individual who is not a physician, registered nurse, advanced practice nurse, or physician assistant, including a health professional who is authorized to be a telepresenter under Section 531.02163. This section may not be construed as authorizing the Texas State Board of Medical Examiners to regulate another licensed or certified health care provider.

(j) The commissioner shall establish an advisory committee to coordinate state telemedicine efforts and assist the commission in:

(1) evaluating policies for telemedicine medical services under Section 531.0216 and this section;

(2) monitoring the types of programs receiving reimbursement under this section; and

(3) coordinating the activities of state agencies interested in the use of telemedicine medical services.

(k) This section does not affect any requirement relating to:

(1) a federally qualified health center;

(2) a rural health clinic; or

(3) physician delegation of the authority to carry out or sign prescription drug orders to an advanced practice nurse or physician assistant.

Added by Acts 1997, 75th Leg., ch. 1251, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.25, eff. Sept. 1, 1999. Renumbered from V.T.C.A., Government Code Sec. 531.047 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(48), eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 661, Sec. 3, eff. June 13, 2001; Acts 2001, 77th Leg., ch. 959, Sec. 10, eff. Sept. 1, 2001; Acts 2001, 77th Leg., ch. 1255, Sec. 3, eff. June 15, 2001; Acts 2005, 79th Leg., ch. 370, Sec. 3, eff. Sept. 1, 2005.

Sec. 531.02171. TELEMEDICINE PILOT PROGRAMS.

Text of section as added by Acts 2001, 77th Leg., ch. 661, Sec.

(a) In this section:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is licensed or certified in this state to perform health care services and who is authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(3) "Telehealth service" means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

(A) compressed digital interactive video, audio, or data transmission;

(B) clinical data transmission using computer imaging by way of still-image capture and store and forward; and

(C) other technology that facilitates access to health care services or medical specialty expertise.

(4) "Telemedicine medical service" means a health care

service initiated by a physician or provided by a health professional acting under physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- (A) compressed digital interactive video, audio, or data transmission;
- (B) clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- (C) other technology that facilitates access to health care services or medical specialty expertise.

(b) The commission shall establish pilot programs in designated areas of this state under which the commission, in administering government-funded health programs, may reimburse a health professional participating in the pilot program for telemedicine medical services or telehealth services authorized under the licensing law applicable to the health professional. Each pilot program established before January 1, 2003, must provide services in areas of this state that are not more than 150 miles from the border between this state and the United Mexican States.

(c) In developing and operating a pilot program under this section, the commission shall:

(1) solicit and obtain support for the program from local officials and the medical community;

(2) focus on enhancing health outcomes in the area served by the pilot program through increased access to medical services, including:

- (A) health screenings;
- (B) prenatal care;
- (C) medical or surgical follow-up visits;
- (D) periodic consultation with specialists regarding chronic disorders;
- (E) triage and pretransfer arrangements; and
- (F) transmission of diagnostic images or data;

(3) establish quantifiable measures and expected health outcomes for each authorized telemedicine medical service or telehealth service;

(4) consider condition-specific applications of telemedicine medical services or telehealth services, including applications for:

- (A) pregnancy;
- (B) diabetes;
- (C) heart disease; and
- (D) cancer; and

(5) demonstrate that the provision of services authorized as telemedicine medical services or telehealth services will not adversely affect the provision of traditional medical services within the area served by the pilot program.

(d) Notwithstanding an eligibility requirement prescribed by other law or rule, the commission may establish requirements for a person to participate in a pilot project under this section.

(e) Participation in the pilot project does not entitle a participant to other services under a government-funded health program.

(f) The commission may limit the number of participants of a pilot project under this section.

Added by Acts 2001, 77th Leg., ch. 661, Sec. 1, eff. June 13, 2001. For text of section as added by Acts 2001, 77th Leg., ch. 959, Sec. 3, see Sec. 531.02171, post.

Sec. 531.02171. TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES PILOT PROGRAMS.

Text of section as added by Acts 2001, 77th Leg., ch. 959, Sec. 3

(a) In this section:

(1) "Health professional" means:

- (A) a physician;
- (B) an individual who is licensed or certified in this state to perform health care services and who is authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or
- (C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means a person licensed to practice

medicine in this state under Subtitle B, Title 3, Occupations Code.

(3) "Telehealth service" has the meaning assigned by Section 57.042, Utilities Code.

(4) "Telemedicine medical service" has the meaning assigned by Section 57.042, Utilities Code.

(b) The commission shall establish pilot programs in designated areas of this state under which the commission, in administering government-funded health programs, may reimburse a health professional participating in the pilot program for telemedicine medical services or telehealth services authorized under the licensing law applicable to the health professional. Each pilot program established before January 1, 2003, must provide services in areas of this state that are not more than 150 miles from the border between this state and the United Mexican States.

(c) In developing and operating a pilot program under this section, the commission shall:

(1) solicit and obtain support for the program from local officials and the medical community;

(2) focus on enhancing health outcomes in the area served by the pilot program through increased access to medical or health care services, including:

(A) health screenings;

(B) prenatal care;

(C) medical or surgical follow-up visits;

(D) periodic consultation with specialists regarding chronic disorders;

(E) triage and pretransfer arrangements; and

(F) transmission of diagnostic images or data;

(3) establish quantifiable measures and expected health outcomes for each authorized telemedicine medical service or telehealth service;

(4) consider condition-specific applications of telemedicine medical services or telehealth services, including applications for:

(A) pregnancy;

(B) diabetes;

(C) heart disease; and

(D) cancer; and

(5) demonstrate that the provision of services authorized as telemedicine medical services or telehealth services will not adversely affect the delivery of traditional medical services or other health care services within the area served by the pilot program.

Added by Acts 2001, 77th Leg., ch. 959, Sec. 3, eff. June 14, 2001. For text of section as added by Acts 2001, 77th Leg., ch. 661, Sec. 1, see Sec. 531.02171, ante.

Sec. 531.02172. TELEMEDICINE ADVISORY COMMITTEE. (a) The commissioner shall establish an advisory committee to assist the commission in:

(1) evaluating policies for telemedical consultations under Sections 531.02163 and 531.0217;

(2) evaluating policies for telemedicine medical services or telehealth services pilot programs established under Section 531.02171;

(3) ensuring the efficient and consistent development and use of telecommunication technology for telemedical consultations and telemedicine medical services or telehealth services reimbursed under government-funded health programs;

(4) monitoring the type of programs receiving reimbursement under Sections 531.0217 and 531.02171; and

(5) coordinating the activities of state agencies concerned with the use of telemedical consultations and telemedicine medical services or telehealth services.

(b) The advisory committee must include:

(1) representatives of health and human services agencies and other state agencies concerned with the use of telemedical consultations in the Medicaid program and the state child health plan program, including representatives of:

(A) the commission;

(B) the Texas Department of Health;

(C) the Office of Rural Community Affairs;

(D) the Telecommunications Infrastructure Fund Board;

(E) the Texas Department of Insurance;

(F) the Texas State Board of Medical Examiners;

- (G) the Board of Nurse Examiners; and
- (H) the Texas State Board of Pharmacy;
- (2) representatives of health science centers in this state;
- (3) experts on telemedicine, telemedical consultation, and telemedicine medical services or telehealth services; and
- (4) representatives of consumers of health services provided through telemedical consultations and telemedicine medical services or telehealth services.

(c) A member of the advisory committee serves at the will of the commissioner.

Added by Acts 2001, 77th Leg., ch. 959, Sec. 3, eff. June 14, 2001; Acts 2001, 77th Leg., ch. 661, Sec. 1, eff. June 13, 2001. Reenacted and amended by Acts 2003, 78th Leg., ch. 609, Sec. 18, eff. Sept. 1, 2003; Acts 2005, 79th Leg., ch. 370, Sec. 4, eff. Sept. 1, 2005.

Sec. 531.02173. ALIGNMENT OF MEDICAID TELEMEDICINE REIMBURSEMENT POLICIES WITH MEDICARE REIMBURSEMENT POLICIES. (a) The commission shall periodically review policies regarding reimbursement under the Medicaid program for telemedicine medical services to identify variations between permissible reimbursement under that program and reimbursement available to providers under the Medicare program.

(b) To the extent practicable, and notwithstanding any other state law, after conducting a review under Subsection (a) the commission may modify rules and procedures applicable to reimbursement under the Medicaid program for telemedicine medical services as necessary to provide for a reimbursement system that is comparable to the reimbursement system for those services under the Medicare program.

(c) The commission shall perform its duties under this section with assistance from the telemedicine advisory committee established under Section 531.02172.

Added by Acts 2003, 78th Leg., ch. 870, Sec. 1, eff. Sept. 1, 2003.

Sec. 531.02174. ADDITIONAL AUTHORITY REGARDING TELEMEDICINE MEDICAL SERVICES. (a) In addition to the authority granted by other law regarding telemedicine medical services, the commission may review rules and procedures applicable to reimbursement of telemedicine medical services provided through any government-funded health program subject to the commission's oversight.

(b) The commission may modify rules and procedures described by Subsection (a) as necessary to ensure that reimbursement for telemedicine medical services is provided in a cost-effective manner and only in circumstances in which the provision of those services is clinically effective.

(c) This section does not affect the commission's authority or duties under other law regarding reimbursement of telemedicine medical services under the Medicaid program.

Added by Acts 2003, 78th Leg., ch. 870, Sec. 1, eff. Sept. 1, 2003.

Sec. 531.02175. REIMBURSEMENT FOR ONLINE MEDICAL CONSULTATIONS.

Text of section as added by Acts 2005, 79th Leg., ch. 349, Sec.

11(b)

(a) In this section, "physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(b) Subject to the requirements of this subsection, the executive commissioner by rule may require the commission and each health and human services agency that administers a part of the Medicaid program to provide Medicaid reimbursement for a medical consultation that is provided by a physician or other health care professional using the Internet as a cost-effective alternative to an in-person consultation. The executive commissioner may require the commission or a health and human services agency to provide the reimbursement described by this subsection only if the Centers for Medicare and Medicaid Services develop an appropriate Current Procedural Terminology code for medical services provided using the Internet.

(c) The executive commissioner may develop and implement a pilot program in one or more sites chosen by the executive commissioner under which Medicaid reimbursements are paid for medical consultations provided by physicians or other health care professionals using the Internet. The pilot program must be

designed to test whether an Internet medical consultation is a cost-effective alternative to an in-person consultation under the Medicaid program. The executive commissioner may modify the pilot program as necessary throughout its implementation to maximize the potential cost-effectiveness of Internet medical consultations. If the executive commissioner determines from the pilot program that Internet medical consultations are cost-effective, the executive commissioner may expand the pilot program to additional sites or may implement Medicaid reimbursements for Internet medical consultations statewide.

(d) The executive commissioner is not required to implement the pilot program authorized under Subsection (c) as a prerequisite to providing Medicaid reimbursement authorized by Subsection (b) on a statewide basis.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 11(b), eff. Sept. 1, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 370, Sec. 5, see Sec. 531.02175, post.

Sec. 531.02175. PILOT PROGRAM FOR TELEHEALTH OR TELEMEDICINE CONSULTATIONS FOR CERTAIN MEDICAID RECIPIENTS.

Text of section as added by Acts 2005, 79th Leg., ch. 370, Sec. 5

Text of section effective until September 1, 2007

(a) In this section, "qualified mental health professional" means an individual who:

(1) is credentialed to provide qualified mental health professional community services; and

(2) holds a bachelor's or more advanced degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention.

(b) The executive commissioner by rule shall develop and the Department of State Health Services shall implement a pilot program under which Medicaid recipients in need of mental health services are provided those services through telehealth or telemedicine.

(c) The executive commissioner shall design the pilot program in a manner that:

(1) enhances the delivery of mental health services to recipients;

(2) ensures adequate supervision of social workers, psychologists, and other licensed professionals who are not psychiatrists and who provide services through the use of telehealth or telemedicine; and

(3) enables the state to determine whether extension of the use of telehealth or telemedicine would improve the delivery of mental health services.

(d) The executive commissioner may not require mental health services to be provided through telehealth or telemedicine under the pilot program if an in-person consultation with a psychiatrist or other licensed mental health professional qualified to provide those services is reasonably available where the recipient resides or works.

(e) The executive commissioner by rule shall establish and adopt minimum standards to permit the use of trained qualified mental health professionals in presenting Medicaid recipients participating in the pilot program for telehealth or telemedicine consultations to be conducted by psychiatrists at distant sites.

(f) The commission may reimburse a provider participating in the pilot program for services provided through telehealth or telemedicine. Notwithstanding Section 531.0217, the commission may provide reimbursement under the state Medicaid program for a telehealth or telemedicine consultation initiated by a trained qualified mental health professional who complies with the minimum standards adopted under Subsection (e).

(g) The Texas State Board of Medical Examiners, in consultation with the commission and the Department of State Health Services, as appropriate, shall adopt rules to establish supervisory requirements for a physician delegating a service to be performed by a qualified mental health professional who is authorized to be a telepresenter under this section. This section may not be construed as authorizing the Texas State Board of Medical Examiners to regulate another licensed or certified health care provider.

(h) The commission may apply for and receive a grant to fund the pilot program under the federal New Freedom Initiative on Mental Health plan or from the Office of the National Coordinator for Health Information Technology. The commission shall seek the assistance of the Office of State-Federal Relations in identifying and applying for federal grants for the pilot program.

(i) Not later than December 1, 2006, the commission shall submit a report to the legislature regarding the results of the pilot program. The report must include recommendations regarding elimination, continuation, or expansion of the pilot program.

(j) This section expires September 1, 2007.  
Added by Acts 2005, 79th Leg., ch. 370, Sec. 5, eff. Sept. 1, 2005.  
For text of section as added by Acts 2005, 79th Leg., ch. 349, Sec. 11(b), see Sec. 531.02175, ante.

Sec. 531.0218. LONG-TERM CARE MEDICAID PROGRAMS. (a) To the extent authorized by state and federal law, the commission shall make uniform the functions relating to the administration and delivery of Section 1915(c) waiver programs, including:

- (1) rate-setting;
- (2) the applicability and use of service definitions;
- (3) quality assurance; and
- (4) intake data elements.

(b) Subsection (a) does not apply to functions of a Section 1915(c) waiver program that is operated in conjunction with a federally funded Medicaid program of the state authorized under Section 1915(b) of the federal Social Security Act (42 U.S.C. Section 1396n(b)).

(c) The commission shall ensure that information on individuals seeking to obtain services from Section 1915(c) waiver programs is maintained in a single computerized database that is accessible to staff of each of the state agencies administering those programs.

Added by Acts 1999, 76th Leg., ch. 899, Sec. 2, eff. Sept. 1, 1999.

Sec. 531.0219. PILOT PROGRAM RELATING TO SECTION 1915C WAIVER PROGRAMS. (a) The commission by rule shall develop and implement a pilot program to assess the advisability of consolidating the Section 1915(c) waiver programs.

(b) The pilot program shall:

(1) be limited to a specific geographic area of the state; and  
(2) serve individuals not currently receiving services under a Section 1915(c) waiver program.

(c) Not later than January 1, 2004, the commission shall submit to the legislature a report evaluating the administrative efficiencies and effectiveness of serving, in a single program, individuals eligible for a Section 1915(c) waiver program.

Added by Acts 1999, 76th Leg., ch. 899, Sec. 2, eff. Sept. 1, 1999.

Sec. 531.02191. PUBLIC INPUT. In complying with the requirements of Sections 531.0218 and 531.0219, the commission shall regularly consult with and obtain input from:

- (1) consumers and family members;
- (2) providers;
- (3) advocacy groups;
- (4) state agencies that administer a Section 1915(c) waiver program; and
- (5) other interested persons.

Added by Acts 1999, 76th Leg., ch. 899, Sec. 2, eff. Sept. 1, 1999.

Sec. 531.022. COORDINATED STRATEGIC PLAN FOR HEALTH AND HUMAN SERVICES. (a) The commissioner shall develop a coordinated, six-year strategic plan for health and human services in this state and shall update the plan biennially.

(b) The commissioner shall submit each biennial update of the plan to the governor, the lieutenant governor, and the speaker of the house of representatives not later than October 1 of each even-numbered year.

(c) The plan must include the following goals:

- (1) the development of a comprehensive, statewide approach to the planning of health and human services;
- (2) the creation of a continuum of care for families and individuals in need of health and human services;
- (3) the integration of health and human services to provide for the efficient and timely delivery of those services;
- (4) the maximization of existing resources through effective funds management and the sharing of administrative functions;

(5) the effective use of management information systems to continually improve service delivery;

(6) the provision of systemwide accountability through effective monitoring mechanisms;

(7) the promotion of teamwork among the health and human services agencies and the provision of incentives for creativity;

(8) the fostering of innovation at the local level; and

(9) the encouragement of full participation of fathers in programs and services relating to children.

(d) In developing a plan and plan updates under this section, the commissioner shall consider:

(1) existing strategic plans of health and human services agencies;

(2) health and human services priorities and plans submitted by governmental entities under Subsection (e);

(3) facilitation of pending reorganizations or consolidations of health and human services agencies and programs;

(4) public comment, including comment documented through public hearings conducted under Section 531.036; and

(5) budgetary issues, including projected agency needs and projected availability of funds.

(e) The commissioner shall identify the governmental entities that coordinate the delivery of health and human services in regions, counties, and municipalities and request that each entity:

(1) identify the health and human services priorities in the entity's jurisdiction and the most effective ways to deliver and coordinate services in that jurisdiction;

(2) develop a coordinated plan for the delivery of health and human services in the jurisdiction, including transition services that prepare special education students for adulthood; and

(3) make the information requested under Subdivisions (1) and (2) available to the commission.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.04(a), eff. Sept. 1, 1997; Acts 2001, 77th Leg., ch. 256, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.0222. WIC PROGRAM ADVISORY COMMITTEE. (a) In this section:

(1) "Committee" means the advisory committee established under this section.

(2) "Department" means the Texas Department of Health.

(3) "WIC program" means the federal special supplemental nutrition program for women, infants, and children authorized by 42 U.S.C. Section 1786, as amended, and administered by the department.

(b) The commissioner shall establish a WIC program advisory committee to provide input from WIC program merchants, vendors, recipient advocacy groups, and local clinics to advise the commissioner and the department on policy, rules, and technology changes concerning the WIC program.

(c) The committee consists of 10 members appointed by the commissioner from geographically diverse areas as follows:

(1) four representatives of retail merchant vendors, with two from national supermarket companies and two from regional or independent food retailers;

(2) one representative of a specialty retailer such as a pharmacy or WIC program-only retailer;

(3) two representatives of advocacy groups for WIC program recipients, such as charities or consumer groups; and

(4) three representatives of staff at WIC program clinics.

(d) The committee shall:

(1) review all current WIC program policies;

(2) review and submit comments concerning proposed WIC program rule and policy changes;

(3) advise state employees developing and implementing the electronic benefits transfer program for the WIC program on the methods for benefits delivery through the use of a card issued to a WIC program recipient;

(4) recommend procedures to be used with pricing issues for WIC program products; and



(5) examine and make recommendations regarding the possibility of adding farmers' markets as WIC program vendors.

(e) A member of the committee may not receive compensation for serving on the committee and may not be reimbursed for travel expenses incurred while conducting the business of the committee.

(f) The department shall provide administrative support, including staff, for the committee.

(g) The committee is not subject to Chapter 2110. Added by Acts 2001, 77th Leg., ch. 603, Sec. 1, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.0221 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(64), eff. Sept. 1, 2003.

Sec. 531.0223. RATES AND EXPENDITURES IN TEXAS-MEXICO BORDER REGION.

Text of section effective until September 1, 2011

(a) In this section:

(1) "Child health plan program" means the state child health plan program authorized by Chapter 62, Health and Safety Code.

(2) "Committee" means the advisory committee on funding disparities in health programs appointed by the commissioner under this section.

(3) "Texas-Mexico border region" has the meaning assigned by Section 2056.002.

(b) The commissioner shall appoint an advisory committee to develop a strategic plan for eliminating the disparities between the Texas-Mexico border region and other areas of the state in:

(1) capitation rates under Medicaid managed care and the child health plan program for services provided to persons younger than 19 years of age;

(2) fee-for-service per capita expenditures under the Medicaid program and the child health plan program for inpatient and outpatient hospital services for services provided to persons younger than 19 years of age; and

(3) total professional services expenditures per Medicaid recipient younger than 19 years of age or per child enrolled in the child health plan program.

(c) Periodically the committee shall perform the research necessary to analyze and compare the rates and expenditures described by Subsection (b) and, not later than the date specified by the commissioner, produce a report based on the results of that analysis and comparison.

(d) The committee shall, as part of the report required by Subsection (c), make recommendations to the commissioner for addressing the problems created by disparities documented in the report, including recommendations for allocation of funds.

(e) The commissioner shall appoint nine members to the advisory committee in a manner that ensures that the committee:

(1) represents the spectrum of geographic areas included in the Texas-Mexico border region;

(2) includes persons who are knowledgeable regarding the Medicaid program, including Medicaid managed care, and the child health plan program; and

(3) represents the interests of physicians, hospitals, patients, managed care organizations, state agencies involved in the management and delivery of medical resources of any kind, affected communities, and other areas of the state.

(f) The committee shall elect officers from among the members of the committee.

(g) Appointments to the committee shall be made without regard to the race, color, disability, sex, religion, age, or national origin of the appointees.

(h) A member of the committee may not receive compensation, but is entitled to reimbursement of travel expenses incurred by the member while conducting the business of the committee as provided by the General Appropriations Act.

(i) The commission shall provide administrative support and resources to the committee as necessary for the committee to perform the duties under this section.

(j) The committee is not subject to Chapter 2110.

(k) With advice from the committee, the commission shall ensure that:

(1) the disparities in rates and expenditures described by Subsection (b) are eliminated as soon as practicable for services provided to a person younger than 19 years of age by increasing the rates and expenditures in the Texas-Mexico border

region, to the extent that funds are specifically appropriated for purposes of this subsection, so that the rates and expenditures in that region equal, or equal as nearly as possible, the statewide average rates and expenditures; and

(2) a physician providing a service to a Medicaid recipient younger than 19 years of age or a recipient of services under the child health plan program in the Texas-Mexico border region receives, in addition to reimbursement at the rate required under Subdivision (1), a bonus to the extent possible with funds specifically appropriated for purposes of this subsection.

(1) For purposes of Subsection (k), the commission shall exclude data from the Texas-Mexico border region in determining the statewide average capitation rates under Medicaid managed care and the child health plan program and the statewide average total expenditures per Medicaid recipient younger than 19 years of age or per child enrolled in the child health plan program.

(m) With advice from the committee and other appropriate groups, the commission may vary the amount of any rate increases for services required by Subsection (k) according to the type of service provided.

(n) The commission shall develop mechanisms to pass any rate increase required by Subsection (k) directly to providers, including providers in Medicaid managed care service delivery areas with health maintenance organization, prepaid health plan, or primary care case management models.

(o) The commission shall contract with a public university to:

(1) measure changes occurring from September 1, 2001, to August 31, 2004, in the number of health care providers participating in the Medicaid program or the child health plan program in the Texas-Mexico border region and resulting effects on consumer access to health care and consumer utilization;

(2) determine:

(A) the effects, if any, of the changes in rates and expenditures required by Subsection (k); and

(B) if funding available and used for changes in rates and expenditures was sufficient to produce measurable effects;

(3) make a recommendation regarding whether Medicaid rate increases should be expanded to include Medicaid services provided to adults in the Texas-Mexico border region; and

(4) not later than December 1, 2004, submit a report to the legislature.

(p) This section expires September 1, 2011.  
Added by Acts 2001, 77th Leg., ch. 1260, Sec. 1, eff. Sept. 1, 2001.  
Renumbered from V.T.C.A., Government Code Sec. 531.0221 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(65), eff. Sept. 1, 2003.

Sec. 531.0224. PLANNING AND POLICY DIRECTION OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM. The commission shall:

(1) plan and direct the financial assistance program under Chapter 31, Human Resources Code, including the procurement, management, and monitoring of contracts necessary to implement the program;

(2) adopt rules and standards governing the financial assistance program under Chapter 31, Human Resources Code; and

(3) establish requirements for and define the scope of the ongoing evaluation of the financial assistance program under Chapter 31, Human Resources Code.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.07, eff. Sept. 1, 2003.

Sec. 531.0225. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES. (a) To ensure appropriate delivery of mental health and substance abuse services, the commission shall regularly evaluate program contractors and subcontractors that provide or arrange for the services for persons enrolled in:

(1) the Medicaid managed care program; and

(2) the state child health plan program.

(b) The commission shall monitor:

(1) penetration rates, as they relate to mental health and substance abuse services provided by or through contractors and subcontractors;

(2) utilization rates, as they relate to mental health and substance abuse services provided by or through contractors and subcontractors; and

(3) provider networks used by contractors and

subcontractors to provide mental health or substance abuse services.

Added by Acts 2003, 78th Leg., ch. 358, Sec. 2, eff. June 18, 2003. Renumbered from V.T.C.A., Government Code Sec. 531.0224 by Acts 2005, 79th Leg., ch. 728, Sec. 23.001(32), eff. Sept. 1, 2005.

Sec. 531.023. SUBMISSION OF PLANS AND UPDATES BY AGENCIES. (a) All health and human services agencies shall submit to the commission strategic plans and biennial updates on a date to be determined by commission rule. The commission shall review and comment on the strategic plans and biennial updates.

(b) Not later than January 1 of each even-numbered year, the commission shall begin formal discussions with each health and human services agency regarding that agency's strategic plan or biennial update.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.05(a), eff. Sept. 1, 1997.

Sec. 531.0235. BIENNIAL DISABILITY REPORTS. (a) The commissioner shall direct and require the Texas Planning Council for Developmental Disabilities and the Office for the Prevention of Developmental Disabilities to prepare a joint biennial report on the state of services to persons with disabilities in this state. The Texas Planning Council for Developmental Disabilities will serve as the lead agency in convening working meetings and in coordinating and completing the report. Not later than December 1 of each even-numbered year, the agencies shall submit the report to the commissioner, governor, lieutenant governor, and speaker of the house of representatives.

(b) The report will include recommendations addressing the following:

(1) fiscal and program barriers to consumer-friendly services;

(2) progress toward a service delivery system individualized to each consumer based on functional needs;

(3) progress on the development of local cross-disability access structures;

(4) projections of future long-term care services needs and availability; and

(5) consumer satisfaction, consumer preferences, and desired outcomes.

(c) The commission, Texas Department of Human Services, and other health and human services agencies shall cooperate with the agencies required to prepare the report under Subsection (a).

Added by Acts 1999, 76th Leg., ch. 1505, Sec. 1.19, eff. Sept. 1, 1999.

Sec. 531.024. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES. The commissioner shall:

(1) facilitate and enforce coordinated planning and delivery of health and human services, including:

(A) compliance with the coordinated strategic plan;

(B) co-location of services;

(C) integrated intake; and

(D) coordinated referral and case management;

(2) develop with the Department of Information Resources automation standards for computer systems to enable health and human services agencies, including agencies operating at a local level, to share pertinent data;

(3) establish and enforce uniform regional boundaries for all health and human services agencies;

(4) carry out statewide health and human services needs surveys and forecasting;

(5) perform independent special-outcome evaluations of health and human services programs and activities;

(6) at the request of a governmental entity identified under Section 531.022(e), assist that entity in implementing a coordinated plan that may include co-location of services, integrated intake, and coordinated referral and case management and is tailored to the needs and priorities of that entity; and

(7) promulgate uniform fair hearing rules for all Medicaid-funded services.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.06, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 342, Sec. 1, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 62, Sec. 8.11, eff. Sept. 1, 1999.

Sec. 531.0241. STREAMLINING DELIVERY OF SERVICES. To integrate and streamline service delivery and facilitate access to services, the commissioner may request a health and human services agency to take a specific action and may recommend the manner in which the streamlining is to be accomplished, including requesting each health and human services agency to:

- (1) simplify agency procedures;
- (2) automate agency procedures;
- (3) coordinate service planning and management tasks between and among health and human services agencies;
- (4) reallocate staff resources;
- (5) adopt rules;
- (6) amend, waive, or repeal existing rules; or
- (7) take other necessary actions.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.07(a), eff. Sept. 1, 1997.

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in the Medicaid program and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of the Medicaid program by any method the commission determines is cost-effective, including:

- (1) expanding the utilization of the electronic claims payment system;
- (2) developing an Internet portal system for prior authorization requests;
- (3) encouraging Medicaid providers to submit their program participation applications electronically;
- (4) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently apply to the program;
- (5) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in the Medicaid program; and
- (6) encouraging the increased use of medical technology by providers, including increasing their use of:
  - (A) electronic communications between patients and their physicians or other health care providers;
  - (B) electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health care practitioner writes a prescription and that support the electronic transmission of a prescription;
  - (C) ambulatory computerized order entry systems that facilitate physician and other health care practitioner orders at the point of care for medications and laboratory and radiological tests;
  - (D) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting;
  - (E) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and
  - (F) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 4(a), eff. Sept. 1, 2005.

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. (a) The commission shall make every effort to ensure the integrity of the Medicaid program. To ensure that integrity, the commission shall:

- (1) perform risk assessments of every element of the Medicaid program and audit those elements of the program that are determined to present the greatest risks;
- (2) ensure that sufficient oversight is in place for the Medicaid medical transportation program;
- (3) ensure that a quality review assessment of the Medicaid medical transportation program occurs; and
- (4) evaluate the Medicaid program with respect to use of the metrics developed through the Texas Health Steps performance improvement plan to guide changes and improvements to the program.

(b) This section does not affect the duty of the Texas Department of Transportation to manage the delivery of

transportation services, including the delivery of transportation services for clients of health and human services programs. Added by Acts 2005, 79th Leg., ch. 349, Sec. 4(a), eff. Sept. 1, 2005.

Sec. 531.0242. USE OF AGENCY STAFF. To the extent requested by the commission, a health and human services agency shall assign existing staff to perform a function imposed under this chapter. Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.07(a), eff. Sept. 1, 1997.

Sec. 531.0243. REPORTS ON DELIVERY OF SERVICES. (a) The executive head of each health and human services agency shall report quarterly to the governing body of that agency on that agency's efforts to streamline and simplify the delivery of services. The agency shall submit a copy of the report to the commission.

(b) The commission shall prepare and deliver a semiannual report to the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, the Legislative Budget Board, and appropriate legislative committees on the efforts of the health and human services agencies to streamline the delivery of services provided by those agencies.

(c) The commissioner shall adopt rules relating to the reports required by Subsection (a), including rules specifying when and in what manner an agency must report and the information to be included in the report. Each agency shall follow the rules adopted by the commissioner under this section.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.07(a), eff. Sept. 1, 1997.

Sec. 531.0244. ENSURING APPROPRIATE CARE SETTING FOR PERSONS WITH DISABILITIES. (a) The commission and appropriate health and human services agencies shall implement a comprehensive, effectively working plan that provides a system of services and support that fosters independence and productivity and provides meaningful opportunities for a person with a disability to live in the most appropriate care setting, considering:

(1) the person's physical, medical, and behavioral needs;

(2) the least restrictive care setting in which the person can reside;

(3) the person's choice of care settings in which to reside;

(4) the availability of state resources; and

(5) the availability of state programs for which the person qualifies that can assist the person.

(b) The comprehensive, effectively working plan required by Subsection (a) must require appropriate health and human services agencies to:

(1) provide to a person with a disability living in an institution and to any other person as required by Sections 531.042 and 531.02442 information regarding care and support options available to the person with a disability, including community-based services appropriate to the needs of that person;

(2) recognize that certain persons with disabilities are represented by legally authorized representatives as defined by Section 241.151, Health and Safety Code, whom the agencies must include in any decision-making process facilitated by the plan's implementation;

(3) facilitate a timely and appropriate transfer of a person with a disability from an institution to an appropriate setting in the community if:

(A) the person chooses to live in the community;

(B) the person's treating professionals determine the transfer is appropriate; and

(C) the transfer can be reasonably accommodated, considering the state's available resources and the needs of other persons with disabilities; and

(4) develop strategies to prevent the unnecessary placement in an institution of a person with a disability who is living in the community but is in imminent risk of requiring placement in an institution because of a lack of community services.

(c) For purposes of developing the strategies required by Subsection (b)(4), a person with a mental illness who is admitted to a facility of the Texas Department of Mental Health and Mental Retardation for inpatient mental health services three or more

times during a 180-day period is presumed to be in imminent risk of requiring placement in an institution. The strategies must be developed in a manner that presumes the person's eligibility for and the appropriateness of intensive community-based services and support.

(d) In implementing the plan required by Subsection (a), a health and human services agency may not deny an eligible person with a disability access to an institution or remove an eligible person with a disability from an institution if the person prefers the type and degree of care provided in the institution and that care is appropriate for the person. A health and human services agency may deny the person access to an institution or remove the person from an institution to protect the person's health or safety.

(e) Each appropriate health and human services agency shall implement the strategies and recommendations under the plan required by Subsection (a) subject to the availability of funds.

(f) This section does not create a cause of action.

(g) Not later than December 1 of each even-numbered year, the commissioner shall submit to the governor and the legislature a report on the status of the implementation of the plan required by Subsection (a). The report must include recommendations on any statutory or other action necessary to implement the plan.

Added by Acts 2001, 77th Leg., ch. 1239, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.02441. INTERAGENCY TASK FORCE ON ENSURING APPROPRIATE CARE SETTINGS FOR PERSONS WITH DISABILITIES. (a) The commissioner shall establish an interagency task force to assist the commission and appropriate health and human services agencies in developing a comprehensive, effectively working plan to ensure appropriate care settings for persons with disabilities.

(b) The commissioner shall determine the number of members of the task force. The commissioner shall appoint as members of the task force:

(1) representatives of appropriate health and human services agencies, including the Texas Department of Human Services and the Texas Department of Mental Health and Mental Retardation;

(2) representatives of related work groups, including representatives of the work groups established under Sections 22.034 and 22.035, Human Resources Code;

(3) representatives of consumer and family advocacy groups; and

(4) representatives of service providers for persons with disabilities.

(c) The commissioner shall designate a member of the task force to serve as presiding officer. The members of the task force shall elect any other necessary officers.

(d) The task force shall meet at the call of the commissioner.

(e) A member of the task force serves at the will of the commissioner.

(f) A member of the task force may not receive compensation for serving on the task force but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the task force as provided by the General Appropriations Act.

(g) The task force shall study and make recommendations to the commission on:

(1) developing the comprehensive, effectively working plan required by Section 531.0244(a) to ensure appropriate care settings for persons with disabilities; and

(2) identifying appropriate components of the pilot program established under Section 22.037, Human Resources Code, for coordination and integration among the Texas Department of Human Services, the Texas Department of Mental Health and Mental Retardation, and the Department of Protective and Regulatory Services.

(h) In addition to making recommendations under Subsection (g), the task force shall advise the commission and appropriate health and human services agencies with respect to implementing the comprehensive, effectively working plan required by Section 531.0244(a), giving primary consideration to:

(1) methods to identify and assess each person who resides in an institution but chooses to live in the community and for whom a transfer from an institution to the community is appropriate, as determined by the person's treating professionals;

(2) determining the health and human services agencies' availability of community care and support options relating to all persons described by Subdivision (1);

(3) identifying, addressing, and monitoring barriers to implementation of the plan to improve that implementation; and

(4) identifying funding options for the plan.

(i) Not later than September 1 of each year, the task force shall submit a report to the commissioner on its findings and recommendations required by Subsection (g).

Added by Acts 2001, 77th Leg., ch. 1239, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.02442. COMMUNITY LIVING OPTIONS INFORMATION PROCESS FOR CERTAIN PERSONS WITH MENTAL RETARDATION. (a) In this section:

(1) "Institution" means:

(A) a residential care facility operated or maintained by the Texas Department of Mental Health and Mental Retardation to provide 24-hour services, including residential services, to persons with mental retardation; or

(B) an ICF-MR, as defined by Section 531.002, Health and Safety Code.

(2) "Legally authorized representative" has the meaning assigned by Section 241.151, Health and Safety Code.

(3) "Local mental retardation authority" has the meaning assigned by Section 531.002, Health and Safety Code.

(b) In addition to providing information regarding care and support options as required by Section 531.042, the Texas Department of Mental Health and Mental Retardation shall implement a community living options information process in each institution to inform persons with mental retardation who reside in the institution and their legally authorized representatives of alternative community living options.

(c) The department shall provide the information required by Subsection (b) through the community living options information process at least annually. The department shall also provide the information at any other time on request by a person with mental retardation who resides in an institution or the person's legally authorized representative.

(d) If a person with mental retardation residing in an institution or the person's legally authorized representative indicates a desire to pursue an alternative community living option after receiving the information provided under this section, the department shall refer the person or the person's legally authorized representative to the local mental retardation authority. The local mental retardation authority shall place the person in an alternative community living option, subject to the availability of funds, or on a waiting list for those options if the options are not available to the person for any reason on or before the 30th day after the date the person or the person's legally authorized representative is referred to the local mental retardation authority.

(e) The department shall document in the records of each person with mental retardation who resides in an institution the information provided to the person or the person's legally authorized representative through the community living options information process and the results of that process.

Added by Acts 2001, 77th Leg., ch. 1239, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.02444. MEDICAID BUY-IN PROGRAM FOR CERTAIN PERSONS WITH DISABILITIES. (a) The executive commissioner shall develop and implement a Medicaid buy-in program for persons with disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (Pub. L. No. 105-33).

(b) The executive commissioner shall adopt rules in accordance with federal law that provide for:

(1) eligibility requirements for the program; and

(2) requirements for participants in the program to pay premiums or cost-sharing payments.

Added by Acts 2005, 79th Leg., ch. 30, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.0245. PERMANENCY PLANNING FOR CERTAIN CHILDREN. (a) The commission and each appropriate health and human services agency shall develop procedures to ensure that permanency planning is provided for each child residing in an institution in this state on a temporary or long-term basis or for whom institutional care is sought.

(b) In this section:

(1) "Institution" has the meaning assigned by Section

242.002, Health and Safety Code.

(2) "Permanency planning" has the meaning assigned by Section 531.151.

Added by Acts 1997, 75th Leg., ch. 913, Sec. 2, eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 9.011, eff. Sept. 1, 2003.

Sec. 531.0246. REGIONAL MANAGEMENT OF HEALTH AND HUMAN SERVICES AGENCIES. Subject to Section 531.0055(c), the commission may require a health and human services agency, under the direction of the commission, to:

(1) locate all or a portion of the agency's employees and programs in the same building as another health and human services agency or at a location near or adjacent to the location of another health and human services agency;

(2) ensure that the agency's location is accessible to disabled employees and agency clients; and

(3) consolidate agency support services, including clerical and administrative support services and information resources support services, with support services provided to or by another health and human services agency.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.02, eff. Sept. 1, 1999.

Sec. 531.0247. ANNUAL BUSINESS PLAN. Subject to Section 531.0055(c), the commission shall develop and implement an annual business services plan for each health and human services region that establishes performance objectives for all health and human services agencies providing services in the region and measures agency effectiveness and efficiency in achieving those objectives. Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.02, eff. Sept. 1, 1999.

Sec. 531.0248. COMMUNITY-BASED SUPPORT SYSTEMS. (a) Subject to Section 531.0055(d), the commission shall assist communities in this state in developing comprehensive, community-based support systems for health and human services. At the request of a community, the commission shall provide resources and assistance to the community to enable the community to:

(1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers that result from the policies and procedures of state health and human services agencies; and

(2) develop a system of blended funds to allow the community to customize services to fit individual community needs.

(b) At the request of the commission, a health and human services agency shall provide resources and assistance to a community as necessary to perform the commission's duties under Subsection (a).

(c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval. The commission shall review the initiative to ensure that the initiative is consistent with other similar programs offered in communities and does not duplicate other services provided in the community.

(d) In implementing this section, the commission shall consider models used in other service delivery systems, including the mental health and mental retardation service delivery system.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.02, eff. Sept. 1, 1999.

Sec. 531.02481. COMMUNITY-BASED SUPPORT AND SERVICE DELIVERY SYSTEMS FOR LONG-TERM CARE SERVICES. (a) The commission, the Texas Department of Human Services, and the Texas Department on Aging shall assist communities in this state in developing comprehensive, community-based support and service delivery systems for long-term care services. At the request of a community-based organization or combination of community-based organizations, the commission may provide a grant to the organization or combination of organizations in accordance with Subsection (g). At the request of a community, the commission shall provide resources and assistance to the community to enable the community to:

(1) identify and overcome institutional barriers to developing more comprehensive community support systems, including barriers that result from the policies and procedures of state health and human services agencies;

(2) develop a system of blended funds, consistent with the requirements of federal law and the General Appropriations Act,



to allow the community to customize services to fit individual community needs; and

(3) develop a local system of access and assistance to aid clients in accessing the full range of long-term care services.

(b) At the request of the commission, a health and human services agency shall provide resources and assistance to a community as necessary to perform the commission's duties under Subsection (a).

(c) A health and human services agency that receives or develops a proposal for a community initiative shall submit the initiative to the commission for review and approval. The commission shall review the initiative to ensure that the initiative is consistent with other similar programs offered in communities and does not duplicate other services provided in the community.

(d) In implementing this section, the commission shall consider models used in other service delivery systems.

(e) The commissioner shall assure the maintenance of no fewer than 28 area agencies on aging in order to assure the continuation of a local system of access and assistance that is sensitive to the aging population.

(f) A community-based organization or a combination of organizations may make a proposal under this section. A community-based organization includes:

- (1) an area agency on aging;
- (2) an independent living center;
- (3) a municipality, county, or other local government;
- (4) a nonprofit or for-profit organization; or
- (5) a community mental health and mental retardation center.

(g) In making a grant to a community-based organization, the commission shall evaluate the organization's proposal based on demonstrated need and the merit of the proposal. If a combination of community-based organizations makes a proposal, the combination must designate a single organization to receive and administer the grant. The commission may adopt guidelines for proposals under this subsection. The commission shall give priority to proposals that will use the Internet and related information technologies to provide to clients referral services, other information regarding local long-term care services, and needs assessment. To receive a grant under this section, a community-based organization must at least partially match the state grant with money or other resources obtained from a nongovernmental entity, from a local government, or if the community-based organization is a local government, from fees or taxes collected by the local government. The community-based organization may then combine the money or resources the organization obtains from a variety of state, local, federal, or private sources to accomplish the purpose of the proposal. If a community-based organization receives a grant on behalf of a combination of community-based organizations or if the community-based organization's proposal involved coordinating with other entities to accomplish the purpose of the proposal, the commission may condition receipt of the grant on the organization's making a good faith effort to coordinate with other entities in the manner indicated in the proposal.

Added by Acts 1999, 76th Leg., ch. 1505, Sec. 1.01, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 1442, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.0249. ADVISORY COMMITTEE FOR LOCAL GOVERNMENTAL ENTITIES. (a) The commission shall appoint an advisory committee composed of representatives of governmental entities identified under Section 531.022(e).

(b) The advisory committee:

(1) shall advise the commission with respect to establishing flexible and responsive strategies for blending federal, state, and other available funding sources to meet local program needs and service priorities, in implementation of Sections 531.022, 531.024, and 531.0248; and

(2) may assist the commission in performing its other functions under Sections 531.022, 531.024, 531.0248, and 531.028(b)(6).

(c) A member of the advisory committee may not receive compensation, but is entitled to reimbursement of the travel expenses incurred by the member while conducting the business of the committee, as provided by the General Appropriations Act.

(d) The advisory committee is not subject to Chapter 2110. Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.02, eff. Sept. 1, 1999.

Sec. 531.02491. JOINT TRAINING FOR CERTAIN CASEWORKERS. (a) The commissioner shall provide for joint training for health and human services caseworkers whose clients are children, including caseworkers employed by:

- (1) the Texas Department of Health;
- (2) the Texas Department of Human Services; and
- (3) the Texas Department of Mental Health and Mental Retardation, a local mental health authority, or a local mental retardation authority.

(b) Training provided under this section must be designed to increase a caseworker's knowledge and awareness of the services available to children at each health and human services agency or local mental health or mental retardation authority, including long-term care programs and services available under a Section 1915(c) waiver program.

Added by Acts 2001, 77th Leg., ch. 156, Sec. 1, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.0244 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(66), eff. Sept. 1, 2003.

Sec. 531.02492. DELIVERY OF HEALTH AND HUMAN SERVICES TO YOUNG TEXANS. (a) The executive head of each health and human services agency shall report annually to the governing body of that agency on that agency's efforts to provide health and human services to children younger than six years of age, including the development of any new programs or the enhancement of existing programs. The agency shall submit a copy of the report to the commission.

(b) The commission shall prepare and deliver a biennial report to the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, the Legislative Budget Board, and appropriate legislative committees on the efforts of the health and human services agencies to provide health and human services to children younger than six years of age. The report may contain recommendations by the commission to better coordinate state agency programs relating to the delivery of health and human services to children younger than six years of age and may propose joint agency collaborative programs.

(c) The commissioner shall adopt rules relating to the reports required by Subsection (a), including rules specifying when and in what manner a health and human services agency must report and the information to be included in the report. Each agency shall follow the rules adopted by the commissioner under this section.

Added by Acts 2001, 77th Leg., ch. 90, Sec. 1, eff. Aug. 27, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.0244 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(67), eff. Sept. 1, 2003.

Sec. 531.025. STATEWIDE NEEDS APPRAISAL PROJECT. (a) The commission may implement the Statewide Needs Appraisal Project to obtain county-specific demographic data concerning health and human services needs in this state. Any collected data shall be made available for use in planning and budgeting for health and human services programs by state agencies.

(b) The commission shall coordinate its activities with the appropriate health and human services agencies.

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

Sec. 531.026. CONSOLIDATED BUDGET RECOMMENDATION. (a) The commission shall prepare and submit to the Legislative Budget Board and the governor a consolidated health and human services budget recommendation not later than October 15 of each even-numbered year.

(b) The commission shall base the budget recommendation prepared under this section on priorities set in the commission's coordinated strategic plan for health and human services.

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

Sec. 531.027. APPROPRIATIONS REQUEST BY AGENCIES. (a) Each health and human services agency shall submit to the commission a biennial agency legislative appropriations request on a date to be determined by commission rule.

(b) A health and human services agency may not submit to the legislature or the governor its legislative appropriations request until the commission reviews and comments on the legislative appropriations request.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.08(a), eff. Sept. 1, 1997.

Sec. 531.0271. HEALTH AND HUMAN SERVICES AGENCIES OPERATING BUDGETS. The commission may, within the limits established by and subject to the General Appropriations Act, transfer amounts appropriated to health and human services agencies among the agencies to:

- (1) enhance the receipt of federal money under the federal funds management system established under Section 531.028;
- (2) achieve efficiencies in the administrative support functions of the agencies; and
- (3) perform the functions assigned to the commissioner under Section 531.0055.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.09(a), eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 3.03, eff. Sept. 1, 1999.

Sec. 531.0273. INFORMATION RESOURCES PLANNING AND MANAGEMENT; ADVISORY COMMITTEE. (a) The commission is responsible for strategic planning for information resources at each health and human services agency and shall direct the management of information resources at each health and human services agency. The commission shall:

- (1) develop a coordinated strategic plan for information resources management that:
  - (A) covers a five-year period;
  - (B) defines objectives for information resources management at each health and human services agency;
  - (C) prioritizes information resources projects and implementation of new technology for all health and human services agencies;
  - (D) integrates planning and development of each information resources system used by a health and human services agency into a coordinated information resources management planning and development system established by the commission;
  - (E) establishes standards for information resources system security and that promotes the ability of information resources systems to operate with each other; and
  - (F) achieves economies of scale and related benefits in purchasing for health and human services information resources systems;
- (2) establish information resources management policies, procedures, and technical standards and ensure compliance with those policies, procedures, and standards; and
- (3) review and approve the information resources management and biennial operating plan of each health and human services agency.

(b) Not later than December 15 of each even-numbered year, the commission shall file the coordinated information resources strategic plan with the governor, the lieutenant governor, and the speaker of the house of representatives.

(c) A health and human services agency may not submit its plans to the Department of Information Resources or the Legislative Budget Board under Subchapter E, Chapter 2054, until those plans are approved by the commission.

(d) The commission shall appoint an advisory committee composed of:

- (1) information resources managers for state agencies and for private employers; and
- (2) the directors, executive directors, and commissioners of health and human services agencies.

(e) The advisory committee appointed under Subsection (d) shall advise the commission with respect to the implementation of the commission's duties under Subsection (a)(1) and:

- (1) shall advise the commission about:
  - (A) overall goals and objectives for information resources management for all health and human services agencies;
  - (B) coordination of agency information resources management plans;
  - (C) development of short-term and long-term strategies for:
    - (i) implementing information resources management policies, procedures, and technical standards; and
    - (ii) ensuring compatibility of information resources systems across health and human services agencies as

technology changes;

(D) information resources training and skill development for health and human services agency employees and policies to facilitate recruitment and retention of trained employees;

(E) standards for determining:

(i) the circumstances in which obtaining information resources services under contract is appropriate;

(ii) the information resources services functions that must be performed by health and human services agency information resources services employees; and

(iii) the information resources services skills that must be maintained by health and human services agency information resources services employees;

(F) optimization of the use of information resources technology that is in place at health and human services agencies; and

(G) existing and potential future information resources technologies and practices and the usefulness of those technologies and practices to health and human services agencies; and

(2) shall review and make recommendations to the commission relating to the consolidation and improved efficiency of information resources management functions, including:

(A) cooperative leasing of information resources systems equipment;

(B) consolidation of data centers;

(C) improved network operations;

(D) technical support functions, including help desk services, call centers, and data warehouses;

(E) administrative applications;

(F) purchases of standard software;

(G) joint training efforts;

(H) recruitment and retention of trained agency employees;

(I) video conferencing; and

(J) other related opportunities for improved efficiency.

(f) A member of the advisory committee may not receive compensation, but is entitled to reimbursement of the travel expenses incurred by the member while conducting the business of the committee, as provided by the General Appropriations Act.

(g) The advisory committee is not subject to Chapter 2110. Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.09(a), eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 3.03, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 188, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.0274. COORDINATION AND APPROVAL OF CASELOAD ESTIMATES; REPORT. (a) The commission shall coordinate and approve caseload estimates made for programs administered by health and human services agencies.

(b) To implement this section, the commission shall:

(1) adopt uniform guidelines to be used by health and human services agencies in estimating their caseloads, with allowances given for those agencies for which exceptions from the guidelines may be necessary;

(2) assemble a single set of economic and demographic data and provide that data to each health and human services agency to be used in estimating its caseloads; and

(3) seek advice from health and human services agencies, the Legislative Budget Board, the governor's budget office, the comptroller, and other relevant agencies as needed to coordinate the caseload estimating process.

(c) The commission shall assemble caseload estimates made by health and human services agencies into a coherent, uniform report and shall update that report quarterly with assistance from those agencies. The commission shall publish the report and make it readily available to state and local agencies and interested private organizations.

(d) In the report prepared under Subsection (c), the commission shall explain the caseload estimates using monthly averages, annual unduplicated recipients, annual service usage, and other commonly used measures.

(e) The commission shall attach a copy of the report prepared under Subsection (c) to the consolidated health and human

services budget recommendation submitted to the Legislative Budget Board under Section 531.026 and shall also submit the report to the legislature when it convenes in regular session.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.09(a), eff. Sept. 1, 1997.

Sec. 531.028. MONITORING AND EFFECTIVE MANAGEMENT OF FUNDS. (a) The commission, within the limits established by and subject to the General Appropriations Act, shall be responsible for planning for, and managing the use of, all federal funds in a manner that maximizes the federal funding available to the state while promoting the delivery of services.

(b) The commissioner shall establish a federal money management system to coordinate and monitor the use of federal money that is received by health and human services agencies to ensure that the money is spent in the most efficient manner and shall:

(1) establish priorities for use of federal money by all health and human services agencies, in coordination with the coordinated strategic plan established under Section 531.022 and the budget prepared under Section 531.026;

(2) coordinate and monitor the use of federal money for health and human services to ensure that the money is spent in the most cost-effective manner throughout the health and human services system;

(3) review and approve all federal funding plans for health and human services in this state;

(4) estimate available federal money, including earned federal money, and monitor unspent money;

(5) ensure that the state meets federal requirements relating to receipt of federal money for health and human services, including requirements relating to state matching money and maintenance of effort;

(6) transfer appropriated amounts as described by Section 531.0271; and

(7) ensure that each governmental entity identified under Section 531.022(e) has access to complete and timely information about all sources of federal money for health and human services programs and that technical assistance is available to governmental entities seeking grants of federal money to provide health and human services.

(c) The commission shall prepare an annual report with respect to the results of the implementation of this section. The report must identify strategies to maximize the receipt and use of federal funds and to improve federal funds management. The commission shall file the report with the governor, the lieutenant governor, and the speaker of the house of representatives not later than December 15 of each year.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.10(a), eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1460, Sec. 3.04, eff. Sept. 1, 1999.

Sec. 531.029. ANNUAL FUNDS REPORT. The commission shall file annually with the governor and the presiding officer of each house of the legislature a complete and detailed written report accounting for all funds received and disbursed by the commission during the preceding fiscal year.

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

Sec. 531.030. FINANCIAL AUDIT. The financial transactions of the commission are subject to audit by the state auditor in accordance with Chapter 321.

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

Sec. 531.031. MANAGEMENT INFORMATION AND COST ACCOUNTING SYSTEM. The commissioner shall establish a management information system and a cost accounting system for all health and human services that is compatible with and meets the requirements of the uniform statewide accounting project.

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

Sec. 531.0311. ANNUAL WORK PLAN. Not later than the end of the first month of each fiscal year, the commissioner shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, and the Legislative Budget Board a work plan outlining the activities of the commission for

that fiscal year. The work plan must establish priorities for the commission's activities based on available resources.  
Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.10(b), eff. Sept. 1, 1997.

Sec. 531.0312. TEXAS INFORMATION AND REFERRAL NETWORK. (a) The Texas Information and Referral Network at the commission is the program responsible for the development, coordination, and implementation of a statewide information and referral network that integrates existing community-based structures with state and local agencies. The network must include information relating to transportation services provided to clients of state and local agencies.

(b) The commission shall cooperate with the Records Management Interagency Coordinating Council and the General Services Commission to establish a single method of categorizing information about health and human services to be used by the Records Management Interagency Coordinating Council and the Texas Information and Referral Network. The network, in cooperation with the council and the General Services Commission, shall ensure that:

(1) information relating to health and human services is included in each residential telephone directory published by a for-profit publisher and distributed to the public at minimal or no cost; and

(2) the single method of categorizing information about health and human services is used in a residential telephone directory described by Subdivision (1).

Text of subsec. (c) as amended [as subsec. (b)] by Acts 1999, 76th Leg., ch. 50, Sec. 1

(c) A health and human services agency or a public or private entity receiving state-appropriated funds to provide health and human services shall provide the Texas Information and Referral Network with information about the health and human services provided by the agency or entity for inclusion in the statewide information and referral network. The agency or entity shall provide the information in a form determined by the commissioner and shall update the information at least quarterly.

Text of subsec. (c) as amended by Acts 1999, 76th Leg., ch. 1460, Sec. 3.05

(c) A health and human services agency shall provide the Texas Information and Referral Network and the Records Management Interagency Coordinating Council with information about the health and human services provided by the agency for inclusion in the statewide information and referral network, residential telephone directories described by Subsection (b), and any other materials produced under the direction of the network or the council. The agency shall provide the information in the format required by the Texas Information and Referral Network or the Records Management Interagency Coordinating Council and shall update the information at least quarterly or as required by the network or the council.

(d) The Texas Department of Housing and Community Affairs shall provide the Texas Information and Referral Network with information regarding the department's housing and community affairs programs for inclusion in the statewide information and referral network. The department shall provide the information in a form determined by the commissioner and shall update the information at least quarterly.

(e) Each local workforce development board, the Texas Head Start State Collaboration Office, and each school district shall provide the Texas Information and Referral Network with information regarding eligibility for and availability of child-care and education services for inclusion in the statewide information and referral network. The local workforce development boards, Texas Head Start State Collaboration Office, and school districts shall provide the information in a form determined by the executive commissioner. In this subsection, "child-care and education services" has the meaning assigned by Section 531.03131.

Added by Acts 1997, 75th Leg., ch. 652, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 50, Sec. 1, eff. May 10, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 3.05, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1367, Sec. 1.31, eff. Sept. 1, 2001; Acts 2005, 79th Leg., ch. 1260, Sec. 23(a), eff. June 18, 2005.

Sec. 531.0313. ELECTRONIC ACCESS TO HEALTH AND HUMAN SERVICES REFERRAL INFORMATION. (a) The Texas Information and Referral Network may develop an Internet site to provide information to the public regarding the health and human services

provided by public or private entities throughout the state.

(b) The material in the Texas Information and Referral Network Internet site must be geographically indexed and designed to inform an individual about the health and human services provided in the area where the individual lives. The material must be further indexed by type of service provided within each geographic area.

(c) The Internet site may contain links to the Internet sites of any local provider of health and human services and may contain:

(1) the name, address, and phone number of organizations providing health and human services in a county;

(2) a description of the type of services provided by those organizations; and

(3) any other information to educate the public about the health and human services provided in a county.

(d) The Texas Information and Referral Network shall coordinate with the Department of Information Resources to maintain the Internet site through the TexasOnline project established by the Department of Information Resources.

(e) In this section, "Internet" means the largest nonproprietary, nonprofit cooperative public computer network, popularly known as the Internet.

Added by Acts 1997, 75th Leg., ch. 652, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 2001, 77th Leg., ch. 357, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.03131. ELECTRONIC ACCESS TO CHILD-CARE AND EDUCATION SERVICES REFERRAL INFORMATION. (a) In this section, "child-care and education services" means:

(1) subsidized child-care services administered by the Texas Workforce Commission and local workforce development boards and funded wholly or partly by federal child-care development funds;

(2) child-care and education services provided by a Head Start or Early Head Start program provider;

(3) child-care and education services provided by a school district through a prekindergarten or after-school program; and

(4) any other government-funded child-care and education services, other than education and services provided by a school district as part of the general program of public and secondary education, designed to educate or provide care for children under the age of 13 in middle-income or low-income families.

(b) In addition to providing health and human services information, the Texas Information and Referral Network Internet site established under Section 531.0313 shall provide information to the public regarding child-care and education services provided by public or private entities throughout the state. The Internet site will serve as a single point of access through which a person may be directed on how or where to apply for all child-care and education services available in the person's community.

(c) To the extent resources are available, the Internet site must:

(1) be geographically indexed and designed to inform an individual about the child-care and education services provided in the area where the person lives;

(2) contain prescreening questions to determine a person's or family's probable eligibility for child-care and education services; and

(3) be designed in a manner that allows staff of the Texas Information and Referral Network to:

(A) provide an applicant with the telephone number, physical address, and electronic mail address of the nearest Head Start or Early Head Start office or center and local workforce development center and the appropriate school district; and

(B) send an electronic mail message to each appropriate entity described by Paragraph (A) containing the name of and contact information for each applicant and a description of the services the applicant is applying for.

(d) On receipt of an electronic mail message from the Texas Information and Referral Network under Subsection (c)(3)(B), each entity shall contact the applicant to verify information regarding the applicant's eligibility for available child-care and education

services and, on certifying eligibility, shall match the applicant with entities providing those services in the applicant's community, including local workforce development boards, local child-care providers, or a Head Start or Early Head Start program provider.

(e) The child-care resource and referral network under Chapter 310, Labor Code, and each entity providing child-care and education services in this state, including local workforce development boards, the Texas Education Agency, school districts, Head Start and Early Head Start program providers, municipalities, counties, and other political subdivisions of this state, shall cooperate with the Texas Information and Referral Network as necessary in the administration of this section.

(f) Not later than the last day of the month following each calendar quarter, the commission shall file with the legislature a report regarding the use of the Internet site in the provision and delivery of child-care and education services during the reporting period. The report must include:

(1) the number of referrals made to Head Start or Early Head Start offices or centers;

(2) the number of referrals made to local workforce development centers; and

(3) the number of referrals made to each school district.

Added by Acts 2005, 79th Leg., ch. 1260, Sec. 23(b), eff. June 18, 2005.

Sec. 531.0314. INFORMATION AND REFERRAL SYSTEM TASK FORCE. (a) The commission shall establish a task force to implement the statewide information and referral system for health and human services and to make recommendations to the commission and other agencies providing health and human services.

(b) The task force shall coordinate the development of state and local information and referral network databases.

(c) The task force must consist of representatives from the state's health and human services agencies, the Texas Alliance of Information and Referral Services, the United Way, and public and private community-based organizations involved in providing information and referral for health and human services.

Added by Acts 1997, 75th Leg., ch. 652, Sec. 1, eff. Sept. 1, 1997.

Sec. 531.0315. IMPLEMENTING NATIONAL ELECTRONIC DATA INTERCHANGE STANDARDS FOR HEALTH CARE INFORMATION. (a) Each health and human services agency and every other state agency that acts as a health care provider or a claims payer for the provision of health care shall:

(1) process information related to health care in compliance with national data interchange standards adopted under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), and its subsequent amendments, within the applicable deadline established under federal law or federal regulations; or

(2) demonstrate to the commission the reasons the agency should not be required to comply with Subdivision (1), and obtain the commission's approval, to the extent allowed under federal law:

(A) to comply with the standards at a later date;

or  
(B) to not comply with one or more of the standards.

(b) This section does not prohibit a state agency from seeking a federal waiver from compliance under applicable federal law.

Added by Acts 1999, 76th Leg., ch. 494, Sec. 1, eff. June 18, 1999.

Sec. 531.0316. MEDICAID HEALTH LITERACY PILOT PROGRAM.

Text of section effective until September 1, 2009

(a) In order to prevent unnecessary emergency room visits and health costs for Medicaid recipients, the commission shall develop and implement a Medicaid health literacy pilot program in Bexar County under which Medicaid recipients with young children receive health information materials and training designed to improve their health care decision-making.

(b) The pilot program must:

(1) establish a statistically significant test group and control group of Medicaid recipients with young children; and

(2) provide the test group with health information materials in English and Spanish that:



(A) are developed with consideration of the literacy level of the test group; and

(B) provide the test group with information to guide their health care decisions, including information about common health problems, prevention, home treatment, and circumstances in which it is appropriate to contact a health care professional.

(c) The commission shall establish the pilot program through a local governmental entity in Bexar County that chooses to participate. The commission shall request participation by the Bexar County Hospital District with the hospital district's subsidiary, Community First Health Plans.

(d) The commission shall ensure that the pilot program is financed using:

(1) money provided to the commission for purposes of the program by the participating local governmental entity to maximize federal matching money under the medical assistance program; and

(2) any corresponding federal matching money.

(e) The participating local governmental entity may provide money to the commission by certification or intergovernmental transfer to finance the pilot program as described by Subsection (d)(1).

(f) Not later than January 1, 2007, the commission shall evaluate the pilot program and report to the 80th Legislature on the effectiveness of the program and the feasibility of expanding the program statewide.

(g) This section expires September 1, 2009.  
Added by Acts 2005, 79th Leg., ch. 1367, Sec. 2(a), eff. June 18, 2005.

Sec. 531.0317. HEALTH AND HUMAN SERVICES INFORMATION MADE AVAILABLE THROUGH THE INTERNET. (a) In this section, "Internet" means the largest nonproprietary, nonprofit cooperative public computer network, popularly known as the Internet.

(b) The commission, in cooperation with the Department of Information Resources, shall establish and maintain through the TexasOnline project established by the Department of Information Resources a generally accessible and interactive Internet site that contains information for the public regarding the services and programs provided or administered by each of the health and human services agencies throughout the state. The commission shall establish the site in such a manner that it can be located easily through electronic means.

(c) The Internet site must:

(1) contain information that is:

(A) in a concise and easily understandable and accessible format; and

(B) organized by the type of service provided rather than by the agency or provider delivering the service;

(2) contain eligibility criteria for each agency program;

(3) contain application forms for each of the public assistance programs administered by health and human services agencies, including application forms for:

(A) financial assistance under Chapter 31, Human Resources Code;

(B) medical assistance under Chapter 32, Human Resources Code; and

(C) nutritional assistance under Chapter 33, Human Resources Code;

(4) to avoid duplication of functions and efforts, provide a link that provides access to a site maintained by the Texas Information and Referral Network under Section 531.0313;

(5) contain the telephone number and, to the extent available, the electronic mail address for each health and human services agency and local provider of health and human services;

(6) be designed in a manner that allows a member of the public to send questions about each agency's programs or services electronically and receive responses to the questions from the agency electronically; and

(7) be updated at least quarterly.

(d) In designing the Internet site, the commission shall comply with any state standards for Internet sites that are prescribed by the Department of Information Resources or any other state agency.

(e) The commission shall ensure that:

(1) the Internet site does not contain any confidential information, including any confidential information regarding a client of a human services provider; and

(2) the Internet site's design and applications comply with generally acceptable standards for Internet accessibility for persons with disabilities and contain appropriate controls for information security.

(f) A health and human services agency, the Texas Information and Referral Network, and the Department of Information Resources shall cooperate with the commission to the extent necessary to enable the commission to perform its duties under this section.

Added by Acts 2001, 77th Leg., ch. 357, Sec. 2, eff. Sept. 1, 2001.

Sec. 531.032. APPLICATION OF OTHER LAWS. The commission is subject to Chapters 2001 and 2002.

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

Sec. 531.033. RULES. The commissioner shall adopt rules necessary to carry out the commission's duties under this chapter.

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

Sec. 531.0335. PROHIBITION ON PUNITIVE ACTION FOR FAILURE TO IMMUNIZE. (a) In this section:

(1) "Person responsible for a child's care, custody, or welfare" has the meaning assigned by Section 261.001, Family Code.

(2) "Punitive action" includes the initiation of an investigation of a person responsible for a child's care, custody, or welfare for alleged or suspected abuse or neglect of a child.

(b) The commissioner by rule shall prohibit a health and human services agency from taking a punitive action against a person responsible for a child's care, custody, or welfare for failure of the person to ensure that the child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

(c) This section does not affect a law, including Chapter 31, Human Resources Code, that specifically provides a punitive action for failure to ensure that a child receives the immunization series prescribed by Section 161.004, Health and Safety Code.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.04, eff. Sept. 1, 2003.

Sec. 531.035. DISPUTE ARBITRATION. The commissioner shall arbitrate and render the final decision on interagency disputes.

Added by Acts 1995, 74th Leg., ch. 76, Sec. 8.002(a), eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 14.10(c), eff. Sept. 1, 1997.

Sec. 531.036. PUBLIC HEARINGS. (a) The commission biennially shall conduct a series of public hearings in diverse locations throughout the state to give citizens of the state an opportunity to comment on health and human services issues.

(b) A hearing held under this section is subject to Chapter 551.

(c) In conducting a public hearing under this section, the commission shall, to the greatest extent possible, encourage participation in the hearings process by diverse groups of citizens in this state. Hearings shall be of a sufficient number to allow reasonable access to citizens in both rural and urban areas, with an emphasis on geographic diversity.

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

Sec. 531.037. NOTICE OF PUBLIC HEARINGS. (a) In addition to the notice required by Chapter 551, the commission shall:

(1) provide written notification to public officials in the affected area; and

(2) publish notice of a public hearing under Section 531.036 in a newspaper of general circulation in the county in which the hearing is to be held.

(b) If the county in which the hearing is to be held does not have a newspaper of general circulation, the commission shall publish notice in a newspaper of general circulation in an adjacent county or in the nearest county in which a newspaper of general circulation is published.

(c) Notice shall be published once a week for two consecutive weeks before the hearing, with the first publication

appearing not later than the 15th day before the date set for the hearing.

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

Sec. 531.038. GIFTS AND GRANTS. The commission may accept a gift or grant from a public or private source to perform any of the commission's powers or duties.

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

Sec. 531.0381. CERTAIN GRANTS TO HEALTH AND HUMAN SERVICES AGENCIES. (a) Subject to this section, a health and human services agency may accept a gift or grant of money, drugs, equipment, or any other item of value from a pharmaceutical manufacturer, distributor, provider, or another entity engaged in a pharmaceutical-related business.

(b) Acceptance of a gift or grant under this section is subject to the written approval of the commissioner. Chapter 575 does not apply to a gift or grant under this section.

(c) The commissioner may adopt rules and procedures to implement this section. The rules must ensure that acceptance of a gift or grant under this section is consistent with any applicable federal law or regulation and does not adversely affect federal financial participation in any state program, including the state Medicaid program.

(d) This section does not affect the authority under other law of the commission or a health and human services agency to accept a gift or grant from a person other than a pharmaceutical manufacturer, distributor, provider, or another entity engaged in a pharmaceutical-related business.

Added by Acts 2003, 78th Leg., ch. 722, Sec. 1, eff. June 20, 2003.

Sec. 531.039. CONTRACTS. The commission may enter into contracts as necessary to perform any of the commission's powers or duties.

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

Sec. 531.0391. SUBROGATION AND THIRD-PARTY REIMBURSEMENT COLLECTION CONTRACT. (a) The commission shall enter into a contract under which the contractor is authorized on behalf of the commission or a health and human services agency to recover money under a subrogation or third-party reimbursement right held by the commission or a health and human services agency arising from payment of medical expenses. The contract must provide that:

(1) the commission or agency, as appropriate, shall compensate the contractor based on a percentage of the amount of money recovered by the contractor for the commission or agency; and

(2) with the approval of the attorney required by other law to represent the commission or agency in court, the contractor may represent the commission or agency in a court proceeding to recover money under a subrogation or third-party reimbursement right if the representation is cost-effective and specifically authorized by the commission.

(b) The commission shall develop a process for identifying claims for the recovery of money under a subrogation or third-party reimbursement right described by this section and referring the claims to the contractor. A health and human services agency shall cooperate with the contractor on a claim of the agency referred to the contractor for collection.

(c) The commission is not required to enter into a contract under Subsection (a) if the commission cannot identify a contractor who is willing to contract with the commission on reasonable terms. If the commission cannot identify such a contractor, the commission shall develop and implement alternative policies to ensure the collection of money under a subrogation or third-party reimbursement right.

(d) The commission may allow a state agency other than a health and human services agency to be a party to the contract required under Subsection (a). In that case, the commission shall modify the contract as necessary to reflect the services to be provided by the contractor to the additional state agency.

Added by Acts 1997, 75th Leg., ch. 1030, Sec. 1, eff. June 19, 1997.

Sec. 531.0392. RECOVERY OF CERTAIN THIRD-PARTY REIMBURSEMENTS UNDER MEDICAID. (a) In this section, "dually eligible individual" means an individual who is eligible to receive health care benefits under both the Medicaid and Medicare programs.

(b) The commission shall obtain Medicaid reimbursement from

each fiscal intermediary who makes a payment to a service provider on behalf of the Medicare program, including a reimbursement for a payment made to a home health services provider or nursing facility for services rendered to a dually eligible individual.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.05, eff. Sept. 1, 2003.

Sec. 531.040. REFERENCE GUIDE; DICTIONARY. (a) The commission shall publish a biennial reference guide describing available public health and human services in this state and shall make the guide available to all interested parties and agencies.

(b) The reference guide must include a dictionary of uniform terms and services.

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

Sec. 531.041. GENERAL POWERS AND DUTIES. The commission has all the powers and duties necessary to administer this chapter.

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

Sec. 531.042. INFORMATION AND ASSISTANCE REGARDING CARE AND SUPPORT OPTIONS; REPORTS. (a) The commissioner by rule shall require each health and human services agency to provide to each patient or client of the agency and to at least one family member of the patient or client, if possible, information regarding all care and support options available to the patient or client, including community-based services appropriate to the needs of the patient or client, before the agency allows the patient or client to be placed in a care setting, including a nursing home, intermediate care facility for the mentally retarded, or institution for the mentally retarded licensed or operated by the Department of Protective and Regulatory Services, to receive care or services provided by the agency or by a person under an agreement with the agency.

(b) The rules must require each health and human services agency to provide information about all long-term care options and long-term support options available to the patient or client, including community-based options and options available through another agency or a private provider. The information must be provided in a manner designed to maximize the patient's or client's understanding of all available options. If the patient or client has a legally authorized representative, as defined by Section 241.151, Health and Safety Code, the information must also be provided to that representative. If the patient or client is in the conservatorship of a health and human services agency, the information must be provided to the patient's or client's agency caseworker and foster parents, if applicable.

(c) A health and human services agency that provides a patient, client, or other person as required by this section with information regarding care and support options available to the patient or client shall assist the patient, client, or other person in taking advantage of an option selected by the patient, client, or other person, subject to the availability of funds. If the selected option is not immediately available for any reason, the agency shall provide assistance in placing the patient or client on a waiting list for that option.

(d) Each health and human services agency annually and as provided by commission rule shall report to the legislature the number of community-based service placements and residential-care placements the agency makes.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.11(a), eff. Sept. 1, 1997. Amended by Acts 2001, 77th Leg., ch. 1239, Sec. 2, eff. Sept. 1, 2001.

Sec. 531.043. LONG-TERM CARE VISION. (a) In conjunction with the appropriate state agencies, the commissioner shall develop a plan for access to individualized long-term care services for persons with functional limitations or medical needs and their families that assists those persons in achieving and maintaining the greatest possible independence, autonomy, and quality of life.

(b) The guiding principles and goals of the plan focusing on the individual and the individual's family must:

(1) recognize that it is the policy of this state that children should grow up in families and that persons with disabilities and elderly persons should live in the setting of their choice; and

(2) ensure that persons needing assistance and their families will have:

(A) the maximum possible control over their

services;

(B) a choice of a broad, comprehensive array of services designed to meet individual needs; and

(C) the easiest possible access to appropriate care and support, regardless of the area of the state in which they live.

(c) The guiding principles and goals of the long-term care plan focusing on services and delivery of those services by the state must:

(1) emphasize the development of home-based and community-based services and housing alternatives to complement the long-term care services already in existence;

(2) ensure that services will be of the highest possible quality, with a minimum amount of regulation, structure, and complexity at the service level;

(3) recognize that maximum independence and autonomy represent major goals, and with those comes a certain degree of risk;

(4) maximize resources to the greatest extent possible, with the consumer receiving only the services that the consumer prefers and that are indicated by a functional assessment of need; and

(5) structure the service delivery system to support these goals, ensuring that any necessary complexity of the system is at the administrative level rather than at the client level.

(d) The commission shall coordinate state services to ensure that:

(1) the roles and responsibilities of the agencies providing long-term care are clarified; and

(2) duplication of services and resources is minimized.

(e) In this section, "long-term care" means the provision of health care, personal care, and assistance related to health and social services over a sustained period to people of all ages and their families, regardless of the setting in which the care is given.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.12(a), eff. Sept. 1, 1997.

Sec. 531.044. AFDC RECIPIENTS ELIGIBLE FOR FEDERAL PROGRAMS. (a) The commission shall assist recipients of financial assistance under Chapter 31, Human Resources Code, who are eligible for assistance under federal programs to apply for benefits under those federal programs. The commission may delegate this responsibility to a health and human service agency, contract with a unit of local government, or use any other cost-effective method to assist financial assistance recipients who are eligible for federal programs.

(b) The commission shall organize a planning group involving the Texas Department of Human Services, the Texas Education Agency, and the Texas Rehabilitation Commission to:

(1) improve workload coordination between those agencies as necessary to administer this section; and

(2) provide information and help train employees to correctly screen applicants under this section as requested by the commission.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.13(a), eff. Sept. 1, 1997.

Sec. 531.045. INTERAGENCY TASK FORCE ON ELECTRONIC BENEFITS TRANSFERS. (a) The interagency task force on electronic benefits transfers shall advise and assist the commission in adding new benefit programs to the statewide electronic benefits transfer system.

(b) The task force is composed of:

(1) a representative of:

(A) the attorney general's office, appointed by the attorney general;

(B) the comptroller's office, appointed by the comptroller;

(C) the commission, appointed by the commissioner;

(D) the Texas Department of Health, appointed by the commissioner of public health;

(E) the Texas Department of Human Services, appointed by the commissioner of human services;

(F) the Texas Workforce Commission, appointed by

the executive director of that agency; and

(G) the Texas Rehabilitation Commission, appointed by the commissioner of that agency; and

(2) two representatives of each of the following groups, appointed by the comptroller:

(A) retailers who maintain electronic benefits transfer point-of-sale equipment;

(B) banks or owners of automatic teller machines; and

(C) consumer or client advocacy organizations.

(c) A member of the task force serves at the will of the appointing agency.

(d) The representative of the comptroller's office serves as presiding officer. The task force may elect any other necessary officers.

(e) The task force shall meet at the call of the presiding officer.

(f) The appointing agency is responsible for the expenses of a member's service on the task force. A member of the task force is not entitled to additional compensation for serving on the task force.

(g) The task force shall:

(1) serve as this state's counterpoint to the federal electronic benefits transfer task force;

(2) identify benefit programs that merit addition to this state's electronic benefits transfer system;

(3) identify and address problems that may occur if a program is added;

(4) pursue state-federal partnerships to facilitate the development and expansion of this state's electronic benefits transfer system;

(5) track and distribute federal legislation and information from other states that relate to electronic benefits transfer systems;

(6) ensure efficiency and planning coordination in relation to this state's electronic benefits transfer system;

(7) develop a plan using the experience and expertise of appropriate state agencies for the use of a photograph or other imaging technology on all electronic benefits transfer cards and, if proven to be effective in reducing fraud and misuse, begin using the new cards starting with replacement cards for cards that were used in the program on June 13, 1995;

(8) review current and potential fraud problems with electronic benefits transfer and propose methods to prevent or deter fraud;

(9) evaluate the feasibility of adding the Medicaid program to the state's electronic benefits transfer system; and

(10) develop a plan to assist beneficiaries of public programs to obtain bank accounts.

(h) In determining which benefit programs can be added to this state's electronic benefits transfer system, the task force shall consider, at a minimum:

(1) the savings to this state;

(2) the ease of addition to existing infrastructure; and

(3) the number of clients served.

(i) A state agency that proposes to deliver public benefits through electronic benefits transfers shall comply with any strategic guidelines adopted by the task force relating to the development and use of an electronic benefits transfer system.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.14(a), eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 827, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 248, Sec. 1, eff. Aug. 30, 1999; Acts 2003, 78th Leg., ch. 817, Sec. 10.03, eff. Sept. 1, 2003.

Sec. 531.046. FEDERAL FUNDING FOR CHEMICAL DEPENDENCY SERVICES. The commission shall coordinate with the Texas Commission on Alcohol and Drug Abuse and the Texas Department of Human Services to amend the eligibility requirements of this state's emergency assistance plan under Title IV-A, Social Security Act (42 U.S.C. Section 601 et seq.), to include either a child or a significant adult in a child's family who needs chemical dependency treatment.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.15(a), eff. Sept. 1, 1997.

Sec. 531.047. SUBSTITUTE CARE PROVIDER OUTCOME STANDARDS. (a) The commission, after consulting with representatives from the Department of Protective and Regulatory Services, the Texas Juvenile Probation Commission, and the Texas Department of Mental Health and Mental Retardation, shall by rule adopt result-oriented standards that a provider of substitute care services for children under the care of the state must achieve.

(b) A health and human services agency that purchases substitute care services must include the result-oriented standards as requirements in each substitute care service provider contract.

(c) A health and human services agency may provide information about a substitute care provider, including rates, contracts, outcomes, and client information, to another agency that purchases substitute care services.

Added by Acts 1997, 75th Leg., ch. 1022, Sec. 98, eff. Sept. 1, 1997.

Sec. 531.048. CASELOAD STANDARDS. (a) After considering the recommendations of the caseload standards advisory committees under Section 531.049(e), the commissioner may establish caseload standards and other standards relating to caseloads for each category of caseworker employed by the Texas Department of Human Services or the Department of Protective and Regulatory Services.

(b) In establishing standards under this section, the commissioner shall:

(1) ensure the standards are based on the actual duties of the caseworker;

(2) ensure the caseload standards are reasonable and achievable;

(3) ensure the standards are consistent with existing professional caseload standards;

(4) consider standards developed by other states for caseworkers in similar positions of employment; and

(5) ensure the standards are consistent with existing caseload standards of other state agencies.

(c) Subject to the availability of funds appropriated by the legislature, the commissioner of human services and the executive director of the Department of Protective and Regulatory Services shall use the standards established by the commissioner under this section to determine the number of personnel to assign as caseworkers for their respective agencies.

(d) Subject to the availability of funds appropriated by the legislature, the Texas Department of Human Services and the Department of Protective and Regulatory Services shall use the standards established by the commissioner to assign caseloads to individual caseworkers employed by those agencies.

(e) The commissioner shall include a recommendation made to the commissioner by a caseload standards advisory committee under Section 531.049(e) in the strategic plan of the agency that is the subject of the recommendation.

(f) Nothing in this section may be construed to create a cause of action.

(g) The executive commissioner shall develop and, subject to the availability of funds, implement a caseload management reduction plan to reduce, not later than January 1, 2011, caseloads for caseworkers employed by the adult protective services division of the Department of Family and Protective Services to a level that does not exceed professional caseload standards by more than five cases per caseworker. The plan must provide specific annual targets for caseload reduction.

Added by Acts 1997, 75th Leg., ch. 1022, Sec. 99, eff. Sept. 1, 1997. Amended by Acts 2005, 79th Leg., ch. 268, Sec. 2.18(a), eff. Sept. 1, 2005.

Sec. 531.049. CASELOAD STANDARDS ADVISORY COMMITTEES. (a) A caseload standards advisory committee is established in the Department of Protective and Regulatory Services, and a caseload standards advisory committee is established in the Texas Department of Human Services.

(b) A caseload standards advisory committee is composed of 10 employees appointed by the commissioner who are unit supervisors or caseworkers in the agency in which the committee is established. To the extent practicable, a caseload standards advisory committee must include a unit supervisor or caseworker from each program area of the agency in which the committee is established.

(c) The commissioner shall make appointments to a caseload

standards advisory committee from a list submitted by the commissioner or the executive director of the agency in which the committee is established.

(d) Members of a caseload standards advisory committee serve at the pleasure of the commissioner.

(e) Each caseload standards advisory committee shall:

(1) review professional caseload standards and other caseload standards and recommendations the committee considers appropriate and recommend to the commissioner minimum and maximum caseloads for each category of caseworker employed by the agency in which the advisory committee is established; and

(2) advise and make recommendations to the commissioner on granting the agency in which the advisory committee has been established the authority to waive certain reporting standards when the caseload of a caseworker employed by the agency exceeds the maximum number established by the commissioner under Section 531.048(a).

(f) The commissioner shall dissolve a caseload standards advisory committee if the commissioner determines that the caseload standards advisory committee is no longer necessary to develop and implement the standards required under Section 531.048(a).

(g) Except as otherwise provided by this section, a caseload standards advisory committee is subject to Article 6252-33, Revised Statutes.

(h) Nothing in this section may be construed to create a cause of action.

Added by Acts 1997, 75th Leg., ch. 1022, Sec. 100, eff. Sept. 1, 1997.

Sec. 531.050. MINIMUM COLLECTION GOAL. (a) Before August 31 of each year, the commission, after consulting with the Texas Department of Human Services, by rule shall set a minimum goal for the Texas Department of Human Services that specifies the percentage of the amount of benefits granted by the department in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code, that the department should recover. The commission shall set the percentage based on comparable recovery rates reported by other states or other appropriate factors identified by the commission and the department.

(b) If the department fails to meet the goal set under Subsection (a) for the fiscal year, the commissioner shall notify the comptroller, and the comptroller shall reduce the department's general revenue appropriation by an amount equal to the difference between the amount of state funds the department would have collected had the department met the goal and the amount of state funds the department actually collected.

(c) The commission, the governor, and the Legislative Budget Board shall monitor the department's performance in meeting the goal set under this section. The department shall cooperate by providing to the commission, the governor, and the Legislative Budget Board, on request, information concerning the department's collection efforts.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.05(a), eff. June 20, 1997. Renumbered from V.T.C.A., Government Code Sec. 531.047 by Acts 1999, 76th Leg., ch. 62, Sec. 19.01(47), eff. Sept. 1, 1999.

Sec. 531.051. VOUCHER PROGRAM FOR PAYMENT OF CERTAIN SERVICES FOR PERSONS WITH DISABILITIES. (a) In this section:

(1) "Consumer" means a person who receives services under the program established by the commission under this section.

(2) "Personal assistance services" and "respite services" have the meanings assigned by Section 142.001, Health and Safety Code.

(b) The commission shall develop and oversee the implementation of a program in which the use of vouchers is established as a payment option for the delivery of certain state-funded and Medicaid-funded services to persons with disabilities.

(c) In adopting rules for the voucher payment program, the commission shall:

(1) ensure that the program includes the:

(A) delivery to persons with disabilities of personal assistance services, respite services, supported employment services, and other services that the commission with assistance from the work group established under Section 531.052, determines are appropriate and applicable and may be provided with



available funding; and

(B) provision of durable medical equipment and assistive technology to persons with disabilities to the extent funds are available for that purpose;

(2) work in conjunction with the comptroller and appropriate health and human services agencies to develop the program;

(3) design the program in a manner in which, for certain programs considered appropriate by the commission, with assistance from the work group established under Section 531.052, a private entity or local governmental entity applies with and is approved by the Internal Revenue Service to act as the agent for a consumer for the limited purpose of:

(A) computing federal and state employment taxes;

(B) preparing and filing income tax forms and reports; and

(C) distributing money to a service provider after a deduction for employment taxes;

(4) ensure that the program is designed to comply with federal and state tax laws;

(5) ensure that a consumer is the employer of and retains control over the selection, management, and dismissal of an individual providing health care services covered by the program;

(6) establish a system to ensure that a potential consumer has adequate and appropriate information, including the responsibilities of a consumer under each payment option, to make an informed choice among the payment options;

(7) require each consumer to sign a statement acknowledging receipt of the information required by Subdivision (6);

(8) develop a system to monitor the program to ensure:

(A) adherence to existing applicable program standards;

(B) appropriate use of funds; and

(C) consumer satisfaction with the delivery of services;

(9) ensure that a consumer may contract with a service provider acting as the consumer's agent under Subdivision (3) to obtain any necessary services, including services not being provided to the consumer under the program; and

(10) work in conjunction with the work group established under Section 531.052 to set a timetable to implement and complete the program.

(d) The voucher payment program developed under this section may be implemented only in appropriate programs of the Texas Department of Human Services, the Texas Department of Mental Health and Mental Retardation, the Texas Rehabilitation Commission, and the Texas Department of Health.

(e) Each health and human services agency in which the voucher payment program is implemented and the comptroller shall provide information to the commission as necessary to facilitate the development and implementation of the program.

(f) Section 301.251(a), Occupations Code, does not apply to delivery of a service for which payment is provided under the voucher payment program developed under this section if:

(1) the person who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter 301, Occupations Code, that is revoked or suspended; and

(C) provides a service listed under Subsection (h); and

(2) the consumer who receives the service:

(A) has a functional disability and the service would have been performed by the consumer, or the parent or guardian for the consumer, except for that disability; and

(B) if:

(i) the consumer is capable of training the person in the proper performance of the service, the consumer directs the person to deliver the service; or

(ii) the consumer is not capable of training the person in the proper performance of the service, the consumer's parent or guardian is capable of training the person in the proper performance of the service and directs the person to

deliver the service.

(g) If the person delivers the service under Subsection (f)(2)(B)(ii), the parent or guardian must be present when the service is performed or immediately accessible to the person who delivers the service. If the person will perform the service when the parent or guardian is not present, the parent or guardian must observe the person performing the service at least once to assure the parent or guardian that the person performing the service can competently perform that service.

(h) The types of services that may be delivered under Subsection (f) are:

- (1) bathing, including feminine hygiene;
- (2) grooming, including nail care, except for clients with medical conditions like diabetes;
- (3) feeding, including feeding through a permanently placed feeding tube;
- (4) routine skin care, including decubitus Stage 1;
- (5) transferring, ambulation, or positioning;
- (6) exercising and range of motion;
- (7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation, and digital stimulation; and
- (8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube.

Added by Acts 1999, 76th Leg., ch. 1288, Sec. 1, eff. June 18, 1999. Amended by Acts 2001, 77th Leg., ch. 1508, Sec. 1, eff. June 17, 2001; Acts 2003, 78th Leg., ch. 553, Sec. 2.006, eff. Feb. 1, 2004.

Sec. 531.052. CONSUMER DIRECTED SERVICES WORK GROUP.

Text of section effective until September 1, 2007

(a) A work group is created to assist the commission in developing and implementing the voucher payment program under Section 531.051.

(b) The work group is composed of:

- (1) representatives of the commission, appointed by the commissioner;
- (2) representatives of the Texas Department of Human Services, appointed by the commissioner of that agency;
- (3) representatives of the Texas Department of Mental Health and Mental Retardation, appointed by the commissioner of that agency;
- (4) representatives of the Texas Department of Health, appointed by the commissioner of that agency;
- (5) representatives of the Texas Rehabilitation Commission, appointed by the commissioner of that agency;
- (6) consumers of services provided under the voucher payment pilot project under former Section 22.0325, Human Resources Code, jointly appointed by the commissioner and the commissioner of the Texas Department of Human Services;
- (7) persons with disabilities, including persons with mental illness and persons with mental retardation, who are consumers or potential consumers of services provided under the voucher payment program, appointed by the commissioner;
- (8) advocates for persons with disabilities, including persons with mental illness and persons with mental retardation, appointed by the commissioner;
- (9) providers of services to be provided under the voucher payment program, appointed by the commissioner;
- (10) representatives of the Texas Workforce Commission, appointed by the executive director of that commission; and
- (11) representatives of any other state agency as considered necessary by the commissioner, appointed by the governing body of their respective agency.

(c) A majority of the members of the work group must be composed of consumers, advocates, or providers described by Subsection (b).

(d) A member of the work group serves at the will of the appointing agency and receives no additional compensation for serving on the work group.

(e) The commissioner shall appoint a member of the work group to serve as presiding officer, and members of the work group shall elect any other necessary officers. The work group shall meet at the call of the presiding officer.

(f) The work group is not subject to Chapter 2110.

(g) This section expires September 1, 2007.  
Added by Acts 1999, 76th Leg., ch. 1288, Sec. 1, eff. June 18, 1999.  
Amended by Acts 2003, 78th Leg., ch. 799, Sec. 1, 2, eff. Sept. 1, 2003.

Sec. 531.053. LEASES AND SUBLEASES OF CERTAIN OFFICE SPACE. (a) A health and human services agency, with the approval of the commission, or the Texas Workforce Commission or any other state agency that administers employment services programs may sublease office space to a private service entity or lease office space from a private service entity that provides publicly funded health, human, or workforce services to enable agency eligibility and enrollment personnel to work with the entity if:

(1) client access to services would be enhanced; and  
(2) the collocation of offices would improve the efficiency of the administration and delivery of services.

(b) Subchapters D and E, Chapter 2165, do not apply to a state agency that leases office space to a private service entity or subleases office space to a private service entity under this section.

(c) Subchapter B, Chapter 2167, does not apply to a state agency that leases office space from a private service entity or subleases office space from a private service entity under this section.

(d) A state agency is delegated the authority to enter into a lease or sublease under this section and may negotiate the terms of the lease or sublease.

(e) To the extent authorized by federal law, a state agency may share business resources with a private service entity that enters into a lease or sublease agreement with the agency under this section.

Acts 1999, 76th Leg. ch. 1013, Sec. 1, eff. Sept. 1, 1999.  
Renumbered from V.T.C.A., Government Code Sec. 531.051 by Acts 2001, 77th Leg., ch. 1420, Sec. 21.001(46), eff. Sept. 1, 2001.

Sec. 531.054. ASSUMPTION OF LEASES FOR IMPLEMENTATIONS OF INTEGRATED ENROLLMENT SERVICES INITIATIVE. (a) A health and human services agency, with the approval of the commission, or the Texas Workforce Commission or any other state agency that administers employment services programs may assume a lease from an integrated enrollment services initiative contractor or subcontractor for the purpose of implementing the initiative at one development center, one mail center, or 10 or more call or change centers.

(b) Subchapter B, Chapter 2167, does not apply to a state agency that assumes a lease from a contractor or subcontractor under this section.

Added by Acts 1999, 76th Leg., ch. 1013, Sec. 1, eff. Sept. 1, 1999.  
Renumbered from V.T.C.A., Government Code Sec. 531.052 by Acts 2001, 77th Leg., ch. 1420, Sec. 21.001(47), eff. Sept. 1, 2001.

Sec. 531.055. MEMORANDUM OF UNDERSTANDING ON SERVICES FOR PERSONS NEEDING MULTIAGENCY SERVICES. (a) Each health and human services agency, the Texas Council on Offenders with Mental Impairments, the Texas Department of Criminal Justice, the Texas Department of Housing and Community Affairs, the Texas Education Agency, the Texas Workforce Commission, and the Texas Youth Commission shall adopt a joint memorandum of understanding to promote a system of local-level interagency staffing groups to coordinate services for persons needing multiagency services.

(b) The memorandum must:

(1) clarify the statutory responsibilities of each agency in relation to persons needing multiagency services, including subcategories for different services such as prevention, family preservation and strengthening, aging in place, emergency shelter, diagnosis and evaluation, residential care, after-care, information and referral, medical care, and investigation services;

(2) include a functional definition of "persons needing multiagency services";

(3) outline membership, officers, and necessary standing committees of local-level interagency staffing groups;

(4) define procedures aimed at eliminating duplication of services relating to assessment and diagnosis, treatment, residential placement and care, and case management of persons needing multiagency services;

(5) define procedures for addressing disputes between the agencies that relate to the agencies' areas of service responsibilities;

(6) provide that each local-level interagency staffing group includes:

(A) a local representative of each agency;  
(B) representatives of local private sector agencies; and  
(C) family members or caregivers of persons needing multiagency services or other current or previous consumers of multiagency services acting as general consumer advocates;

(7) provide that the local representative of each agency has authority to contribute agency resources to solving problems identified by the local-level interagency staffing group;

(8) provide that if a person's needs exceed the resources of an agency, the agency may, with the consent of the person's legal guardian, if applicable, submit a referral on behalf of the person to the local-level interagency staffing group for consideration;

(9) provide that a local-level interagency staffing group may be called together by a representative of any member agency;

(10) provide that an agency representative may be excused from attending a meeting if the staffing group determines that the age or needs of the person to be considered are clearly not within the agency's service responsibilities, provided that each agency representative is encouraged to attend all meetings to contribute to the collective ability of the staffing group to solve a person's need for multiagency services;

(11) define the relationship between state-level interagency staffing groups and local-level interagency staffing groups in a manner that defines, supports, and maintains local autonomy;

(12) provide that records that are used or developed by a local-level interagency staffing group or its members that relate to a particular person are confidential and may not be released to any other person or agency except as provided by this section or by other law; and

(13) provide a procedure that permits the agencies to share confidential information while preserving the confidential nature of the information.

(c) The agencies that participate in the formulation of the memorandum of understanding shall consult with and solicit input from advocacy and consumer groups.

(d) Each agency shall adopt the memorandum of understanding and all revisions to the memorandum. The agencies shall develop revisions as necessary to reflect major agency reorganizations or statutory changes affecting the agencies.

(e) The agencies shall ensure that a state-level interagency staffing group provides a biennial report to the executive director of each agency, the legislature, and the governor that includes:

(1) the number of persons served through the local-level interagency staffing groups and the outcomes of the services provided;

(2) a description of any barriers identified to the state's ability to provide effective services to persons needing multiagency services; and

(3) any other information relevant to improving the delivery of services to persons needing multiagency services.

Added by Acts 2001, 77th Leg., ch. 114, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.056. REVIEW OF SURVEY PROCESS IN CERTAIN INSTITUTIONS AND FACILITIES. (a) The commission shall adopt procedures to review:

(1) citations or penalties assessed for a violation of a rule or law against an institution or facility licensed under Chapter 242, 247, or 252, Health and Safety Code, or certified in accordance with Chapter 32, Human Resources Code, considering:

(A) the number of violations by geographic region;

(B) the patterns of violations in each region; and

(C) the outcomes following the assessment of a penalty or citation; and

(2) the performance of duties by employees and agents of the Texas Department of Human Services or another state agency responsible for licensing, inspecting, surveying, or investigating institutions and facilities licensed under Chapter 242, 247, or

252, Health and Safety Code, or certified in accordance with Chapter 32, Human Resources Code, related to:

(A) complaints received by the commission; or  
(B) any standards or rules violated by an employee or agent of a state agency.

(b) The commission shall annually report to the speaker of the house of representatives, the lieutenant governor, and the governor on the findings of the review conducted under Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 7.02, eff. June 15, 2001.

Sec. 531.058. INFORMAL DISPUTE RESOLUTION FOR CERTAIN LONG-TERM CARE FACILITIES. (a) The commission by rule shall establish an informal dispute resolution process in accordance with this section. The process must provide for adjudication by an appropriate disinterested person of disputes relating to a proposed enforcement action or related proceeding of the Texas Department of Human Services under Section 32.021(d), Human Resources Code, or Chapter 242, 247, or 252, Health and Safety Code. The informal dispute resolution process must require:

(1) the institution or facility to request informal dispute resolution not later than the 10th calendar day after notification by the department of the violation of a standard or standards;

(2) the commission to complete the process not later than the 30th calendar day after receipt of a request from the institution or facility for informal dispute resolution; and

(3) any individual representing an institution or facility in an informal dispute resolution process to register with the commission and disclose the following:

(A) the individual's employment history during the preceding five years, including employment in regulatory agencies of this state and other states;

(B) ownership, including the identity of the controlling person or persons, of the institution or facility the individual is representing before the commission; and

(C) the identity of other entities the individual represents or has represented before the commission during the previous 24 months.

(b) The commission shall adopt rules to adjudicate claims in contested cases.

(c) The commission may not delegate its responsibility to administer the informal dispute resolution process established by this section to another state agency.

Added by Acts 2001, 77th Leg., ch. 1284, Sec. 7.02, eff. June 15, 2001.

Sec. 531.059. VOUCHER PROGRAM FOR TRANSITIONAL LIVING ASSISTANCE FOR PERSONS WITH DISABILITIES. (a) In this section:

(1) "Institutional housing" means:

(A) an ICF-MR, as defined by Section 531.002, Health and Safety Code;

(B) a nursing facility;

(C) a state hospital, state school, or state center maintained and managed by the Texas Department of Mental Health and Mental Retardation; or

(D) an institution for the mentally retarded licensed or operated by the Department of Protective and Regulatory Services.

(2) "Integrated housing" means housing in which a person with a disability resides or may reside that is found in the community but that is not exclusively occupied by persons with disabilities and their care providers.

(b) Subject to the availability of funds, the commission shall coordinate with the Texas Department of Human Services, the Texas Department of Housing and Community Affairs, and the Texas Department of Mental Health and Mental Retardation to develop a housing assistance program to assist persons with disabilities in moving from institutional housing to integrated housing. In developing the program, the agencies shall address:

(1) eligibility requirements for assistance;

(2) the period during which a person with a disability may receive assistance;

(3) the types of housing expenses to be covered under the program; and

(4) the locations at which the program will be

operated.

(c) Subject to the availability of funds, the commission shall require the Texas Department of Human Services to implement and administer the housing assistance program under this section. The department shall coordinate with the Texas Department of Housing and Community Affairs in implementing and administering the program, determining the availability of funding from the United States Department of Housing and Urban Development, and obtaining those funds.

(d) The Texas Department of Human Services and the Texas Department of Housing and Community Affairs shall provide information to the commission as necessary to facilitate the development and implementation of the housing assistance program. Added by Acts 2001, 77th Leg., ch. 1239, Sec. 3, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(68), eff. Sept. 1, 2003.

Sec. 531.060. FAMILY-BASED ALTERNATIVES FOR CHILDREN. (a) The purpose of the system of family-based alternatives required by this section is to further the state's policy of providing for a child's basic needs for safety, security, and stability through ensuring that a child becomes a part of a successful permanent family as soon as possible.

(b) In achieving the purpose described by Subsection (a), the system is intended to be operated in a manner that recognizes that parents are a valued and integral part of the process established under the system. The system shall encourage parents to participate in all decisions affecting their children and shall respect the authority of parents, other than parents whose parental rights have been terminated, to make decisions regarding their children.

(c) In this section:

(1) "Child" means a person younger than 22 years of age who has a physical or developmental disability or who is medically fragile.

(2) "Family-based alternative" means a family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(3) "Institution" means any congregate care facility, including:

(A) a nursing home;  
(B) an ICF-MR facility, as defined by Section 531.002, Health and Safety Code;  
(C) a group home operated by the Texas Department of Mental Health and Mental Retardation; and  
(D) an institution for the mentally retarded licensed by the Department of Protective and Regulatory Services.

(4) "Waiver services" means services provided under:

(A) the Medically Dependent Children Program;  
(B) the Community Living Assistance and Support Services Program;

(C) the Home and Community-based Waiver Services Program, including the HCS-OBRA Program;

(D) the Mental Retardation-Local Authority Pilot Project (MRLA);

(E) the Deaf, Blind, and Multiply Disabled Program; and

(F) any other Section 1915(c) waiver program that provides long-term care services for children.

(d) The commission shall contract with a community organization, including a faith-based community organization, or a nonprofit organization for the development and implementation of a system under which a child who cannot reside with the child's birth family may receive necessary services in a family-based alternative instead of an institution. To be eligible for the contract under this subsection, an organization must possess knowledge regarding the support needs of children with disabilities and their families. For purposes of this subsection, a community organization, including a faith-based community organization, or a nonprofit organization does not include:

(1) any governmental entity; or  
(2) any quasi-governmental entity to which a state agency delegates its authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

(e) The contractor may subcontract for one or more components of implementation of the system with:

- (1) community organizations, including faith-based community organizations;
- (2) nonprofit organizations;
- (3) governmental entities; or
- (4) quasi-governmental entities to which state agencies delegate authority and responsibility for planning, supervising, providing, or ensuring the provision of state services.

(f) The commission shall begin implementation of the system in areas of this state with high numbers of children who reside in institutions.

(g) Each affected health and human services agency shall cooperate with the contractor and any subcontractors and take all action necessary to implement the system and comply with the requirements of this section. The commission has final authority to make any decisions and resolve any disputes regarding the system.

(h) The system may be administered in cooperation with public and private entities.

(i) The system must provide for:

(1) recruiting and training alternative families to provide services for children;

(2) comprehensively assessing each child in need of services and each alternative family available to provide services, as necessary to identify the most appropriate alternative family for placement of the child;

(3) providing to a child's parents or guardian information regarding the availability of a family-based alternative;

(4) identifying each child residing in an institution and offering support services, including waiver services, that would enable the child to return to the child's birth family or be placed in a family-based alternative; and

(5) determining through a child's permanency plan other circumstances in which the child must be offered waiver services, including circumstances in which changes in an institution's status affect the child's placement or the quality of services received by the child.

(j) In complying with the requirement imposed by Subsection (i)(3), the commission shall ensure that the procedures for providing information to parents or a guardian permit and encourage the participation of an individual who is not affiliated with the institution in which the child resides or with an institution in which the child could be placed.

(k) In placing a child in a family-based alternative, the system may use a variety of placement options, including an arrangement in which shared parenting occurs between the alternative family and the child's birth family. Regardless of the option used, a family-based alternative placement must be designed to be a long-term arrangement, except in cases in which the child's birth family chooses to return the child to their home. In cases in which the birth family's parental rights have been terminated, adoption of the child by the child's alternative family is an available option.

(l) The commission or the contractor may solicit and accept gifts, grants, and donations to support the system's functions under this section.

(m) In designing the system, the commission shall consider and, when appropriate, incorporate current research and recommendations developed by other public and private entities involved in analyzing public policy relating to children residing in institutions.

(n) As necessary to implement this section, the commission shall:

(1) ensure that an appropriate number of openings for waiver services that become available as a result of funding for the purpose of transferring persons with disabilities into community-based services are made available to both children and adults;

(2) ensure that service definitions applicable to waiver services are modified as necessary to permit the provision of waiver services through family-based alternatives;

(3) ensure that procedures are implemented for making

a level of care determination for each child and identifying the most appropriate waiver service for the child, including procedures under which the director of long-term care for the commission, after considering any preference of the child's birth family or alternative family, resolves disputes among agencies about the most appropriate waiver service; and

(4) require that the health and human services agency responsible for providing a specific waiver service to a child also assume responsibility for identifying any necessary transition activities or services.

(o) Not later than January 1 of each year, the commission shall report to the legislature on the implementation of the system. The report must include a statement of:

(1) the number of children currently receiving care in an institution;

(2) the number of children placed in a family-based alternative under the system during the preceding year;

(3) the number of children who left an institution during the preceding year under an arrangement other than a family-based alternative under the system or for another reason unrelated to the availability of a family-based alternative under the system;

(4) the number of children waiting for an available placement in a family-based alternative under the system; and

(5) the number of alternative families trained and available to accept placement of a child under the system.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 2, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(69), eff. Sept. 1, 2003.

Sec. 531.061. PARTICIPATION BY FATHERS. (a) The commission and each health and human services agency shall periodically examine commission or agency policies and procedures to determine if the policies and procedures deter or encourage participation of fathers in commission or agency programs and services relating to children.

(b) Based on the examination required under Subsection (a), the commission and each health and human services agency shall modify policies and procedures as necessary to permit full participation of fathers in commission or agency programs and services relating to children in all appropriate circumstances.

Added by Acts 2001, 77th Leg., ch. 256, Sec. 2, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(70), eff. Sept. 1, 2003.

Sec. 531.062. PILOT PROJECTS RELATING TO TECHNOLOGY APPLICATIONS. (a) Notwithstanding any other law, the commission may establish one or more pilot projects through which reimbursement under the medical assistance program under Chapter 32, Human Resources Code, is made to demonstrate the applications of technology in providing services under that program.

(b) A pilot project established under this section may relate to providing rehabilitation services, services for the aging or disabled, or long-term care services, including community care services and support.

(c) Notwithstanding an eligibility requirement prescribed by any other law or rule, the commission may establish requirements for a person to receive services provided through a pilot project under this section.

(d) Receipt of services provided through a pilot project under this section does not entitle the recipient to other services under a government-funded health program.

(e) The commission may set a maximum enrollment limit for a pilot project established under this section.

Added by Acts 2001, 77th Leg., ch. 959, Sec. 1, eff. June 14, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.055 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(71), eff. Sept. 1, 2003.

Sec. 531.063. CALL CENTERS. (a) The commission, by rule, shall establish at least one but not more than four call centers for purposes of determining and certifying or recertifying a person's eligibility and need for services related to the programs listed under Section 531.008(c), if cost-effective. The commission must conduct a public hearing before establishing the initial call center.

(b) The commission shall contract with at least one but not more than four private entities for the operation of call centers required by this section unless the commission determines that



contracting would not be cost-effective.

(c) Each call center required by this section must be located in this state. This subsection does not prohibit a call center located in this state from processing overflow calls through a center located in another state.

(d) Each call center required by this section shall provide translation services as required by federal law for clients unable to speak, hear, or comprehend the English language.

(e) The commission shall develop consumer service and performance standards for the operation of each call center required by this section. The standards shall address a call center's:

(1) ability to serve its consumers in a timely manner, including consideration of the consumers' ability to access the call center, whether the call center has toll-free telephone access, the average amount of time a consumer spends on hold, the frequency of call transfers, whether a consumer is able to communicate with a live person at the call center, and whether the call center makes mail correspondence available;

(2) staff, including employee courtesy, friendliness, training, and knowledge about the programs listed under Section 531.008(c); and

(3) complaint handling procedures, including the level of difficulty involved in filing a complaint and whether the call center's complaint responses are timely.

(f) The commission shall make available to the public the standards developed under Subsection (e).

(g) The commission shall develop:

(1) mechanisms for measuring consumer service satisfaction; and

(2) performance measures to evaluate whether each call center meets the standards developed under Subsection (e).

(h) The commission may inspect each call center and analyze its consumer service performance through use of a consumer service evaluator who poses as a consumer of the call center.

(i) Notwithstanding Subsection (a), the commissioner shall develop and implement policies that provide an applicant for services related to the programs listed under Section 531.008(c) with an opportunity to appear in person to establish initial eligibility or to comply with periodic eligibility recertification requirements if the applicant requests a personal interview. In implementing the policies, the commission shall maintain offices to serve applicants who request a personal interview. This subsection does not affect a law or rule that requires an applicant to appear in person to establish initial eligibility or to comply with periodic eligibility recertification requirements.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.06, eff. Sept. 1, 2003.

Sec. 531.064. VACCINES FOR CHILDREN PROGRAM PROVIDER ENROLLMENT AND REIMBURSEMENT. (a) In this section, "vaccines for children program" means the program operated by the Texas Department of Health under authority of 42 U.S.C. Section 1396s, as amended.

(b) The commission shall ensure that a provider can enroll in the vaccines for children program on the same form the provider completes to apply as a Medicaid health care provider.

(c) The commission shall allow providers to report vaccines administered under the vaccines for children program to the immunization registry established under Section 161.007, Health and Safety Code, and to use the immunization registry, including individually identifiable information in accordance with state and federal law, to determine whether a child has received an immunization.

Added by Acts 2003, 78th Leg., ch. 613, Sec. 2, eff. Sept. 1, 2003. Renumbered from V.T.C.A., Government Code Sec. 531.063 by Acts 2005, 79th Leg., ch. 728, Sec. 23.001(33), eff. Sept. 1, 2005.

Sec. 531.065. CONSOLIDATION AND COORDINATION OF HEALTH INSURANCE PREMIUM PAYMENT REIMBURSEMENT PROGRAMS. (a) The commission shall develop and implement a plan to consolidate and coordinate the administration of the health insurance premium payment reimbursement programs prescribed by Section 62.059, Health and Safety Code, and Section 32.0422, Human Resources Code.

(b) If cost-effective, the commission may contract with a private entity to assist the commission in developing and implementing a plan required by this section.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.07(a), eff. Sept. 1, 2003.

Sec. 531.067. PUBLIC ASSISTANCE HEALTH BENEFIT REVIEW AND DESIGN COMMITTEE. (a) The commission shall appoint a Public Assistance Health Benefit Review and Design Committee. The committee consists of nine representatives of health care providers participating in the Medicaid program or the child health plan program, or both. The committee membership must include at least three representatives from each program.

(b) The commissioner shall designate one member to serve as presiding officer for a term of two years.

(c) The committee shall meet at the call of the presiding officer.

(d) The committee shall review and provide recommendations to the commission regarding health benefits and coverages provided under the state Medicaid program, the child health plan program, and any other income-based health care program administered by the commission or a health and human services agency. In performing its duties under this subsection, the committee must:

(1) review benefits provided under each of the programs; and

(2) review procedures for addressing high utilization of benefits by recipients.

(e) The commission shall provide administrative support and resources as necessary for the committee to perform its duties under this section.

(f) Section 2110.008 does not apply to the committee.

(g) In performing the duties under this section, the commission may design and implement a program to improve and monitor clinical and functional outcomes of a recipient of services under the state child health plan or medical assistance program. The program may use financial, clinical, and other criteria based on pharmacy, medical services, and other claims data related to the child health plan or the state medical assistance program. The commission must report to the committee on the fiscal impact, including any savings associated with the strategies utilized under this section.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.08, eff. Sept. 1, 2003.

Sec. 531.068. MEDICAID OR OTHER HEALTH BENEFIT COVERAGE. In adopting rules or standards governing the state Medicaid program or rules or standards for the development or implementation of health benefit coverage for a program administered by the commission or a health and human services agency, the commission and each health and human services agency, as appropriate, may take into consideration any recommendation made with respect to health benefits provided under their respective programs or the state Medicaid program by the Public Assistance Health Benefit Review and Design Committee established under Section 531.067.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.09, eff. Sept. 1, 2003.

Sec. 531.069. PERIODIC REVIEW OF VENDOR DRUG PROGRAM. (a) The commission shall periodically review all purchases made under the vendor drug program to determine the cost-effectiveness of including a component for prescription drug benefits in any capitation rate paid by the state under a Medicaid managed care program or the child health plan program.

(b) In making the determination required by Subsection (a), the commission shall consider the value of any prescription drug rebates received by the state.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.10, eff. Sept. 1, 2003.

Sec. 531.070. SUPPLEMENTAL REBATES. (a) In this section:

(1) "Labeler" means a person that:

(A) has a labeler code from the United States Food and Drug Administration under 21 C.F.R. Section 207.20; and

(B) receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

(2) "Manufacturer" means a manufacturer of prescription drugs as defined by 42 U.S.C. Section 1396r-8(k)(5) and its subsequent amendments, including a subsidiary or affiliate of a manufacturer.

(3) "Wholesaler" means a person licensed under Subchapter I, Chapter 431, Health and Safety Code.

(b) For purposes of this section, the term "supplemental rebates" means cash rebates paid by a manufacturer to the state on the basis of appropriate quarterly health and human services program utilization data relating to the manufacturer's products, pursuant to a state supplemental rebate agreement negotiated with the manufacturer and, if necessary, approved by the federal government under Section 1927 of the federal Social Security Act.

(c) The commission may enter into a written agreement with a manufacturer to accept certain program benefits in lieu of supplemental rebates, as defined by this section, only if:

(1) the program benefit yields savings that are at least equal to the amount the manufacturer would have provided under a state supplemental rebate agreement during the current biennium as determined by the written agreement;

(2) the manufacturer posts a performance bond guaranteeing savings to the state, and agrees that if the savings are not achieved in accordance with the written agreement, the manufacturer will forfeit the bond to the state less any savings that were achieved; and

(3) the program benefit is in addition to other program benefits currently offered by the manufacturer to recipients of medical assistance or related programs.

(d) For purposes of this section, a program benefit may mean disease management programs authorized under this title, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to a program operated by a health and human services agency.

(e) Other than as required to satisfy the provisions of this section, the program benefits shall be deemed an alternative to, and not the equivalent of, supplemental rebates and shall be treated in the state's submissions to the federal government (including, as appropriate, waiver requests and quarterly Medicaid claims) so as to maximize the availability of federal matching payments.

(f) Agreements by the commission to accept program benefits as defined by this section:

(1) may not prohibit the commission from entering into similar agreements related to different drug classes with other entities;

(2) shall be limited to a time period expressly determined by the commission; and

(3) may only cover products that have received approval by the Federal Drug Administration at the time of the agreement, and new products approved after the agreement may be incorporated only under an amendment to the agreement.

(g) For purposes of this section, the commission may consider a monetary contribution or donation to the arrangements described in Subsection (c) for the purpose of offsetting expenditures to other state health care programs, but which funding may not be used to offset expenditures for covered outpatient drugs as defined by 42 U.S.C. Section 1396r-8(k)(2) under the vendor drug program. An arrangement under this subsection may not yield less than the amount the state would have benefited under a supplemental rebate. The commission may consider an arrangement under this section as satisfying the requirements related to Section 531.072(b).

(h) Subject to Subsection (i), the commission shall negotiate with manufacturers and labelers, including generic manufacturers and labelers, to obtain supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including community mental health centers and state mental health hospitals.

(i) The commission may by contract authorize a private entity to negotiate with manufacturers and labelers on behalf of the commission.

(j) A manufacturer or labeler that sells prescription drugs in this state may voluntarily negotiate with the commission and enter into an agreement to provide supplemental rebates for

prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including community mental health centers and state mental health hospitals.

(k) In negotiating terms for a supplemental rebate amount, the commission shall consider:

(1) rebates calculated under the Medicaid rebate program in accordance with 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) any other available information on prescription drug prices or rebates; and

(3) other program benefits as specified in Subsection (c).

(1) Each year the commission shall provide a written report to the legislature and the governor. The report shall cover:

(1) the cost of administering the preferred drug lists adopted under Section 531.072;

(2) an analysis of the utilization trends for medical services provided by the state and any correlation to the preferred drug lists;

(3) an analysis of the effect on health outcomes and results for recipients;

(4) statistical information related to the number of approvals granted or denied; and

(5) an analysis of the effect during the preceding year of the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. No. 108-173) on the preferred drug list adopted under Section 531.072 and the prior authorization requirements under Section 531.073 applicable under the Medicaid vendor drug program.

(m) In negotiating terms for a supplemental rebate, the commission shall use the average manufacturer price (AMP), as defined in Section 1396r-8(k)(1) of the Omnibus Budget Reconciliation Act of 1990, as the cost basis for the product.

(n) Prior to or during supplemental rebate agreement negotiations for drugs being considered for the preferred drug list, the commission shall disclose to pharmaceutical manufacturers any clinical edits or clinical protocols that may be imposed on drugs within a particular drug category that are placed on the preferred list during the contract period. Clinical edits will not be imposed for a preferred drug during the contract period unless the above disclosure is made.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.11(a), eff. Sept. 1, 2003. Amended by Acts 2005, 79th Leg., ch. 349, Sec. 16(a), eff. Sept. 1, 2005.

Sec. 531.071. CONFIDENTIALITY OF INFORMATION REGARDING DRUG REBATES, PRICING, AND NEGOTIATIONS. (a) Notwithstanding any other state law, information obtained or maintained by the commission regarding prescription drug rebate negotiations or a supplemental medical assistance or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure under Chapter 552.

(b) Information that is confidential under Subsection (a) includes information described by Subsection (a) that is obtained or maintained by the commission in connection with the Medicaid vendor drug program, the child health plan program, the kidney health care program, the children with special health care needs program, or another state program administered by the commission or a health and human services agency.

(c) General information about the aggregate costs of different classes of drugs is not confidential under Subsection (a).

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.12, eff. Sept. 1, 2003.

Sec. 531.072. PREFERRED DRUG LISTS. (a) In a manner that complies with applicable state and federal law, the commission shall adopt preferred drug lists for the Medicaid vendor drug program and for prescription drugs purchased through the child health plan program. The commission may adopt preferred drug lists for community mental health centers, state mental health hospitals,

and any other state program administered by the commission or a state health and human services agency.

(b) The preferred drug lists may contain only drugs provided by a manufacturer or labeler that reaches an agreement with the commission on supplemental rebates under Section 531.070.

(c) In making a decision regarding the placement of a drug on each of the preferred drug lists, the commission shall consider:

(1) the recommendations of the Pharmaceutical and Therapeutics Committee established under Section 531.074;

(2) the clinical efficacy of the drug;

(3) the price of competing drugs after deducting any federal and state rebate amounts; and

(4) program benefit offerings solely or in conjunction with rebates and other pricing information.

(d) The commission shall provide for the distribution of current copies of the preferred drug lists by posting the list on the Internet. In addition, the commission shall mail copies of the lists to any health care provider on request of that provider.

(e) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 531.070. The commission shall ensure that:

(1) a manufacturer or labeler may submit written evidence supporting the inclusion of a drug on the preferred drug lists before a supplemental agreement is reached with the commission; and

(2) any drug that has been approved or has had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the Pharmaceutical and Therapeutics Committee at the next regularly scheduled meeting of the committee. On receiving notice from a manufacturer or labeler of the availability of a new product, the commission, to the extent possible, shall schedule a review for the product at the next regularly scheduled meeting of the committee.

(f) A recipient of drug benefits under the Medicaid vendor drug program may appeal a denial of prior authorization under Section 531.073 of a covered drug or covered dosage through the Medicaid fair hearing process.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.13(a), eff. Sept. 1, 2003.

Sec. 531.073. PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTION DRUGS. (a) The commission, in its rules and standards governing the Medicaid vendor drug program and the child health plan program, shall require prior authorization for the reimbursement of a drug that is not included in the appropriate preferred drug list adopted under Section 531.072, except for any drug exempted from prior authorization requirements by federal law. The commission may require prior authorization for the reimbursement of a drug provided through any other state program administered by the commission or a state health and human services agency, including a community mental health center and a state mental health hospital if the commission adopts preferred drug lists under Section 531.072 that apply to those facilities and the drug is not included in the appropriate list. The commission shall require that the prior authorization be obtained by the prescribing physician or prescribing practitioner.

(a-1) Until the commission has completed a study evaluating the impact of a requirement of prior authorization on recipients of certain drugs, the commission shall delay requiring prior authorization for drugs that are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies.

(a-2) Not later than the 30th day before the date on which prior authorization requirements are implemented, the commission shall post on the Internet for consumers and providers:

(1) a notification of the implementation date; and

(2) a detailed description of the procedures to be used in obtaining prior authorization.

(b) The commission shall establish procedures for the prior authorization requirement under the Medicaid vendor drug program to ensure that the requirements of 42 U.S.C. Section 1396r-8(d)(5) and its subsequent amendments are met. Specifically, the procedures must ensure that:

(1) a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Pharmaceutical and Therapeutics Committee established under Section 531.074;

(2) there will be a response to a request for prior authorization by telephone or other telecommunications device within 24 hours after receipt of a request for prior authorization; and

(3) a 72-hour supply of the drug prescribed will be provided in an emergency or if the commission does not provide a response within the time required by Subdivision (2).

(c) The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient under the child health plan program, the Medicaid program, or another state program administered by the commission or a health and human services agency or for a person who becomes eligible under the child health plan program, the Medicaid program, or another state program administered by the commission or a health and human services agency is not subject to any requirement for prior authorization under this section unless the recipient has exhausted all the prescription, including any authorized refills, or a period prescribed by the commission has expired, whichever occurs first.

(d) The commission shall implement procedures to ensure that a recipient under the child health plan program, the Medicaid program, or another state program administered by the commission or a person who becomes eligible under the child health plan program, the Medicaid program, or another state program administered by the commission or a health and human services agency receives continuity of care in relation to certain prescriptions identified by the commission.

(e) The commission may by contract authorize a private entity to administer the prior authorization requirements imposed by this section on behalf of the commission.

(f) The commission shall ensure that the prior authorization requirements are implemented in a manner that minimizes the cost to the state and any administrative burden placed on providers.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.14, eff. Sept. 1, 2003.

Sec. 531.074. PHARMACEUTICAL AND THERAPEUTICS COMMITTEE. (a) The Pharmaceutical and Therapeutics Committee is established for the purposes of developing recommendations for preferred drug lists adopted by the commission under Section 531.072.

(b) The committee consists of the following members appointed by the governor:

(1) six physicians licensed under Subtitle B, Title 3, Occupations Code, and participating in the Medicaid program, at least one of whom is a licensed physician who is actively engaged in mental health providing care and treatment to persons with severe mental illness and who has practice experience in the state Medicaid plan; and

(2) five pharmacists licensed under Subtitle J, Title 3, Occupations Code, and participating in the Medicaid vendor drug program.

(c) In making appointments to the committee under Subsection (b), the governor shall ensure that the committee includes physicians and pharmacists who:

(1) represent different specialties and provide services to all segments of the Medicaid program's diverse population;

(2) have experience in either developing or practicing under a preferred drug list; and

(3) do not have contractual relationships, ownership interests, or other conflicts of interest with a pharmaceutical manufacturer or labeler or with an entity engaged by the commission to assist in the development of the preferred drug lists or the administration of the prior authorization system.

(d) A member of the committee is appointed for a two-year term and may serve more than one term.

(e) The governor shall appoint a physician to be the presiding officer of the committee. The presiding officer serves at the pleasure of the governor.

(f) The committee shall meet at least monthly during the

six-month period following establishment of the committee to enable the committee to develop recommendations for the initial preferred drug lists. After that period, the committee shall meet at least quarterly and at other times at the call of the presiding officer or a majority of the committee members.

(g) A member of the committee may not receive compensation for serving on the committee but is entitled to reimbursement for reasonable and necessary travel expenses incurred by the member while conducting the business of the committee, as provided by the General Appropriations Act.

(h) In developing its recommendations for the preferred drug lists, the committee shall consider the clinical efficacy, safety, and cost-effectiveness and any program benefit associated with a product.

(i) The commission shall adopt rules governing the operation of the committee, including rules governing the procedures used by the committee for providing notice of a meeting and rules prohibiting the committee from discussing confidential information described by Section 531.071 in a public meeting. The committee shall comply with the rules adopted under this subsection.

(j) To the extent feasible, the committee shall review all drug classes included in the preferred drug lists adopted under Section 531.072 at least once every 12 months and may recommend inclusions to and exclusions from the lists to ensure that the lists provide for cost-effective medically appropriate drug therapies for Medicaid recipients, children receiving health benefits coverage under the child health plan program, and any other affected individuals.

(k) The commission shall provide administrative support and resources as necessary for the committee to perform its duties.

(l) Chapter 2110 does not apply to the committee.

(m) The commission or the commission's agent shall publicly disclose each specific drug recommended for preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The disclosure must be made in writing after the conclusion of committee deliberations that result in recommendations made to the executive commissioner regarding the placement of drugs on the preferred drug list.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.15(a), eff. Sept. 1, 2003. Amended by Acts 2005, 79th Leg., ch. 349, Sec. 17, eff. Sept. 1, 2005.

Sec. 531.075. PRIOR AUTHORIZATION FOR HIGH-COST MEDICAL SERVICES. The commission may evaluate and implement, as appropriate, procedures, policies, and methodologies to require prior authorization for high-cost medical services and procedures and may contract with qualified service providers or organizations to perform those functions. Any such program shall recognize any prohibitions in state or federal law on limits in the amount, duration, or scope of medically necessary services for children on Medicaid.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.16, eff. Sept. 1, 2003.

Sec. 531.077. RECOVERY OF MEDICAL ASSISTANCE. (a) The commissioner shall ensure that the state Medicaid program implements 42 U.S.C. Section 1396p(b)(1).

(b) The Medicaid account is an account in the general revenue fund. Any funds recovered by implementing 42 U.S.C. Section 1396p(b)(1) shall be deposited in the Medicaid account. Money in the account may be appropriated only to fund long-term care, including community-based care and facility-based care.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.17, eff. Sept. 1, 2003.

Sec. 531.078. POOLED FUNDING FOR FOSTER CARE PREVENTIVE SERVICES.

Text of section as added by Acts 2005, 79th Leg., ch. 268, Sec.

1.70(a)

(a) The commission and the Department of Family and Protective Services shall develop and implement a plan to combine, to the extent and in the manner allowed by Section 51, Article III, Texas Constitution, and other applicable law, funds of those agencies with funds of other appropriate state agencies and local governmental entities to provide services designed to prevent children from being placed in foster care. The preventive services may include:

- (1) child and family counseling;
- (2) instruction in parenting and homemaking skills;
- (3) parental support services;
- (4) temporary respite care; and
- (5) crisis services.

(b) The plan must provide for:

(1) state funding to be distributed to other state agencies, local governmental entities, or private entities only as specifically directed by the terms of a grant or contract to provide preventive services;

(2) procedures to ensure that funds received by the commission by gift, grant, or interagency or interlocal contract from another state agency, a local governmental entity, the federal government, or any other public or private source for purposes of this section are disbursed in accordance with the terms under which the commission received the funds; and

(3) a reporting mechanism to ensure appropriate use of funds.

(c) For the purposes of this section, the commission may request and accept gifts and grants under the terms of a gift, grant, or contract from a local governmental entity, a private entity, or any other public or private source for use in providing services designed to prevent children from being placed in foster care. If required by the terms of a gift, grant, or contract or by applicable law, the commission shall use the amounts received:

(1) from a local governmental entity to provide the services in the geographic area of this state in which the entity is located; and

(2) from the federal government or a private entity to provide the services statewide or in a particular geographic area of this state.

Added by Acts 2005, 79th Leg., ch. 268, Sec. 1.70(a), eff. Sept. 1, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 896, Sec. 1, and Acts 2005, 79th Leg., ch. 1008, Sec. 3.01, see Sec. 531.078, post.

Sec. 531.078. QUALITY ASSURANCE FEES ON CERTAIN WAIVER PROGRAM SERVICES.

Text of section as added by Acts 2005, 79th Leg., ch. 896, Sec. 1

(a) In this section, "gross receipts" means money received as compensation for services under an intermediate care facilities for the mentally retarded waiver program such as a home and community services waiver or a community living assistance and support services waiver. The term does not include a charitable contribution, revenues received for services or goods other than waivers, or any money received from consumers or their families as reimbursement for services or goods not normally covered by the waivers.

(b) The executive commissioner by rule shall modify the quality assurance fee program under Subchapter H, Chapter 252, Health and Safety Code, by providing for a quality assurance fee program that imposes a quality assurance fee on persons providing services under a home and community services waiver or a community living assistance and support services waiver.

(c) The executive commissioner shall establish the fee at an amount that will produce annual revenues of not more than six percent of the total annual gross receipts in this state.

(d) The executive commissioner shall adopt rules governing:

(1) the reporting required to compute and collect the fee and the manner and times of collecting the fee; and

(2) the administration of the fee, including the imposition of penalties for a violation of the rules.

(e) Fees collected under this section shall be deposited in the waiver program quality assurance fee account.

Added by Acts 2005, 79th Leg., ch. 896, Sec. 1, eff. June 17, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 268, Sec. 1.70(a), see Sec. 531.078, ante, and for text of section as added by Acts 2005, 79th Leg., ch. 1008, Sec. 3.01, see Sec. 531.078, post.

#### Expiration

Government Code Secs. 531.078 to 531.082 expire if Subchapter H, Chapter 252, Health and Safety Code expires pursuant to the terms of Sec. 531.082.

Sec. 531.078. CERTAIN MEDICATION FOR SEX OFFENDERS PROHIBITED.

Text of section as added by Acts 2005, 79th Leg., ch. 1008, Sec.



3.01

(a) To the maximum extent allowable under federal law, the commission may not provide sexual performance enhancing medication under the Medicaid vendor drug program or any other health and human services program to a person required to register as a sex offender under Chapter 62, Code of Criminal Procedure.

(b) The executive commissioner of the Health and Human Services Commission may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., ch. 1008, Sec. 3.01, eff. Sept. 1, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 268, Sec. 1.70(a), and Acts 2005, 79th Leg., ch. 896, Sec. 1, see Sec. 531.078, ante.

Sec. 531.079. WAIVER PROGRAM QUALITY ASSURANCE FEE ACCOUNT. (a) The waiver program quality assurance fee account is a dedicated account in the general revenue fund. The account is exempt from the application of Section 403.095. Interest earned on money in the account shall be credited to the account.

(b) The account consists of fees collected under Section 531.078 and interest earned on money in the account.

(c) Subject to legislative appropriation and state and federal law, money in the account may be appropriated only to the Department of Aging and Disability Services to increase reimbursement rates paid under the home and community services waiver program or the community living assistance and support services waiver program or to offset allowable expenses under the state Medicaid program.

Added by Acts 2005, 79th Leg., ch. 896, Sec. 1, eff. June 17, 2005.

Expiration

Government Code Secs. 531.078 to 531.082 expire if Subchapter H, Chapter 252, Health and Safety Code expires pursuant to the terms of Sec. 531.082.

Sec. 531.080. INTEGRATED BENEFITS ISSUANCE.

Text of section as added by Acts 2005, 79th Leg., ch. 666, Sec. 1.

(a) The commission may develop and implement a method to consolidate, to the extent possible, recipient identification and benefits issuance for the commission and health and human services agencies if the commission determines that the implementation would be feasible and cost-effective.

(b) The method may:

(1) provide for the use of a single integrated benefits issuance card or multiple cards capable of integrating benefits issuance or other program functions;

(2) incorporate a fingerprint image identifier to enable personal identity verification at a point of service and reduce fraud as permitted by Section 531.1063;

(3) enable immediate electronic verification of recipient eligibility; and

(4) replace multiple forms, cards, or other methods used for fraud reduction or provision of health and human services benefits, including:

(A) electronic benefits transfer cards; and

(B) smart cards used in the Medicaid program.

(c) In developing and implementing the method, the commission shall:

(1) to the extent possible, use industry-standard communication, messaging, and electronic benefits transfer protocols;

(2) ensure that all identifying and descriptive information of recipients of each health and human services program included in the method can only be accessed by providers or other entities participating in the particular program;

(3) ensure that a provider or other entity participating in a health and human services program included in the method cannot identify whether a recipient of the program is receiving benefits under another program included in the method; and

(4) ensure that the storage and communication of all identifying and descriptive information included in the method complies with existing federal and state privacy laws governing individually identifiable information for recipients of public benefits programs.

Added by Acts 2005, 79th Leg., ch. 666, Sec. 1, eff. June 17, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 896, Sec.

1, and Acts 2005, 79th Leg., ch. 899, Sec. 6.01, see Sec. 531.080, post.

Sec. 531.080. REIMBURSEMENT OF WAIVER PROGRAMS.

Text of section as added by Acts 2005, 79th Leg., ch. 896, Sec. 1.

Subject to legislative appropriation and state and federal law, the Department of Aging and Disability Services shall use money from the waiver program quality assurance fee account, together with any federal money available to match money from the account, to increase reimbursement rates paid under the home and community services waiver program or the community living assistance and support services waiver program.

Added by Acts 2005, 79th Leg., ch. 896, Sec. 1, eff. June 17, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 666, Sec. 1, see Sec. 531.080, ante.

For text of section as added by Acts 2005, 79th Leg., ch. 899, Sec. 6.01, see Sec. 531.080, post.

Expiration

Government Code Secs. 531.078 to 531.082 expire if Subchapter H, Chapter 252, Health and Safety Code expires pursuant to the terms of Sec. 531.082.

Sec. 531.080. JOINT PURCHASING OF PRESCRIPTION DRUGS AND OTHER MEDICATIONS.

Text of section as added by Acts 2005, 79th Leg., ch. 899, Sec. 6.01.

(a) Subject to Subsection (b), the commission and each health and human services agency authorized by the executive commissioner may enter into an agreement with one or more other states for the joint bulk purchasing of prescription drugs and other medications to be used in the Medicaid program, the state child health plan, or another program under the authority of the commission.

(b) An agreement under this section may not be entered into until:

(1) the commission determines that entering into the agreement would be feasible and cost-effective; and

(2) if appropriated money would be spent under the proposed agreement, the governor and the Legislative Budget Board grant prior approval to expend appropriated money under the proposed agreement.

(c) If an agreement is entered into, the commission shall adopt procedures applicable to an agreement and joint purchase required by this section. The procedures must ensure that this state receives:

(1) all prescription drugs and other medications purchased with money provided by this state; and

(2) an equitable share of any price benefits resulting from the joint bulk purchase.

(d) In determining the feasibility and cost-effectiveness of entering into an agreement under this section, the commission shall identify:

(1) the most cost-effective existing joint bulk purchasing agreement; and

(2) any potential groups of states with which this state could enter into a new cost-effective joint bulk purchasing agreement.

Added by Acts 2005, 79th Leg., ch. 899, Sec. 6.01, eff. Aug. 29, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 666, Sec. 1, and Acts 2005, 79th Leg., ch. 896, Sec. 1, see Sec. 531.080, ante.

Sec. 531.081. INVALIDITY; FEDERAL FUNDS. If any portion of Sections 531.078-531.080 is held invalid by a final order of a court that is not subject to appeal, or if the commission determines that the imposition of the quality assurance fee and the expenditure of the money collected as provided by those sections will not entitle this state to receive additional federal money under the Medicaid program, the commission shall:

(1) stop collection of the quality assurance fee; and

(2) not later than the 30th day after the date the collection of the quality assurance fee is stopped, return any money collected under Section 531.078, but not spent under Section 531.080, to the persons who paid the fees in proportion to the total amount paid by those persons.

Added by Acts 2005, 79th Leg., ch. 896, Sec. 1, eff. June 17, 2005.

Expiration

Government Code Secs. 531.078 to 531.082 expire if Subchapter H, Chapter 252, Health and Safety Code expires pursuant to the terms of Sec. 531.082.

Sec. 531.082. EXPIRATION OF QUALITY ASSURANCE FEE ON WAIVER PROGRAMS.

Text of section as added by Acts 2005, 79th Leg., ch. 896, Sec. 1

If Subchapter H, Chapter 252, Health and Safety Code, expires, this section and Sections 531.078-531.081 expire on the same date.

Added by Acts 2005, 79th Leg., eff. June 17, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 985, Sec. 1, see Sec. 531.082, post.

Expiration

Government Code Secs. 531.078 to 531.082 expire if Subchapter H, Chapter 252, Health and Safety Code expires pursuant to the terms of Sec. 531.082.

Sec. 531.082. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES.

Text of section as added by Acts 2005, 79th Leg., ch. 985, Sec. 1.

(a) The commission shall quantify the amount of money appropriated by the legislature that would have been spent during the remainder of a state fiscal biennium to care for a person who lives in a nursing facility but who is leaving that facility before the end of the biennium to live in the community with the assistance of community-based services.

(b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the executive commissioner shall direct, as appropriate:

(1) the comptroller, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection among the health and human services agencies and the commission as necessary to comply with this section; or

(2) the commission or a health and human services agency, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection within the agency's budget as necessary to comply with this section.

(c) The commission shall ensure that the amount transferred under this section is redirected by the commission or health and human services agency, as applicable, to one or more community-based programs in the amount necessary to provide community-based services to the person after the person leaves the nursing facility.

Added by Acts 2005, 79th Leg., ch. 985, Sec. 1, eff. Sept. 1, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 896, Sec. 1, see Sec. 531.082, ante.

Sec. 531.083. MEDICAID LONG-TERM CARE SYSTEM. The commission shall ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds. The commission shall also make every effort to improve the quality of care for recipients of Medicaid long-term care services by:

(1) evaluating the need for expanding the provider base for consumer-directed services and, if the commission identifies a demand for that expansion, encouraging area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with the Department of Aging and Disability Services;

(2) ensuring that all recipients who reside in a nursing facility are provided information about end-of-life care options and the importance of planning for end-of-life care; and

(3) developing policies to encourage a recipient who resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an appropriate continuum of care.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 5(a), eff. Sept. 1, 2005.

Sec. 531.084. MEDICAID LONG-TERM CARE COST CONTAINMENT STRATEGIES. (a) The commission shall make every effort to achieve cost efficiencies within the Medicaid long-term care program. To achieve those efficiencies, the commission shall:

(1) establish a fee schedule for reimbursable incurred medical expenses for dental services controlled in long-term care

facilities;

(2) implement a fee schedule for reimbursable incurred medical expenses for durable medical equipment in nursing facilities and ICF-MR facilities;

(3) implement a durable medical equipment fee schedule action plan;

(4) establish a system for private contractors to secure and coordinate the collection of Medicare funds for recipients who are dually eligible for Medicare and Medicaid;

(5) create additional partnerships with pharmaceutical companies to obtain discounted prescription drugs for Medicaid recipients; and

(6) develop and implement a system for auditing the Medicaid hospice care system that provides services in long-term care facilities to ensure correct billing for pharmaceuticals.

(b) The executive commissioner and the commissioner of aging and disability services shall jointly appoint persons to serve on a work group to assist the commission in developing the fee schedule required by Subsection (a)(1). The work group must consist of providers of long-term care services, including dentists and long-term care advocates.

(c) In developing the fee schedule required by Subsection (a)(1), the commission shall consider:

(1) the need to ensure access to dental services for residents of long-term care facilities who are unable to travel to a dental office to obtain care;

(2) the most recent Comprehensive Fee Report published by the National Dental Advisory Service;

(3) the difficulty of providing dental services in long-term care facilities;

(4) the complexity of treating medically compromised patients; and

(5) time-related and travel-related costs incurred by dentists providing dental services in long-term care facilities.

(d) The commission shall annually update the fee schedule required by Subsection (a)(1).

Added by Acts 2005, 79th Leg., ch. 349, Sec. 5(a), eff. Sept. 1, 2005.

Sec. 531.085. HOSPITAL EMERGENCY ROOM USE REDUCTION INITIATIVES. The commission shall develop and implement a comprehensive plan to reduce the use of hospital emergency room services by recipients under the medical assistance program. The plan may include:

(1) a pilot program designed to facilitate program participants in accessing an appropriate level of health care, which may include as components:

(A) providing program participants access to bilingual health services providers; and

(B) giving program participants information on how to access primary care physicians, advanced practice nurses, and local health clinics;

(2) a pilot program under which health care providers, other than hospitals, are given financial incentives for treating recipients outside of normal business hours to divert those recipients from hospital emergency rooms;

(3) payment of a nominal referral fee to hospital emergency rooms that perform an initial medical evaluation of a recipient and subsequently refer the recipient, if medically stable, to an appropriate level of health care, such as care provided by a primary care physician, advanced practice nurse, or local clinic;

(4) a program under which the commission or a managed care organization that enters into a contract with the commission under Chapter 533 contacts, by telephone or mail, a recipient who accesses a hospital emergency room three times during a six-month period and provides the recipient with information on ways the recipient may secure a medical home to avoid unnecessary treatment at hospital emergency rooms;

(5) a health care literacy program under which the commission develops partnerships with other state agencies and private entities to:

(A) assist the commission in developing materials that:

(i) contain basic health care information for parents of young children who are recipients under the medical

assistance program and who are participating in public or private child-care or prekindergarten programs, including federal Head Start programs; and

(ii) are written in a language understandable to those parents and specifically tailored to be applicable to the needs of those parents;

(B) distribute the materials developed under Paragraph (A) to those parents; and

(C) otherwise teach those parents about the health care needs of their children and ways to address those needs; and

(6) other initiatives developed and implemented in other states that have shown success in reducing the incidence of unnecessary treatment in hospital emergency rooms.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 12(a), eff. Sept. 1, 2005.

Sec. 531.086. PERFORMANCE BONUS PILOT PROGRAM.

Text of section effective until September 1, 2007

(a) The commission shall develop a proposal for providing higher reimbursement rates to primary care case management providers under the Medicaid program who treat program recipients with chronic health conditions in accordance with evidence-based, nationally accepted best practices and standards of care.

(b) The commission shall define the parameters of the proposed program, including:

(1) the types of chronic health conditions the program would target;

(2) the best practices and standards of care that must be followed for a provider to obtain a higher reimbursement rate under the proposed program; and

(3) the types of providers to whom the higher reimbursement rate would be offered under the proposed program.

(c) Not later than December 1, 2006, the Health and Human Services Commission shall report to the standing committees of the senate and the house of representatives having primary jurisdiction over welfare programs regarding the proposed program under this section. The report must include:

(1) the anticipated effect of the higher reimbursement rates to be offered under the program on the quality of care provided and the health outcomes for program recipients;

(2) a determination of whether the program would be cost-effective; and

(3) a recommendation regarding implementation of the program.

(d) This section expires September 1, 2007.

Added by Acts 2005, 79th Leg., ch. 349, Sec. 13, eff. Sept. 1, 2005.

Sec. 531.087. DISTRIBUTION OF EARNED INCOME TAX CREDIT INFORMATION. (a) The commission shall ensure that educational materials relating to the federal earned income tax credit are provided in accordance with this section to each person receiving assistance or benefits under:

(1) the child health plan program;

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

(3) the medical assistance program under Chapter 32, Human Resources Code;

(4) the food stamp program under Chapter 33, Human Resources Code; or

(5) another appropriate health and human services program.

(b) In accordance with Section 531.0317, the commission shall, by mail or through the Internet, provide a person described by Subsection (a) with access to:

(1) Internal Revenue Service publications relating to the federal earned income tax credit or information prepared by the comptroller under Section 403.025 relating to that credit;

(2) federal income tax forms necessary to claim the federal earned income tax credit; and

(3) where feasible, the location of at least one program in close geographic proximity to the person that provides free federal income tax preparation services to low-income and other eligible persons.

(c) In January of each year, the commission or a representative of the commission shall mail to each person described by Subsection (a) information about the federal earned

income tax credit that provides the person with referrals to the resources described by Subsection (b).

Added by Acts 2005, 79th Leg., ch. 925, Sec. 2, eff. Sept. 1, 2005.

SUBCHAPTER C. MEDICAID AND OTHER HEALTH AND HUMAN SERVICES FRAUD,  
ABUSE, OR OVERCHARGES

Sec. 531.101. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may grant an award to an individual who reports activity that constitutes fraud or abuse of funds in the state Medicaid program or reports overcharges in the program if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity reported by the individual.

(b) The commission shall determine the amount of an award. The award may not exceed five percent of the amount of the administrative penalty imposed under Section 32.039, Human Resources Code, that resulted from the individual's disclosure. In determining the amount of the award, the commission shall consider how important the disclosure is in ensuring the fiscal integrity of the program. The commission may also consider whether the individual participated in the fraud, abuse, or overcharge.

(c) A person who brings an action under Subchapter C, Chapter 36, Human Resources Code, is not eligible for an award under this section.

Added by Acts 1997, 75th Leg., ch. 165, Sec. 14.16, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.18(a), eff. Sept. 1, 2003.

Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:

(1) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law.

(2) "Furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual (either as an employee or in the individual's own capacity), a provider, or other supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

(3) "Hold on payment" means the temporary denial of reimbursement under the Medicaid program for items or services furnished by a specified provider.

(4) "Practitioner" means a physician or other individual licensed under state law to practice the individual's profession.

(5) "Program exclusion" means the suspension of a provider from being authorized under the Medicaid program to request reimbursement of items or services furnished by that specific provider.

(6) "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

(A) provide medical assistance under contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.37A, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 257, Sec. 8, eff. Sept. 1, 2003.

Sec. 531.102. OFFICE OF INSPECTOR GENERAL. (a) The commission, through the commission's office of inspector general, is responsible for the investigation of fraud and abuse in the provision of health and human services and the enforcement of state law relating to the provision of those services. The commission may obtain any information or technology necessary to enable the office to meet its responsibilities under this subchapter or other law.

(a-1) The governor shall appoint an inspector general to serve as director of the office. The inspector general serves a one-year term that expires on February 1.

(b) The commission, in consultation with the inspector general, shall set clear objectives, priorities, and performance standards for the office that emphasize:

(1) coordinating investigative efforts to aggressively recover money;

(2) allocating resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and

(3) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 531.103.

(c) The commission shall train office staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.

(d) The commission may require employees of health and human services agencies to provide assistance to the office in connection with the office's duties relating to the investigation of fraud and abuse in the provision of health and human services. The office is entitled to access to any information maintained by a health and human services agency, including internal records, relevant to the functions of the office.

(e) The commission, in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office to begin an investigation.

(f)(1) If the commission receives a complaint of Medicaid fraud or abuse from any source, the office must conduct an integrity review to determine whether there is sufficient basis to warrant a full investigation. An integrity review must begin not later than the 30th day after the date the commission receives a complaint or has reason to believe that fraud or abuse has occurred. An integrity review shall be completed not later than the 90th day after it began.

(2) If the findings of an integrity review give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the office must take the following action, as appropriate, not later than the 30th day after the completion of the integrity review:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions; or

(B) if there is reason to believe that a recipient has defrauded the Medicaid program, the office may conduct a full investigation of the suspected fraud.

(g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(2) In addition to other instances authorized under state or federal law, the office shall impose without prior notice a hold on payment of claims for reimbursement submitted by a provider to compel production of records or when requested by the state's Medicaid fraud control unit, as applicable. The office must notify the provider of the hold on payment not later than the fifth working day after the date the payment hold is imposed.

(3) On timely written request by a provider subject to a hold on payment under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold. The provider must request an expedited hearing under this subdivision not later than the 10th day after the date the provider receives notice from the office under Subdivision (2).

(4) The commission shall adopt rules that allow a provider subject to a hold on payment under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must seek an informal resolution under this subdivision not later than the deadline prescribed by Subdivision (3). A provider's decision to seek an informal resolution under this subdivision does not extend the time by which the provider must request an expedited

administrative hearing under Subdivision (3). However, a hearing initiated under Subdivision (3) shall be stayed at the office's request until the informal resolution process is completed.

(5) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which holds on payment or program exclusions:

(A) may permissively be imposed on a provider;  
or

(B) shall automatically be imposed on a provider.

(h) In addition to performing functions and duties otherwise provided by law, the office may:

(1) assess administrative penalties otherwise authorized by law on behalf of the commission or a health and human services agency;

(2) request that the attorney general obtain an injunction to prevent a person from disposing of an asset identified by the office as potentially subject to recovery by the office due to the person's fraud or abuse;

(3) provide for coordination between the office and special investigative units formed by managed care organizations under Section 531.113 or entities with which managed care organizations contract under that section;

(4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from a health and human services agency;

(5) conduct investigations relating to the funds described by Subdivision (4); and

(6) recommend policies promoting economical and efficient administration of the funds described by Subdivision (4) and the prevention and detection of fraud and abuse in administration of those funds.

(i) Notwithstanding any other provision of law, a reference in law or rule to the commission's office of investigations and enforcement means the office of inspector general established under this section.

(j) The office shall prepare a final report on each audit or investigation conducted under this section. The final report must include:

(1) a summary of the activities performed by the office in conducting the audit or investigation;

(2) a statement regarding whether the audit or investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(k) A final report on an audit or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit or investigation remain confidential and not subject to required disclosure in accordance with Section 531.1021(g).

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 1289, Sec. 3, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 2.19(a), eff. Sept. 1, 2003; Acts 2005, 79th Leg., ch. 349, Sec. 18(a), eff. Sept. 1, 2005.

Sec. 531.1021. SUBPOENAS. (a) The office of inspector general may request that the commissioner or the commissioner's designee approve the issuance by the office of a subpoena in connection with an investigation conducted by the office. If the request is approved, the office may issue a subpoena to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence that is in this state.

(b) A subpoena may be served personally or by certified mail.

(c) If a person fails to comply with a subpoena, the office, acting through the attorney general, may file suit to enforce the subpoena in a district court in this state.

(d) On finding that good cause exists for issuing the subpoena, the court shall order the person to comply with the subpoena. The court may punish a person who fails to obey the court order.

(e) The office shall pay a reasonable fee for photocopies subpoenaed under this section in an amount not to exceed the amount the office may charge for copies of its records.

(f) The reimbursement of the expenses of a witness whose attendance is compelled under this section is governed by Section



2001.103.

(g) All information and materials subpoenaed or compiled by the office in connection with an audit or investigation are confidential and not subject to disclosure under Chapter 552, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the office or its employees or agents involved in the audit or investigation conducted by the office, except that this information may be disclosed to the office of the attorney general, the state auditor's office, and law enforcement agencies.

(h) A person who receives information under Subsection (g) may disclose the information only in accordance with Subsection (g) and in a manner that is consistent with the authorized purpose for which the person first received the information.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.20, eff. Sept. 1, 2003. Amended by Acts 2005, 79th Leg., ch. 349, Sec. 18(b), eff. Sept. 1, 2005.

Sec. 531.103. INTERAGENCY COORDINATION. (a) The commission, acting through the commission's office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law, or other violations of state or federal law under the state Medicaid program or other program administered by the commission or a health and human services agency, including the financial assistance program under Chapter 31, Human Resources Code, a nutritional assistance program under Chapter 33, Human Resources Code, and the child health plan program. The memorandum of understanding shall require:

(1) the office of inspector general and the office of the attorney general to set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to enhance deterrence of fraud, waste, abuse, or other violations of state or federal law, including a violation of Chapter 102, Occupations Code, in the programs and maximize the imposition of penalties, the recovery of money, and the successful prosecution of cases;

(1-a) the office of inspector general to refer each case of suspected provider fraud, waste, or abuse to the office of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(1-b) the office of the attorney general to take appropriate action in response to each case referred to the attorney general, which action may include direct initiation of prosecution, with the consent of the appropriate local district or county attorney, direct initiation of civil litigation, referral to an appropriate United States attorney, a district attorney, or a county attorney, or referral to a collections agency for initiation of civil litigation or other appropriate action;

(2) the office of inspector general to keep detailed records for cases processed by that office or the office of the attorney general, including information on the total number of cases processed and, for each case:

(A) the agency and division to which the case is referred for investigation;

(B) the date on which the case is referred; and

(C) the nature of the suspected fraud, waste, or abuse;

(3) the office of inspector general to notify each appropriate division of the office of the attorney general of each case referred by the office of inspector general;

(4) the office of the attorney general to ensure that information relating to each case investigated by that office is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse;

(5) the office of the attorney general to notify the office of inspector general of each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(6) representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case; and

(7) the office of inspector general and the office of

the attorney general to submit information requested by the comptroller about each resolved case for the comptroller's use in improving fraud detection.

(b) An exchange of information under this section between the office of the attorney general and the commission, the office of inspector general, or a health and human services agency does not affect whether the information is subject to disclosure under Chapter 552.

(c) The commission and the office of the attorney general shall jointly prepare and submit a semiannual report to the governor, lieutenant governor, speaker of the house of representatives, and comptroller concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under the state Medicaid program or other program administered by the commission or a health and human services agency. The report may be consolidated with any other report relating to the same subject matter the commission or office of the attorney general is required to submit under other law.

(d) The commission and the office of the attorney general may not assess or collect investigation and attorney's fees on behalf of any state agency unless the office of the attorney general or other state agency collects a penalty, restitution, or other reimbursement payment to the state.

(e) In addition to the provisions required by Subsection (a), the memorandum of understanding required by this section must also ensure that no barriers to direct fraud referrals to the office of the attorney general's Medicaid fraud control unit or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are imposed, and must include procedures to facilitate the referral of cases directly to the office of the attorney general.

(f) A district attorney, county attorney, city attorney, or private collection agency may collect and retain costs associated with a case referred to the attorney or agency in accordance with procedures adopted under this section and 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.21(a), eff. Sept. 1, 2003.

Sec. 531.104. ASSISTING INVESTIGATIONS BY ATTORNEY GENERAL. (a) The commission and the attorney general shall execute a memorandum of understanding under which the commission shall provide investigative support as required to the attorney general in connection with cases under Subchapter B, Chapter 36, Human Resources Code. Under the memorandum of understanding, the commission shall assist in performing preliminary investigations and ongoing investigations for actions prosecuted by the attorney general under Subchapter C, Chapter 36, Human Resources Code.

(b) The memorandum of understanding must specify the type, scope, and format of the investigative support provided to the attorney general under this section.

(c) The memorandum of understanding must ensure that no barriers to direct fraud referrals to the state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the state's Medicaid fraud control unit will be imposed.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997. Amended by Acts 2003 78th Leg., ch. 198, Sec. 2.22, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 257, Sec. 11, eff. Sept. 1, 2003.

Sec. 531.105. FRAUD DETECTION TRAINING. (a) The commission shall develop and implement a program to provide annual training to contractors who process Medicaid claims and appropriate staff of the Texas Department of Health and the Texas Department of Human Services in identifying potential cases of fraud, waste, or abuse under the state Medicaid program. The training provided to the contractors and staff must include clear criteria that specify:

(1) the circumstances under which a person should refer a potential case to the commission; and

(2) the time by which a referral should be made.

(b) The Texas Department of Health and the Texas Department of Human Services, in cooperation with the commission, shall periodically set a goal of the number of potential cases of fraud, waste, or abuse under the state Medicaid program that each agency

will attempt to identify and refer to the commission. The commission shall include information on the agencies' goals and the success of each agency in meeting the agency's goal in the report required by Section 531.103(c).

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997.

Sec. 531.106. LEARNING OR NEURAL NETWORK TECHNOLOGY. (a) The commission shall use learning or neural network technology to identify and deter fraud in the Medicaid program throughout this state.

(b) The commission shall contract with a private or public entity to develop and implement the technology. The commission may require the entity it contracts with to install and operate the technology at locations specified by the commission, including commission offices.

(c) The data used for neural network processing shall be maintained as an independent subset for security purposes.

(d) The commission shall require each health and human services agency that performs any aspect of the state Medicaid program to participate in the implementation and use of the technology.

(e) The commission shall maintain all information necessary to apply the technology to claims data covering a period of at least two years.

(f) The commission shall refer cases identified by the technology to the commission's office of investigations and enforcement or the office of the attorney general, as appropriate.

(g) Each month, the learning or neural network technology implemented under this section must match bureau of vital statistics death records with Medicaid claims filed by a provider. If the commission determines that a provider has filed a claim for services provided to a person after the person's date of death, as determined by the bureau of vital statistics death records, the commission shall refer the case for investigation to the commission's office of investigations and enforcement.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 215, Sec. 2, eff. Sept. 1, 1999.

Sec. 531.1061. FRAUD INVESTIGATION TRACKING SYSTEM. (a) The commission shall use an automated fraud investigation tracking system through the commission's office of investigations and enforcement to monitor the progress of an investigation of suspected fraud, abuse, or insufficient quality of care under the state Medicaid program.

(b) For each case of suspected fraud, abuse, or insufficient quality of care identified by the learning or neural network technology required under Section 531.106, the automated fraud investigation tracking system must:

(1) receive electronically transferred records relating to the identified case from the learning or neural network technology;

(2) record the details and monitor the status of an investigation of the identified case, including maintaining a record of the beginning and completion dates for each phase of the case investigation;

(3) generate documents and reports related to the status of the case investigation; and

(4) generate standard letters to a provider regarding the status or outcome of an investigation.

(c) The commission shall require each health and human services agency that performs any aspect of the state Medicaid program to participate in the implementation and use of the automated fraud investigation tracking system.

Added by Acts 1999, 76th Leg., ch. 206, Sec. 1, eff. Sept. 1, 1999.

Sec. 531.1062. RECOVERY MONITORING SYSTEM. (a) The commission shall use an automated recovery monitoring system to monitor the collections process for a settled case of fraud, abuse, or insufficient quality of care under the state Medicaid program.

(b) The recovery monitoring system must:

(1) monitor the collection of funds resulting from settled cases, including:

(A) recording monetary payments received from a provider who has agreed to a monetary payment plan; and

(B) recording deductions taken through the recoupment program from subsequent Medicaid claims filed by the

provider; and

(2) provide immediate notice of a provider who has agreed to a monetary payment plan or to deductions through the recoupment program from subsequent Medicaid claims who fails to comply with the settlement agreement, including providing notice of a provider who does not make a scheduled payment or who pays less than the scheduled amount.

Added by Acts 1999, 76th Leg., ch. 206, Sec. 1, eff. Sept. 1, 1999.

Sec. 531.1063. MEDICAID FRAUD PILOT PROGRAM. (a) The commission, with cooperation from the Texas Department of Human Services, shall develop and implement a front-end Medicaid fraud reduction pilot program in one or more counties in this state to address provider fraud and appropriate cases of third-party and recipient fraud.

(b) The program must be designed to reduce:

(1) the number of fraud cases arising from authentication fraud and abuse;

(2) the total amount of Medicaid expenditures; and

(3) the number of fraudulent participants.

(c) The program must include:

(1) participant smart cards and biometric readers that reside at the point of contact with Medicaid providers, recipients, participating pharmacies, hospitals, and appropriate third-party participants;

(2) a secure finger-imaging system that is compliant with the Health Insurance Portability and Accountability Act (HIPAA) and the use of any existing state database of fingerprint images developed in connection with the financial assistance program under Chapter 31, Human Resources Code; fingerprint images collected as part of the program shall only be placed on the smart card; and

(3) a monitoring system.

(d) In implementing the program, the commission may:

(1) exempt recipients who are children or who are elderly or disabled; and

(2) obtain a fingerprint image from a parent or caretaker of a recipient who is a child, regardless of whether the parent or caretaker is a recipient.

(e) The commission must ensure that the procedures for obtaining fingerprint images of participating recipients and parents and caretakers who are not recipients are designed in a flexible manner that gives consideration to transportation barriers and work schedules of those individuals.

(f) To ensure reliability, the program and all associated hardware and software must easily integrate into participant settings and must be initially tested in a physician environment in this state and determined to be successful in authenticating recipients, providers, and provider staff members before the program is implemented throughout the program area.

(g) The commission shall implement the program statewide as provided by Subsection (h) if the commission determines that statewide implementation would be cost-effective.

(h) The commission shall adopt a plan to implement the program statewide in phases and shall terminate the statewide implementation at any stage of the process if the commission determines that statewide implementation would not be cost-effective. The plan must include for each phase:

(1) a description of the policies and procedures to be tested concerning the handling of lost, forgotten, or stolen cards carrying a fingerprint image or situations in which a fingerprint match cannot be confirmed;

(2) a determination of whether the commission will require children or persons who are elderly or disabled to participate in the phase and the reason or reasons for including children or persons who are elderly or disabled in the phase; and

(3) a description of the manner and location in which the fingerprint images will be initially collected.

(i) In developing the plan required by Subsection (h), the commission shall seek comments from recipients, providers, and other stakeholders in the state Medicaid program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.23(a), eff. Sept. 1, 2003. Amended by Acts 2005, 79th Leg., ch. 806, Sec. 17(a), eff. Sept. 1, 2005.

Sec. 531.107. MEDICAID AND PUBLIC ASSISTANCE FRAUD OVERSIGHT TASK FORCE. (a) The Medicaid and Public Assistance Fraud Oversight

Task Force advises and assists the commission and the commission's office of investigations and enforcement in improving the efficiency of fraud investigations and collections.

- (b) The task force is composed of a representative of the:
- (1) attorney general's office, appointed by the attorney general;
  - (2) comptroller's office, appointed by the comptroller;
  - (3) Department of Public Safety, appointed by the public safety director;
  - (4) state auditor's office, appointed by the state auditor;
  - (5) commission, appointed by the commissioner of health and human services;
  - (6) Texas Department of Human Services, appointed by the commissioner of human services;
  - (7) Texas Department of Insurance, appointed by the commissioner of insurance; and
  - (8) Texas Department of Health, appointed by the commissioner of public health.

(c) The comptroller or the comptroller's designee serves as the presiding officer of the task force. The task force may elect any other necessary officers.

(d) The task force shall meet at least once each fiscal quarter at the call of the presiding officer.

(e) The appointing agency is responsible for the expenses of a member's service on the task force. Members of the task force receive no additional compensation for serving on the task force.

(f) At least once each fiscal quarter, the commission's office of investigations and enforcement shall provide to the task force:

- (1) information detailing:
  - (A) the number of fraud referrals made to the office and the origin of each referral;
  - (B) the time spent investigating each case;
  - (C) the number of cases investigated each month, by program and region;
  - (D) the dollar value of each fraud case that results in a criminal conviction; and
  - (E) the number of cases the office rejects and the reason for rejection, by region; and
- (2) any additional information the task force requires.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.24, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 257, Sec. 12, eff. Sept. 1, 2003.

Sec. 531.108. FRAUD PREVENTION. (a) The commission's office of investigations and enforcement shall compile and disseminate accurate information and statistics relating to:

- (1) fraud prevention; and
- (2) post-fraud referrals received and accepted or rejected from the commission's case management system or the case management system of a health and human services agency.

(b) The commission shall:

- (1) aggressively publicize successful fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases issued in coordination with the Texas Department of Human Services; and
- (2) ensure that a toll-free hotline for reporting suspected fraud in programs administered by the commission or a health and human services agency is maintained and promoted, either by the commission or by a health and human services agency.

(c) The commission shall develop a cost-effective method of identifying applicants for public assistance in counties bordering other states and in metropolitan areas selected by the commission who are already receiving benefits in other states. If economically feasible, the commission may develop a computerized matching system.

(d) The commission shall:

- (1) verify automobile information that is used as criteria for eligibility; and
- (2) establish a computerized matching system with the Texas Department of Criminal Justice to prevent an incarcerated individual from illegally receiving public assistance benefits

administered by the commission.

(e) The commission shall submit to the governor and Legislative Budget Board a semiannual report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas Department of Criminal Justice. The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.

Added by Acts 1997, 75th Leg., ch. 1153, Sec. 1.06(a), eff. Sept. 1, 1997.

Sec. 531.109. SELECTION AND REVIEW OF CLAIMS. (a) The commission shall annually select and review a random, statistically valid sample of all claims for reimbursement under the state Medicaid program, including the vendor drug program, for potential cases of fraud, waste, or abuse.

(b) In conducting the annual review of claims under Subsection (a), the commission may directly contact a recipient by telephone or in person, or both, to verify that the services for which a claim for reimbursement was submitted by a provider were actually provided to the recipient.

(c) Based on the results of the annual review of claims, the commission shall determine the types of claims at which commission resources for fraud and abuse detection should be primarily directed.

Added by Acts 1999, 76th Leg., ch. 1289, Sec. 4, eff. Sept. 1, 1999.

Sec. 531.110. ELECTRONIC DATA MATCHING PROGRAM. (a) The commission shall conduct electronic data matches for a recipient of assistance under the state Medicaid program at least quarterly to verify the identity, income, employment status, and other factors that affect the eligibility of the recipient.

(b) To verify eligibility of a recipient for assistance under the state Medicaid program, the electronic data matching must match information provided by the recipient with information contained in databases maintained by appropriate federal and state agencies.

(c) The Texas Department of Human Services shall cooperate with the commission by providing data or any other assistance necessary to conduct the electronic data matches required by this section.

(d) The commission may contract with a public or private entity to conduct the electronic data matches required by this section.

(e) The commission, or a health and human services agency designated by the commission, by rule shall establish procedures to verify the electronic data matches conducted by the commission under this section. Not later than the 20th day after the date the electronic data match is verified, the Texas Department of Human Services shall remove from eligibility a recipient who is determined to be ineligible for assistance under the state Medicaid program.

(f) The commission shall report biennially to the legislature the results of the electronic data matching program. The report must include a summary of the number of applicants who were removed from eligibility for assistance under the state Medicaid program as a result of an electronic data match conducted under this section.

Added by Acts 1999, 76th Leg., ch. 1289, Sec. 4, eff. Sept. 1, 1999.

Sec. 531.111. FRAUD DETECTION TECHNOLOGY. The commission may contract with a contractor who specializes in developing technology capable of identifying patterns of fraud exhibited by Medicaid recipients to:

(1) develop and implement the fraud detection technology; and

(2) determine if a pattern of fraud by Medicaid recipients is present in the recipients' eligibility files maintained by the Texas Department of Human Services.

Added by Acts 1999, 76th Leg., ch. 1289, Sec. 4, eff. Sept. 1, 1999.

Sec. 531.112. EXPUNCTION OF INFORMATION RELATED TO CERTAIN CHEMICAL DEPENDENCY DIAGNOSES IN CERTAIN RECORDS. (a) In this section:

(1) "Chemical dependency" has the meaning assigned by Section 461.002, Health and Safety Code.

(2) "Child" means a person 13 years of age or younger.

(b) Following the final conviction of a chemical dependency treatment provider for an offense, an element of which involves

submitting a fraudulent claim for reimbursement for services under the state Medicaid program, the commission or other health and human services agency that operates a portion of the state Medicaid program shall expunge or provide for the expunction of a diagnosis of chemical dependency in a child that has been made by the treatment provider and entered in any:

(1) appropriate official record of the commission or agency;

(2) applicable medical record that is in the commission's or agency's custody; and

(3) applicable record of a company that the commission contracts with for the processing and payment of claims under the state Medicaid program.

Added by Acts 2001, 77th Leg., ch. 1081, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.113. MANAGED CARE ORGANIZATIONS: SPECIAL INVESTIGATIVE UNITS OR CONTRACTS. (a) Each managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program, including the Medicaid program and the child health plan program, shall:

(1) establish and maintain a special investigative unit within the managed care organization to investigate fraudulent claims and other types of program abuse by recipients and service providers; or

(2) contract with another entity for the investigation of fraudulent claims and other types of program abuse by recipients and service providers.

(b) Each managed care organization subject to this section shall adopt a plan to prevent and reduce fraud and abuse and annually file that plan with the commission's office of inspector general for approval. The plan must include:

(1) a description of the managed care organization's procedures for detecting and investigating possible acts of fraud or abuse;

(2) a description of the managed care organization's procedures for the mandatory reporting of possible acts of fraud or abuse to the commission's office of inspector general;

(3) a description of the managed care organization's procedures for educating and training personnel to prevent fraud and abuse;

(4) the name, address, telephone number, and fax number of the individual responsible for carrying out the plan;

(5) a description or chart outlining the organizational arrangement of the managed care organization's personnel responsible for investigating and reporting possible acts of fraud or abuse;

(6) a detailed description of the results of investigations of fraud and abuse conducted by the managed care organization's special investigative unit or the entity with which the managed care organization contracts under Subsection (a)(2); and

(7) provisions for maintaining the confidentiality of any patient information relevant to an investigation of fraud or abuse.

(c) If a managed care organization contracts for the investigation of fraudulent claims and other types of program abuse by recipients and service providers under Subsection (a)(2), the managed care organization shall file with the commission's office of inspector general:

(1) a copy of the written contract;

(2) the names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the managed care organization has contracted; and

(3) a description of the qualifications of the principals of the entity with which the managed care organization has contracted.

(d) The commission's office of inspector general may review the records of a managed care organization to determine compliance with this section.

(e) The commissioner shall adopt rules as necessary to accomplish the purposes of this section.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.25(a), eff. Sept. 1, 2003.

Sec. 531.114. FINANCIAL ASSISTANCE FRAUD. (a) For purposes of establishing or maintaining the eligibility of a person and the

person's family for financial assistance under Chapter 31, Human Resources Code, or for purposes of increasing or preventing a reduction in the amount of that assistance, a person may not intentionally:

- (1) make a statement that the person knows is false or misleading;
- (2) misrepresent, conceal, or withhold a fact; or
- (3) knowingly misrepresent a statement as being true.

(b) If after an investigation the commission determines that a person violated Subsection (a), the commission shall:

(1) notify the person of the alleged violation not later than the 30th day after the date the commission completes the investigation and provide the person with an opportunity for a hearing on the matter; or

(2) refer the matter to the appropriate prosecuting attorney for prosecution.

(c) If a person waives the right to a hearing or if a hearing officer at an administrative hearing held under this section determines that a person violated Subsection (a), the person is ineligible to receive financial assistance as provided by Subsection (d). A person who a hearing officer determines violated Subsection (a) may appeal that determination by filing a petition in the district court in the county in which the violation occurred not later than the 30th day after the date the hearing officer made the determination.

(d) A person determined under Subsection (c) to have violated Subsection (a) is not eligible for financial assistance:

(1) before the first anniversary of the date of that determination, if the person has no previous violations; and

(2) permanently, if the person was previously determined to have committed a violation.

(e) If a person is convicted of a state or federal offense for conduct described by Subsection (a), or if the person is granted deferred adjudication or placed on community supervision for that conduct, the person is permanently disqualified from receiving financial assistance.

(f) This section does not affect the eligibility for financial assistance of any other member of the household of a person ineligible as a result of Subsection (d) or (e).

(g) The commission shall adopt rules as necessary to implement this section.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.26(a), eff. Sept. 1, 2003.

Sec. 531.115. FEDERAL FELONY MATCH. The commission shall develop and implement a system to cross-reference data collected for the programs listed under Section 531.008(c) with the list of fugitive felons maintained by the federal government.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.27, eff. Sept. 1, 2003.

Sec. 531.116. COMPLIANCE WITH LAW PROHIBITING SOLICITATION. A provider who furnishes services under the Medicaid program or child health plan program is subject to Chapter 102, Occupations Code, and the provider's compliance with that chapter is a condition of the provider's eligibility to participate as a provider under those programs.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.28, eff. Sept. 1, 2003.

#### SUBCHAPTER D. GUARDIANSHIP ADVISORY BOARD

Sec. 531.121. DEFINITIONS. In this subchapter:

(1) "Advisory board" means the Guardianship Advisory Board.

(2) "Guardian" has the meaning assigned by Section 601, Texas Probate Code.

(3) "Guardianship program" has the meaning assigned by Section 111.001.

(4) "Incapacitated individual" means an incapacitated person as defined by Section 601, Texas Probate Code.

(5) "Private professional guardian" has the meaning assigned by Section 111.001.

(6) "Statutory probate court" has the meaning assigned by Section 601, Texas Probate Code.

Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 2005, 79th Leg., ch. 268, Sec. 3.19, eff. Sept. 1, 2005.

Sec. 531.122. ADVISORY BOARD; MEMBERSHIP.. (a) The



Guardianship Advisory Board is composed of one representative from each of the health and human services regions, as defined by the commission, three public representatives, and one representative of the Department of Aging and Disability Services. The representatives of the health and human services regions are appointed by a majority vote of the judges of the statutory probate courts in each region. If a health and human services region does not contain a statutory probate court, the representative shall be appointed by a majority vote of the judges of the statutory probate courts in the state. The public representatives are appointed by the executive commissioner and the representative of the Department of Aging and Disability Services is appointed by the commissioner of aging and disability services.

(b) Deleted by Acts 2005 79th Leg., ch. 268, Sec. 3.21, eff. Sept. 1, 2005.

(c) To be eligible for an appointment under this section, an individual must have demonstrated experience working with:

- (1) a guardianship program;
- (2) an organization that advocates on behalf of or in the interest of elderly individuals or individuals with mental illness or mental retardation; or
- (3) incapacitated individuals.

(d) A member of the advisory board serves at the pleasure of a majority of the judges of the statutory probate courts that appointed the member, of the executive commissioner, or of the commissioner of aging and disability services, as appropriate.

(e) The presiding judge of the statutory probate courts, elected as provided by Chapter 25, may adopt rules as necessary for the operation of the advisory board.

(f) Sections 2 and 8, Article 6252-33, Revised Statutes, do not apply to the advisory board.  
Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997.  
Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 5.01, eff. Sept. 1, 1999; Acts 2005, 79th Leg., ch. 268, Sec. 3.20, 3.21, eff. Sept. 1, 2005.

Sec. 531.123. ADVISORY BOARD; OFFICERS AND MEETINGS. (a) The advisory board shall elect from its members a presiding officer and other officers considered necessary.

(b) The advisory board shall meet at the call of the presiding officer.

(c) The advisory board shall develop and implement policies to provide the public with a reasonable opportunity to appear before the members of the advisory board and to speak on any issue under the jurisdiction of the advisory board.

Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997.

Sec. 531.1235. ADVISORY BOARD; DUTIES; STATEWIDE GUARDIANSHIP SYSTEM. (a) The advisory board shall advise the commission in administering the commission's duties under this subchapter. In addition, the advisory board shall:

(1) advise the commission and the Department of Aging and Disability Services with respect to a statewide guardianship program and develop a proposal for a statewide guardianship program; and

(2) review and comment on the guardianship policies of all health and human services agencies and recommend changes to the policies the advisory board considers necessary or advisable.

(b) The advisory board shall prepare an annual report with respect to the recommendations of the advisory board under Subsection (a). The advisory board shall file the report with the commission, the Department of Aging and Disability Services, the governor, the lieutenant governor, and the speaker of the house of representatives not later than December 15 of each year.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 5.02, eff. Sept. 1, 1999. Amended by Acts 2005, 79th Leg., ch. 268, Sec. 3.22, eff. Sept. 1, 2005.

Sec. 531.124. COMMISSION DUTIES. (a) With the advice of the advisory board, the commission shall develop and, subject to appropriations, implement a plan to:

(1) ensure that each incapacitated individual in this state who needs a guardianship or another less restrictive type of assistance to make decisions concerning the incapacitated individual's own welfare and financial affairs receives that assistance; and

(2) foster the establishment and growth of local volunteer guardianship programs.

(b) The advisory board shall annually review and comment on the minimum standards adopted under Section 111.041 and the plan implemented under Subsection (a) and shall include its conclusions in the report submitted under Section 531.1235.

Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 5.03, eff. Sept. 1, 1999; Acts 2005, 79th Leg., ch. 268, Sec. 3.23, eff. Sept. 1, 2005.

Sec. 531.125. GRANTS. The commission by rule may award grants to:

- (1) a local guardianship program; and
- (2) a local legal guardianship program to enable low-income family members and friends to have legal representation in court if they are willing and able to be appointed guardians of proposed wards who are indigent.

Added by Acts 1997, 75th Leg., ch. 1033, Sec. 1, eff. Sept. 1, 1997. Amended by Acts 1999, 76th Leg., ch. 1116, Sec. 1, eff. Sept. 1, 1999.

#### SUBCHAPTER D-1. PERMANENCY PLANNING

Sec. 531.151. DEFINITIONS. In this subchapter:

(1) "Child" means a person with a developmental disability who is younger than 22 years of age.

(2) "Community resource coordination group" means a coordination group established under the memorandum of understanding adopted under Section 531.055.

(3) "Institution" means:

(A) an ICF-MR, as defined by Section 531.002, Health and Safety Code;

(B) a group home operated under the authority of the Texas Department of Mental Health and Mental Retardation, including a residential service provider under a Medicaid waiver program authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended, that provides services at a residence other than the child's home or foster home;

(C) a foster group home or an agency foster group home as defined by Section 42.002, Human Resources Code;

(D) a nursing facility;

(E) an institution for the mentally retarded licensed by the Department of Protective and Regulatory Services; or

(F) another residential arrangement other than a foster home as defined by Section 42.002, Human Resources Code, that provides care to four or more children who are unrelated to each other.

(4) "Permanency planning" means a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 1276, Sec. 9.010, eff. Sept. 1, 2003.

Sec. 531.152. POLICY STATEMENT. It is the policy of the state to strive to ensure that the basic needs for safety, security, and stability are met for each child in Texas. A successful family is the most efficient and effective way to meet those needs. The state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.1521. PREADMISSION INFORMATION. (a) The executive commissioner by rule shall develop and implement a system by which the Department of Aging and Disability Services ensures that, for each child with respect to whom the department or a local mental retardation authority is notified of a request for placement in an institution, the child's parent or guardian is fully informed before the child is placed in the institution of all community-based services and any other service and support options for which the child may be eligible. The system must be designed to ensure that the department provides the information through:

(1) a local mental retardation authority;

(2) any private entity that has knowledge and expertise regarding the needs of and full spectrum of care options

available to children with disabilities as well as the philosophy and purpose of permanency planning; or

(3) a department employee.

(b) An institution in which a child's parent or guardian is considering placing the child may provide information required under Subsection (a), but the information must also be provided by a local mental retardation authority, private entity, or employee of the Department of Aging and Disability Services as required by Subsection (a).

(c) The Department of Aging and Disability Services shall develop comprehensive information consistent with the policy stated in Section 531.152 to explain to a parent or guardian considering placing a child in an institution:

(1) options for community-based services;

(2) the benefits to the child of living in a family or community setting;

(3) that the placement of the child in an institution is considered temporary in accordance with Section 531.159; and

(4) that an ongoing permanency planning process is required under this subchapter and other state law.

(d) Except as otherwise provided by this subsection and Subsection (e), the Department of Aging and Disability Services shall ensure that, not later than the 14th working day after the date the department is notified of a request for the placement of a child in an institution, the child's parent or guardian is provided the information described by Subsections (a) and (c). The department may provide the information after the 14th working day after the date the department is notified of the request if the child's parent or guardian waives the requirement that the information be provided within the period otherwise required by this subsection.

(e) The requirements of this section do not apply to a request for the placement of a child in an institution if the child:

(1) is involved in an emergency situation, as defined by rules adopted by the executive commissioner; or

(2) has been committed to an institution under Chapter 46B, Code of Criminal Procedure, or Chapter 55, Family Code.

Added by Acts 2005, 79th Leg., ch. 1131, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.153. DEVELOPMENT OF PERMANENCY PLAN. (a) To further the policy stated in Section 531.152 and except as provided by Subsection (b), the commission and each appropriate health and human services agency shall develop procedures to ensure that a permanency plan is developed for each child who resides in an institution in this state on a temporary or long-term basis or with respect to whom the commission or appropriate health and human services agency is notified in advance that institutional care is sought.

(b) The Department of Protective and Regulatory Services shall develop a permanency plan as required by this subchapter for each child who resides in an institution in this state for whom the department has been appointed permanent managing conservator. The department is not required to develop a permanency plan under this subchapter for a child for whom the department has been appointed temporary managing conservator, but may incorporate the requirements of this subchapter in a permanency plan developed for the child under Section 263.3025, Family Code.

(c) In developing procedures under Subsection (a), the commission and other appropriate health and human services agencies shall develop to the extent possible uniform procedures applicable to each of the agencies and each child who is the subject of a permanency plan that promote efficiency for the agencies and stability for each child.

(d) In implementing permanency planning procedures under Subsection (a) to develop a permanency plan for each child, the Department of Aging and Disability Services shall:

(1) delegate the department's duty to develop a permanency plan to a local mental retardation authority, as defined by Section 531.002, Health and Safety Code, or enter into a memorandum of understanding with the local mental retardation authority to develop the permanency plan for each child who resides in an institution in this state or with respect to whom the department is notified in advance that institutional care is sought;

(2) contract with a private entity, other than an entity that provides long-term institutional care, to develop a

permanency plan for a child who resides in an institution in this state or with respect to whom the department is notified in advance that institutional care is sought; or

(3) perform the department's duties regarding permanency planning procedures using department personnel.

(d-1) A contract or memorandum of understanding under Subsection (d) must include performance measures by which the Department of Aging and Disability Services may evaluate the effectiveness of a local mental retardation authority's or private entity's permanency planning efforts.

(d-2) In implementing permanency planning procedures under Subsection (a) to develop a permanency plan for each child, the Department of Aging and Disability Services shall engage in appropriate activities in addition to those required by Subsection (d) to minimize the potential conflicts of interest that, in developing the plan, may exist or arise between:

(1) the institution in which the child resides or in which institutional care is sought for the child; and

(2) the best interest of the child.

(e) The Texas Department of Human Services, the Texas Department of Mental Health and Mental Retardation, and the Department of Protective and Regulatory Services may solicit and accept gifts, grants, and donations to support the development of permanency plans for children residing in institutions by individuals or organizations not employed by or affiliated with those institutions.

(f) A health and human services agency that contracts with a private entity under Subsection (d) to develop a permanency plan shall ensure that the entity is provided training regarding the permanency planning philosophy under Section 531.151 and available resources that will assist a child residing in an institution in making a successful transition to a community-based residence.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001; Acts 2005, 79th Leg., ch. 783, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.1531. ASSISTANCE WITH PERMANENCY PLANNING EFFORTS. An institution in which a child resides shall assist with providing effective permanency planning for the child by:

(1) cooperating with the health and human services agency, local mental retardation authority, or private entity responsible for developing the child's permanency plan; and

(2) participating in meetings to review the child's permanency plan as requested by a health and human services agency, local mental retardation authority, or private entity responsible for developing the child's permanency plan.

Added by Acts 2005, 79th Leg., ch. 783, Sec. 2, eff. Sept. 1, 2005.

Sec. 531.1532. INTERFERENCE WITH PERMANENCY PLANNING EFFORTS.

Text of section as added by Acts 2005, 79th Leg., ch. 783, Sec. 2.

An entity that provides information to a child's parent or guardian relating to permanency planning shall refrain from providing the child's parent or guardian with inaccurate or misleading information regarding the risks of moving the child to another facility or community setting.

Added by Acts 2005, 79th Leg., ch. 783, Sec. 2, eff. Sept. 1, 2005.

For text of section as added by Acts 2005, 79th Leg., ch. 1131, Sec. 1 see Sec. 531.1532, post.

Sec. 531.1532. REQUIREMENTS ON ADMISSIONS OF CHILDREN TO CERTAIN INSTITUTIONS.

Text of section as added by Acts 2005, 79th Leg., ch. 1131, Sec. 1

On the admission of a child to an institution described by Section 531.151(3)(A), (B), or (D), the Department of Aging and Disability Services shall require the child's parent or guardian to submit:

(1) an admission form that includes:

(A) the parent's or guardian's:

(i) name, address, and telephone number;

(ii) driver's license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(iii) place of employment and the employer's address and telephone number; and

(B) the name, address, and telephone number of a relative of the child or other person whom the department or institution may contact in an emergency, a statement indicating the

relation between that person and the child, and at the parent's or guardian's option, that person's:

(i) driver's license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer; and

(2) a signed acknowledgment of responsibility stating that the parent or guardian agrees to:

(A) notify the institution in which the child is placed of any changes to the information submitted under Subdivision (1)(A); and

(B) make reasonable efforts to participate in the child's life and in planning activities for the child.

Added by Acts 2005, 79th Leg., ch. 1131, Sec. 1, eff. Sept. 1, 2005. For text of section as added by Acts 2005, 79th Leg., ch. 783, Sec. 2 see Sec. 531.1532, ante.

Sec. 531.154. NOTIFICATION REQUIRED. (a) Not later than the third day after the date a child is initially placed in an institution, the institution shall notify:

(1) the Texas Department of Human Services, if the child is placed in a nursing home;

(2) the local mental retardation authority, as defined by Section 531.002, Health and Safety Code, where the institution is located, if the child:

(A) is placed in an ICF-MR, as defined by Section 531.002, Health and Safety Code; or

(B) is placed by a state or local child protective services agency in an institution for the mentally retarded licensed by the Department of Protective and Regulatory Services;

(3) the community resource coordination group in the county of residence of a parent or guardian of the child;

(4) if the child is at least three years of age, the school district for the area in which the institution is located; and

(5) if the child is less than three years of age, the local early intervention program for the area in which the institution is located.

(b) The Texas Department of Human Services shall notify the local mental retardation authority, as defined by Section 531.002, Health and Safety Code, of a child's placement in a nursing home if the child is known or suspected to suffer from mental retardation or another disability for which the child may receive services through the Texas Department of Mental Health and Mental Retardation.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.155. OFFER OF SERVICES. Each entity receiving notice of the initial placement of a child in an institution under Section 531.154 may contact the child's parent or guardian to ensure that the parent or guardian is aware of:

(1) services and support that could provide alternatives to placement of the child in the institution;

(2) available placement options; and

(3) opportunities for permanency planning.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.156. DESIGNATION OF ADVOCATE. (a) Except as provided by Subsection (b), the Texas Department of Human Services shall designate a person, including a member of a community-based organization, to serve as a volunteer advocate for a child residing in an institution to assist in developing a permanency plan for the child if:

(1) the child's parent or guardian requests the assistance of an advocate; or

(2) the institution in which the child is placed cannot locate the child's parent or guardian.

(b) The Texas Department of Mental Health and Mental Retardation shall designate the person to serve as a volunteer advocate for a child in accordance with Subsection (a) if the child resides in an institution operated by the department.

(c) The person designated by the Texas Department of Human Services or the Texas Department of Mental Health and Mental

Retardation to serve as the child's volunteer advocate under this section may be:

(1) a person selected by the child's parent or guardian, except that the person may not be employed by or under a contract with the institution in which the child resides;

(2) an adult relative of the child; or

(3) a representative of a child advocacy group.

(d) The Texas Department of Human Services or the Texas Department of Mental Health and Mental Retardation, as appropriate, shall provide to each person designated to serve as a child's volunteer advocate information regarding permanency planning under this subchapter.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.157. COMMUNITY-BASED SERVICES. A state agency that receives notice of a child's placement in an institution shall ensure that, on or before the third day after the date the agency is notified of the child's placement in the institution, the child is also placed on a waiting list for waiver program services under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended, appropriate to the child's needs.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.158. LOCAL PERMANENCY PLANNING SITES. The commission shall develop an implementation system that consists initially of four or more local sites and that is designed to coordinate planning for a permanent living arrangement and relationship for a child with a family. In developing the system, the commission shall:

(1) include criteria to identify children who need permanency plans;

(2) require the establishment of a permanency plan for each child who lives outside the child's family or for whom care or protection is sought in an institution;

(3) include a process to determine the agency or entity responsible for developing and overseeing implementation of a child's permanency plan;

(4) identify, blend, and use funds from all available sources to provide customized services and programs to implement a child's permanency plan;

(5) clarify and expand the role of a local community resource coordination group in ensuring accountability for a child who resides in an institution or who is at risk of being placed in an institution;

(6) require reporting of each placement or potential placement of a child in an institution or other living arrangement outside of the child's home; and

(7) assign in each local permanency planning site area a single gatekeeper for all children in the area for whom placement in an institution through a program funded by the state is sought with authority to ensure that:

(A) family members of each child are aware of:

(i) intensive services that could prevent placement of the child in an institution; and

(ii) available placement options; and

(B) permanency planning is initiated for each child.

Added by Acts 1997, 75th Leg., ch. 421, Sec. 1, eff. May 23, 1997. Renumbered from V.T.C.A., Government Code Sec. 531.154 by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.159. MONITORING OF PERMANENCY PLANNING EFFORTS. (a) The commission and each appropriate health and human services agency shall require a person who develops a permanency plan for a child residing in an institution to identify and document in the child's permanency plan all ongoing permanency planning efforts at least semiannually to ensure that, as soon as possible, the child will benefit from a permanent living arrangement with an enduring and nurturing parental relationship.

(b) The chief executive officer of each appropriate health and human services agency or the officer's designee must approve the placement of a child in an institution. The initial placement of the child in the institution is temporary and may not exceed six months unless the appropriate chief executive officer or the officer's designee approves an extension of an additional six months after conducting a review of documented permanency planning efforts to unite the child with a family in a permanent living arrangement. After the initial six-month extension of a child's

placement in an institution approved under this subsection, the chief executive officer or the officer's designee shall conduct a review of the child's placement in the institution at least semiannually to determine whether a continuation of that placement is warranted. If, based on the review, the chief executive officer or the officer's designee determines that an additional extension is warranted, the officer or the officer's designee shall recommend to the commissioner that the child continue residing in the institution.

(c) On receipt of a recommendation made under Subsection (b) for an extension of a child's placement, the commissioner, the commissioner's designee, or another person with whom the commission contracts shall conduct a review of the child's placement. Based on the results of the review, the commissioner or the commissioner's designee may approve a six-month extension of the child's placement if the extension is appropriate.

(d) The child may continue residing in the institution after the six-month extension approved under Subsection (c) only if the chief executive officer of the appropriate health and human services agency or the officer's designee makes subsequent recommendations as provided by Subsection (b) for each additional six-month extension and the commissioner or the commissioner's designee approves each extension as provided by Subsection (c).

(e) The commissioner or the commissioner's designee shall conduct a semiannual review of data received from health and human services agencies regarding all children who reside in institutions in this state. The commissioner, the commissioner's designee, or a person with whom the commission contracts shall also review the recommendations of the chief executive officers of each appropriate health and human services agency or the officer's designee if the officer or the officer's designee repeatedly recommends that children continue residing in an institution.

(f) The commission by rule shall develop procedures by which to conduct the reviews required by Subsections (c), (d), and (e). In developing the procedures, the commission shall seek input from the work group on children's long-term care and health programs established under Section 22.035, Human Resources Code.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.1591. ANNUAL REAUTHORIZATION OF PLANS OF CARE FOR CERTAIN CHILDREN. (a) The executive commissioner shall adopt rules under which the Department of Aging and Disability Services requires a nursing facility in which a child resides to request from the child's parent or guardian a written reauthorization of the child's plan of care.

(b) The rules adopted under this section must require that the written reauthorization be requested annually.

Added by Acts 2005, 79th Leg., ch. 1131, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.160. INSPECTIONS. As part of each inspection, survey, or investigation of an institution, including a nursing home, institution for the mentally retarded licensed by the Department of Protective and Regulatory Services, or ICF-MR, as defined by Section 531.002, Health and Safety Code, in which a child resides, the agency or the agency's designee shall determine the extent to which the nursing home, institution, or ICF-MR is complying with the permanency planning requirements under this subchapter.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.161. ACCESS TO RECORDS. Each institution in which a child resides shall allow the following to have access to the child's records to assist in complying with the requirements of this subchapter:

(1) the commission;

(2) appropriate health and human services agencies;

and

(3) to the extent not otherwise prohibited by state or federal confidentiality laws, a local mental retardation authority or private entity that enters into a contract or memorandum of understanding under Section 531.153(d) to develop a permanency plan for the child.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Amended by Acts 2005, 79th Leg., ch. 783, Sec. 3, eff. Sept. 1, 2005.

Sec. 531.162. PERMANENCY REPORTING. (a) For each of the local permanency planning sites, the commission shall develop a reporting system under which each appropriate health and human

services agency responsible for permanency planning under this subchapter is required to provide to the commission semiannually:

(1) the number of permanency plans developed by the agency for children residing in institutions or children at risk of being placed in institutions;

(2) progress achieved in implementing permanency plans;

(3) the number of children served by the agency residing in institutions;

(4) the number of children served by the agency at risk of being placed in an institution served by the local permanency planning sites;

(5) the number of children served by the agency reunited with their families or placed with alternate permanent families; and

(6) cost data related to the development and implementation of permanency plans.

(b) The commissioner shall submit a semiannual report to the governor and the committees of each house of the legislature that have primary oversight jurisdiction over health and human services agencies regarding:

(1) the number of children residing in institutions in this state and, of those children, the number for whom a recommendation has been made for a transition to a community-based residence but who have not yet made that transition;

(2) the circumstances of each child described by Subdivision (1), including the type of institution and name of the institution in which the child resides, the child's age, the residence of the child's parents or guardians, and the length of time in which the child has resided in the institution;

(3) the number of permanency plans developed for children residing in institutions in this state, the progress achieved in implementing those plans, and barriers to implementing those plans;

(4) the number of children who previously resided in an institution in this state and have made the transition to a community-based residence;

(5) the number of children who previously resided in an institution in this state and have been reunited with their families or placed with alternate families;

(6) the community supports that resulted in the successful placement of children described by Subdivision (5) with alternate families; and

(7) the community supports that are unavailable but necessary to address the needs of children who continue to reside in an institution in this state after being recommended to make a transition from the institution to an alternate family or community-based residence.

Added by Acts 1997, 75th Leg., ch. 241, Sec. 1, eff. May 23, 1997. Renumbered from V.T.C.A., Government Code Sec. 531.155 and amended by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.163. EFFECT ON OTHER LAW. This subchapter does not affect responsibilities imposed by federal or other state law on a physician or other professional.

Added by Acts 2001, 77th Leg., ch. 590, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.164. DUTIES OF CERTAIN INSTITUTIONS. (a) This section applies only to an institution described by Section 531.151(3)(A), (B), or (D).

(b) An institution described by Section 531.151(3)(A) or (B) shall notify the local mental retardation authority for the region in which the institution is located of a request for placement of a child in the institution. An institution described by Section 531.151(3)(D) shall notify the Department of Aging and Disability Services of a request for placement of a child in the institution.

(c) An institution must make reasonable accommodations to promote the participation of the parent or guardian of a child residing in the institution in all planning and decision-making regarding the child's care, including participation in:

(1) the initial development of the child's permanency plan and periodic review of the plan;

(2) an annual review and reauthorization of the child's service plan;

(3) decision-making regarding the child's medical care;



(4) routine interdisciplinary team meetings; and  
(5) decision-making and other activities involving the child's health and safety.

(d) Reasonable accommodations that an institution must make under this section include:

(1) conducting a meeting in person or by telephone, as mutually agreed upon by the institution and the parent or guardian;

(2) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the institution and the parent or guardian;

(3) if a parent or guardian has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.), including providing an accessible meeting location or a sign language interpreter, as applicable; and

(4) providing a language interpreter, if applicable.

(e) Except as otherwise provided by Subsection (f):

(1) an ICF-MR must:

(A) attempt to notify the parent or guardian of a child who resides in the ICF-MR in writing of a periodic permanency planning meeting or annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian; and

(2) a nursing facility must:

(A) attempt to notify the parent or guardian of a child who resides in the facility in writing of an annual service plan review and reauthorization meeting not later than the 21st day before the date the meeting is scheduled to be held; and

(B) request a response from the parent or guardian.

(f) If an emergency situation involving a child residing in an ICF-MR or nursing facility occurs, the ICF-MR or nursing facility, as applicable, must:

(1) attempt to notify the child's parent or guardian as soon as possible; and

(2) request a response from the parent or guardian.

(g) If a child's parent or guardian does not respond to a notice under Subsection (e) or (f), the ICF-MR or nursing facility, as applicable, must attempt to locate the parent or guardian by contacting another person whose information was provided by the parent or guardian under Section 531.1532(1)(B).

(h) Not later than the 30th day after the date an ICF-MR or nursing facility determines that it is unable to locate a child's parent or guardian for participation in activities listed under Subsection (e)(1) or (2), the ICF-MR or nursing facility must notify the Department of Aging and Disability Services of that determination and request that the department initiate a search for the child's parent or guardian.

Added by Acts 2005, 79th Leg., ch. 1131, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.165. SEARCH FOR PARENT OR GUARDIAN OF A CHILD. (a) The Department of Aging and Disability Services shall develop and implement a process by which the department, on receipt of notification under Section 531.164(h) that a child's parent or guardian cannot be located, conducts a search for the parent or guardian. If, on the first anniversary of the date the department receives the notification under Section 531.164(h), the department has been unsuccessful in locating the parent or guardian, the department shall refer the case to:

(1) the child protective services division of the Department of Family and Protective Services if the child is 17 years of age or younger; or

(2) the adult protective services division of the Department of Family and Protective Services if the child is 18 years of age or older.

(b) On receipt of a referral under Subsection (a)(1), the child protective services division of the Department of Family and Protective Services shall exercise intense due diligence in attempting to locate the child's parent or guardian. If the division is unable to locate the child's parent or guardian, the department shall file a suit affecting the parent-child relationship requesting an order appointing the department as the child's temporary managing conservator.

(c) A child is considered abandoned for purposes of the

Family Code if the child's parent or guardian cannot be located following the exercise of intense due diligence in attempting to locate the parent or guardian by the Department of Family and Protective Services under Subsection (b).

(d) On receipt of a referral under Subsection (a)(2), the adult protective services division of the Department of Family and Protective Services shall notify the court that appointed the child's guardian that the guardian cannot be located.

Added by Acts 2005, 79th Leg., ch. 1131, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.166. TRANSFER OF CHILD BETWEEN INSTITUTIONS. (a) This section applies only to an institution described by Section 531.151(3)(A), (B), or (D) in which a child resides.

(b) Before transferring a child who is 17 years of age or younger, or a child who is at least 18 years of age and for whom a guardian has been appointed, from one institution to another institution, the institution in which the child resides must attempt to obtain consent for the transfer from the child's parent or guardian unless the transfer is in response to an emergency situation, as defined by rules adopted by the executive commissioner.

Added by Acts 2005, 79th Leg., ch. 1131, Sec. 1, eff. Sept. 1, 2005.

Sec. 531.167. COLLECTION OF INFORMATION REGARDING INVOLVEMENT OF CERTAIN PARENTS AND GUARDIANS. (a) The Department of Aging and Disability Services shall collect and maintain aggregate information regarding the involvement of parents and guardians of children residing in institutions described by Sections 531.151(3)(A), (B), and (D) in the lives of and planning activities relating to those children. The department shall obtain input from stakeholders concerning the types of information that are most useful in assessing the involvement of those parents and guardians.

(b) The Department of Aging and Disability Services shall make the aggregate information available to the public on request.

Added by Acts 2005, 79th Leg., ch. 1131, Sec. 1, eff. Sept. 1, 2005.

#### SUBCHAPTER E. HEALTH AND HUMAN SERVICES LEGISLATIVE OVERSIGHT

Sec. 531.171. COMMITTEE DUTIES. (a) The standing or other committees of the house of representatives and the senate that have jurisdiction over the Health and Human Services Commission and other agencies relating to implementation of this chapter, as identified by the speaker of the house of representatives and the lieutenant governor, shall:

(1) monitor the commission's implementation of Section 531.0055 and the commission's other duties in consolidating and integrating health and human services to ensure implementation consistent with law;

(2) recommend, as needed, adjustments to the implementation of Section 531.0055 and the commission's other duties in consolidating and integrating health and human services; and

(3) review the rulemaking process used by the commission, including the commission's plan for obtaining public input.

(b) The commission shall provide copies of all required reports to the committees and shall provide the committees with copies of proposed rules before the rules are published in the Texas Register. At the request of a committee or the commissioner, a health and human services agency shall provide other information to the committee, including information relating to the health and human services system, and shall report on agency progress in implementing statutory directives identified by the committee and the directives of the commission.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 11.01, eff. Sept. 1, 1999.

#### SUBCHAPTER F. TEXAS INTEGRATED ENROLLMENT SERVICES

Sec. 531.191. INTEGRATED ELIGIBILITY DETERMINATION. (a) The commission, subject to the approval of the governor and the Legislative Budget Board, shall develop and implement a plan for the integration of services and functions relating to eligibility determination and service delivery by health and human services agencies, the Texas Workforce Commission, and other agencies. The plan must include a reengineering of eligibility determination business processes, streamlined service delivery, a unified and integrated process for the transition from welfare to work, and improved access to benefits and services for clients. In developing and implementing the plan, the commission:

(1) shall give priority to the design and development of computer hardware and software for and provide technical support relating to the integrated eligibility determination system;

(2) shall consult with agencies whose programs are included in the plan, including the Texas Department of Human Services, the Texas Department of Health, and the Texas Workforce Commission;

(3) may contract for appropriate professional and technical assistance; and

(4) may use the staff and resources of agencies whose programs are included in the plan.

(b) The integrated eligibility determination and service delivery system shall be developed and implemented to achieve increased quality of and client access to services and savings in the cost of providing administrative and other services and staff resulting from streamlining and eliminating duplication of services. The commission, subject to any spending limitation prescribed in the General Appropriations Act, may use the resulting savings to further develop the integrated system and to provide other health and human services.

(c) The commission shall examine cost-effective methods to address:

(1) fraud in the assistance programs; and

(2) the error rate in eligibility determination.

(d) On receipt by the state of any necessary federal approval and subject to the approval of the governor and the Legislative Budget Board, the commission may contract for implementation of all or part of the plan required by Subsection (a) if the commission determines that contracting may advance the objectives of Subsections (a) and (b) and meets the criteria set out in the cost-benefit analysis described in this subsection. Before the awarding of a contract, the commission shall provide a detailed cost-benefit analysis to the governor and the Legislative Budget Board. The analysis must demonstrate the cost-effectiveness of the plan, mechanisms for monitoring performance under the plan, and specific improvements to the service delivery system and client access made by the plan. The commission shall make the analysis available to the public. Within 10 days after the release of a request for bids, proposals, offers, or other applicable expressions of interest relating to the development or implementation of the plan required by Subsection (a), the commission shall hold a public hearing and receive public comment on the request.

(e) If requested by the commission, the agencies whose programs are included in the plan required by Subsection (a) shall cooperate with the commission to provide available staff and resources that will be subject to the direction of the commission.

(f) The design, development, and operation of an automated data processing system to support the plan required by Subsection (a) may be financed through the issuance of bonds or other obligations under Chapter 1232.

Added by Acts 1999, 76th Leg., ch. 1460, Sec. 3.08, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 1420, Sec. 8.238, eff. Sept. 1, 2001.

#### SUBCHAPTER G. LEGISLATIVE OVERSIGHT FOR TEXAS INTEGRATED ENROLLMENT SERVICES

Sec. 531.201. DEFINITION. In this subchapter, "committee" means the Texas Integrated Enrollment Services Legislative Oversight Committee.

Added by Acts 1997, 75th Leg., ch. 1116, Sec. 2, eff. June 16, 1997.

Sec. 531.202. COMPOSITION OF COMMITTEE; PRESIDING OFFICER. (a) The committee is composed of:

(1) three members of the senate appointed by the lieutenant governor; and

(2) three members of the house of representatives appointed by the speaker of the house of representatives.

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

(c) The lieutenant governor and speaker of the house of representatives shall appoint the presiding officer of the committee on an alternating basis. The presiding officer shall serve a two-year term expiring February 1 of each odd-numbered year.

Added by Acts 1997, 75th Leg., ch. 1116, Sec. 2, eff. June 16, 1997.

Sec. 531.203. COMMITTEE POWERS AND DUTIES. (a) The

committee shall:

- (1) meet at the call of the presiding officer;
- (2) receive information about rules proposed or adopted by the commission;
- (3) review specific recommendations for legislation proposed by the commission; and
- (4) hold public hearings concerning the development and implementation of the plan required by Subchapter F in at least four geographically diverse locations in the state.

(b) The committee shall advise the commission in the development of the plan and monitor the implementation and efficiency of the Texas Integrated Enrollment Services.

(c) The commission shall, at the committee's request, provide reports and other information relating to the operation of the integrated enrollment system.

(d) The committee may use staff of standing committees in the senate and house of representatives with appropriate jurisdiction, the Department of Information Resources, the state auditor, the Texas Legislative Council, and the Legislative Budget Board in carrying out its responsibilities.

Added by Acts 1997, 75th Leg., ch. 1116, Sec. 2, eff. June 16, 1997. Amended by Acts 1999, 76th Leg., ch. 1460, Sec. 3.10, eff. Sept. 1, 1999.

Sec. 531.204. REPORT. (a) The committee shall report to the governor, lieutenant governor, and speaker of the house of representatives not later than December 31 of each year.

(b) The report must include:

(1) identification of significant problems in the Texas Integrated Enrollment Services, with recommendations for action by the commissioner;

(2) the status of the effectiveness of the Texas Integrated Enrollment Services in providing necessary services to the people of this state, with recommendations for any necessary research;

(3) an analysis of the feasibility of including indigent health care programs provided by counties, public hospitals, and hospital districts in the Texas Integrated Enrollment Services, a schedule for inclusion of these programs, and a statement of how the Texas Integrated Enrollment Services may be structured to address the wide variation in information systems used by counties, public hospitals, and hospital districts; and

(4) recommendations for legislative action.

Added by Acts 1997, 75th Leg., ch. 1116, Sec. 2, eff. June 16, 1997. Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.26, eff. Sept. 1, 1999.

Sec. 531.205. DURATION OF COMMITTEE. The committee is abolished September 1, 2002.

Added by Acts 1997, 75th Leg., ch. 1116, Sec. 2, eff. June 16, 1997.

SUBCHAPTER G-1. DEVELOPING LOCAL MENTAL HEALTH CARE SYSTEMS FOR CERTAIN CHILDREN

Sec. 531.251. PILOT PROJECT CONSORTIUM; EXPANSION PLAN. (a) The commission shall form a consortium to develop criteria for and implement the expansion of the Texas Integrated Funding Initiative pilot project and to develop local mental health care systems in communities for minors who are receiving residential mental health services or who are at risk of residential placement to receive mental health services. The consortium must include representatives of the Texas Department of Mental Health and Mental Retardation, Department of Protective and Regulatory Services, Texas Education Agency, Texas Youth Commission, Texas Juvenile Probation Commission, and Texas Commission on Alcohol and Drug Abuse and an equal number of family advocates.

(b) The commission and the consortium shall:

(1) develop a model and guidelines for the delivery of mental health services and support to a minor, initiated before the person's 18th birthday, including best practices in the financing, administration, governance, and delivery of those services;

(2) establish a plan to expand the Texas Integrated Funding Initiative so that the initiative may operate in up to six communities; and

(3) identify appropriate sources of state and federal funding to finance mental health services under the initiative from a central fund for expansion communities.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Sec. 531.252. PROPOSALS FOR EXPANSION COMMUNITIES. (a) The commission by rule shall establish a request-for-proposal process to select expansion communities to participate in the initiative.

(b) The commission and the consortium shall develop criteria to evaluate proposals for selecting expansion communities to participate in the expanded initiative. The criteria must:

(1) reflect the underlying principles of the Texas Integrated Funding Initiative;

(2) emphasize services that are culturally competent, family-centered, and seamless;

(3) identify populations to be served under the proposals;

(4) establish for the expansion communities service outcome goals related to minors who are receiving residential mental health services or who are at risk of residential placement to receive mental health services, including:

(A) decreasing incidents of abuse or neglect of the minors;

(B) reducing recidivism rates of juvenile offenders;

(C) increasing school attendance and progress of the minors;

(D) reducing the rate of placement of the minors in residential treatment;

(E) increasing the rate of reunification of the minors with their families;

(F) improving the emotional, behavioral, and social adjustment of the minors; and

(G) improving the stability of placements of the minors;

(5) provide for locations of participating communities in urban, suburban, and rural settings; and

(6) specify information that must be provided in a proposal for a community, including:

(A) information on the costs of the activities proposed; and

(B) the characteristics of minors in the community who are in residential care for mental health services or who are at risk of being placed in residential care to receive mental health services.

(c) Populations to be served, as identified under Subsection (b)(3), must include youth at risk of residential placement, incarceration, or reincarceration because of severe emotional disturbance, including:

(1) students in a special education program under Subchapter A, Chapter 29, Education Code; and

(2) youth with a severe emotional disturbance and a co-occurring:

(A) substance abuse disorder; or

(B) developmental disability.

(d) Outcome criteria established under Subsection (b)(4) must be consistent with outcome measures used in evaluations of individualized children's services projects in other states.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Sec. 531.253. SELECTION OF EXPANSION COMMUNITIES. The commission and the consortium shall review proposals for expansion communities and approve participation of not more than six communities to participate in the initiative. The selected communities must be those that best meet the criteria developed under Section 531.252.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Sec. 531.254. SYSTEM DEVELOPMENT COLLABORATION. The commission, the consortium, and the expansion communities shall collaborate to develop and shall share technical assistance and training resources to aid communities in developing local systems for delivering mental health services to minors.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Sec. 531.255. EVALUATION. (a) The commission and the Texas Department of Mental Health and Mental Retardation jointly shall monitor the progress of the expansion communities.

(b) The commission, the consortium, and the expansion communities shall collaborate to develop a system to evaluate the success of the expansion communities in achieving outcome goals for the minors the communities serve, including outcome goals developed under Section 531.252. An evaluation under the system must include

information on cost avoidance and net savings that result from participation in the initiative.

(c) Each expansion community shall identify the baseline information to compare with the information on outcomes in evaluating the achievements of the community. A community is responsible for collecting and reporting outcome information to the commission in accordance with the requirements of the evaluation system developed under Subsection (b).

(d) To the extent practicable, an expansion community shall use instruments to measure outcomes that have known reliability and validity and that allow comparisons with similar projects in other states and with national evaluation efforts.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Sec. 531.256. MENTAL HEALTH SERVICES FOR YOUTH GRANTS. (a) The commission shall expand the Texas Integrated Funding Initiative pilot project so that, on or before September 1, 2001, the initiative is able to award grants to community projects for mental health services for youth.

(b) The commission by rule shall develop criteria for awarding grants under this section that will encourage a community to establish services and programs that suit the mental health services needs of minors of the community.

(c) The grants may be paid from the fund developed for the Texas Integrated Funding Initiative. The commission may establish and identify money for related projects.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Sec. 531.257. TECHNICAL ASSISTANCE FOR GRANT PROJECTS. The commission may provide technical assistance to a community that receives a grant under Section 531.256.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

Sec. 531.258. STATEWIDE EVALUATION SYSTEM. The commission shall develop an evaluation system to measure outcomes of the Texas Integrated Funding Initiative.

Added by Acts 1999, 76th Leg., ch. 446, Sec. 1, eff. June 18, 1999.

#### SUBCHAPTER H. OFFICE OF EARLY CHILDHOOD COORDINATION

Sec. 531.281. DEFINITIONS. In this chapter:

(1) "Office" means the Office of Early Childhood Coordination.

(2) "Advisory committee" means the Office of Early Childhood Coordination Advisory Committee.

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.282. OFFICE; STAFF. (a) The Office of Early Childhood Coordination is an office within the commission.

(b) The commissioner shall employ staff as needed to carry out the duties of the office.

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.283. GOALS. The goals of the office are to:

(1) promote community support for parents of all children younger than six years of age through an integrated state and local-level decision-making process; and

(2) provide for the seamless delivery of health and human services to all children younger than six years of age to ensure that all children are prepared to succeed in school.

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.284. STRATEGIC PLAN. (a) The office shall create and implement a statewide strategic plan for the delivery of health and human services to children younger than six years of age.

(b) In developing the statewide strategic plan, the office shall:

(1) consider existing programs and models to serve children younger than six years of age, including:

(A) community resource coordination groups;

(B) the Texas Integrated Funding Initiative;

(C) the Texas Information and Referral Network;

and

(D) efforts to create a 2-1-1 telephone number for access to human services;

(2) attempt to maximize federal funds and local existing infrastructure and funds; and

(3) provide for local participation to the greatest extent possible.

(c) The statewide strategic plan must address the needs of children younger than six years of age with disabilities.

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.285. POWERS AND DUTIES. (a) The office shall

identify:

(1) gaps in early childhood services by functional area and geographical area;

(2) state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing available services;

(3) sources of funds for early childhood services, including federal, state, and private-public ventures;

(4) opportunities for collaboration between the Texas Education Agency and health and human services agencies to better serve the needs of children younger than six years of age;

(5) methods for coordinating the provision of early childhood services provided by the Texas Head Start-State Collaboration Project, the Texas Education Agency, and the Texas Workforce Commission;

(6) quantifiable benchmarks for success within early childhood service delivery; and

(7) national best practices in early care and educational delivery models.

(b) The office shall establish outreach efforts to communities and ensure adequate communication lines that provide the office with information about community-level efforts and communities with information about funds and programs available to communities.

(c) The office shall make recommendations to the commission on strategies to:

(1) ensure optimum collaboration and coordination between state agencies serving the needs of children younger than six years of age and other community stakeholders;

(2) fill geographical and functional gaps in early childhood services; and

(3) amend state policies, rules, and service procedures that prevent or inhibit children younger than six years of age from accessing services.

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.286. ADVISORY COMMITTEE. (a) The commissioner shall appoint an advisory committee to assist the office in the performance of its duties. The commissioner shall appoint to the advisory committee persons with a demonstrated interest in early childhood development, including parents and representatives of business, religious organizations, law enforcement, social services, and state agencies that have programs affecting or serving children younger than six years of age.

(b) The advisory committee shall meet and serve under rules established by the commissioner, but the advisory committee shall elect its own presiding officer.

(c) The advisory committee is subject to Chapter 2110.

Added by Acts 2001, 77th Leg., ch. 103, Sec. 1, eff. Sept. 1, 2001.

#### SUBCHAPTER I. STATE PRESCRIPTION DRUG PROGRAM

Sec. 531.301. DEVELOPMENT AND IMPLEMENTATION OF STATE PROGRAM; FUNDING. (a) The commission shall develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to recipients of medical assistance under Chapter 32, Human Resources Code.

(b) A person is eligible for prescription drug benefits under the state program if the person is:

(1) a qualified Medicare beneficiary, as defined by 42 U.S.C. Section 1396d(p)(1), as amended;

(2) a specified low-income Medicare beneficiary who is eligible for medical assistance for Medicare cost-sharing payments under 42 U.S.C. Section 1396a(a)(10)(E)(iii), as amended;

(3) a qualified disabled and working individual, as defined by 42 U.S.C. Section 1396d(s), as amended;

(4) a qualifying individual who is eligible for that assistance under 42 U.S.C. Section 1396a(a)(10)(E)(iv)(I), as amended; or

(5) a qualifying individual who is eligible for that assistance under 42 U.S.C. Section 1396a(a)(10)(E)(iv)(II), as amended.

(c) Prescription drugs under the state program may be funded only with state money, unless funds are available under federal law to fund all or part of the program.

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.302. RULES. (a) The commission shall adopt all

rules necessary for implementation of the state prescription drug program.

(b) In adopting rules for the state prescription drug program, the commission may:

(1) require a person who is eligible for prescription drug benefits to pay a cost-sharing payment;

(2) authorize the use of a prescription drug formulary to specify which prescription drugs the state program will cover;

(3) to the extent possible, require clinically appropriate prior authorization for prescription drug benefits in the same manner as prior authorization is required under the vendor drug program; and

(4) establish a drug utilization review program to ensure the appropriate use of prescription drugs under the state program.

(c) In adopting rules for the state prescription drug program, the commission shall consult with an advisory panel composed of an equal number of physicians, pharmacists, and pharmacologists appointed by the commissioner.

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.303. GENERIC EQUIVALENT AUTHORIZED. In adopting rules under the state program, the commission may require that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, the pharmacist may select a generic equivalent of the prescribed drug.

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

Sec. 531.304. PROGRAM FUNDING PRIORITIES. If money available for the state prescription drug program is insufficient to provide prescription drug benefits to all persons who are eligible under Section 531.301(b), the commission shall limit the number of enrollees based on available funding and shall provide the prescription drug benefits to eligible persons in the following order of priority:

(1) persons eligible under Section 531.301(b)(1);

(2) persons eligible under Section 531.301(b)(2); and

(3) persons eligible under Sections 531.301(b)(3),

(4), and (5).

Added by Acts 2001, 77th Leg., ch. 1008, Sec. 1, eff. Sept. 1, 2001.

#### SUBCHAPTER J. PROVISION OF INFORMATION ABOUT PATIENT ASSISTANCE PROGRAMS

Sec. 531.351. DEFINITION. In this subchapter, "patient assistance program" means a program offered by a pharmaceutical company under which the company provides a drug to persons in need of assistance at no charge or at a substantially reduced cost. The term does not include the provision of a drug as part of a clinical trial.

Added by Acts 2001, 77th Leg., ch. 1277, Sec. 1, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.301 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(74), eff. Sept. 1, 2003.

Sec. 531.352. PROVIDING INFORMATION TO COMMISSION. Each pharmaceutical company that does business in this state and that offers a patient assistance program shall inform the commission of the existence of the program, the eligibility requirements for the program, the drugs covered by the program, and information such as a telephone number used for applying for the program.

Added by Acts 2001, 77th Leg., ch. 1277, Sec. 1, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.302 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(74), eff. Sept. 1, 2003.

Sec. 531.353. TOLL-FREE TELEPHONE NUMBER. (a) The commission shall establish a system under which members of the public can call a toll-free telephone number to obtain information about available patient assistance programs. The commission shall ensure that the system is staffed at least during normal business hours with persons who can:

(1) determine whether a patient assistance program is offered for a particular drug;

(2) determine whether a person may be eligible to participate in a program; and

(3) assist persons who wish to apply for a program.

(b) The commission shall publicize the telephone number to pharmacies and prescribers of drugs.

Added by Acts 2001, 77th Leg., ch. 1277, Sec. 1, eff. Sept. 1, 2001. Renumbered from V.T.C.A., Government Code Sec. 531.303 by Acts 2003, 78th Leg., ch. 1275, Sec. 2(74), eff. Sept. 1, 2003.

#### SUBCHAPTER K. HEALTH AND HUMAN SERVICES COUNCIL



Sec. 531.401. DEFINITION. In this subchapter, "council" means the Health and Human Services Council. Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.402. HEALTH AND HUMAN SERVICES COUNCIL. (a) The Health and Human Services Council is created to assist the executive commissioner in developing rules and policies for the commission.

(b) The council is composed of nine members of the public appointed by the governor with the advice and consent of the senate. To be eligible for appointment to the council, a person must have demonstrated an interest in and knowledge of problems and available services related to the child health plan program, the financial assistance program under Chapter 31, Human Resources Code, the medical assistance program under Chapter 32, Human Resources Code, or the nutritional assistance programs under Chapter 33, Human Resources Code.

(c) The council shall study and make recommendations to the executive commissioner regarding the management and operation of the commission, including policies and rules governing the delivery of services to persons who are served by the commission and the rights and duties of persons who are served or regulated by the commission.

(d) Chapter 551 applies to the council.

(e) Chapter 2110 does not apply to the council.

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

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.403. APPOINTMENTS. (a) Appointments to the council shall be made without regard to the race, color, disability, sex, religion, age, or national origin of the appointees.

(b) Appointments to the council shall be made so that each geographic area of the state is represented on the council. Notwithstanding Subsection (a), appointments to the council must reflect the ethnic diversity of this state.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.404. TRAINING PROGRAM FOR COUNCIL MEMBERS. (a) A person who is appointed as a member of the council may not vote, deliberate, or be counted as a member in attendance at a meeting of the council until the person completes a training program that complies with this section.

(b) The training program must provide the person with information regarding:

(1) the legislation that created the commission and the council;

(2) the programs operated by the commission;

(3) the role and functions of the commission and the council, including detailed information regarding the advisory responsibilities of the council;

(4) the rules of the executive commissioner applicable to the commission, with an emphasis on the rules that relate to disciplinary and investigatory authority;

(5) the current budget for the commission;

(6) the results of the most recent formal audit of the commission;

(7) the requirements of:

(A) the open meetings law, Chapter 551;

(B) the public information law, Chapter 552;

(C) the administrative procedure law, Chapter 2001; and

(D) other laws relating to public officials, including conflict-of-interest laws; and

(8) any applicable ethics policies adopted by the executive commissioner or the Texas Ethics Commission.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.405. TERMS. (a) Council members serve for staggered six-year terms with the terms of three members expiring February 1 of each odd-numbered year.

(b) A member of the council may not serve more than two consecutive full terms as a council member.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.406. VACANCY. The governor by appointment shall fill the unexpired term of a vacancy on the council.  
Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.407. PRESIDING OFFICER; OTHER OFFICERS; MEETINGS. (a) The governor shall designate a member of the council as the presiding officer to serve in that capacity at the pleasure of the governor.

(b) The members of the council shall elect any other necessary officers.

(c) The council shall meet quarterly and at other times at the call of the presiding officer. The council may hold meetings in different areas of the state.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.408. REIMBURSEMENT FOR EXPENSES. A council member may not receive compensation for service as a member of the council but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the council as provided by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.409. PUBLIC INTEREST INFORMATION AND COMPLAINTS. (a) The executive commissioner, with the advice of the council, shall prepare information of public interest describing the functions of the commission and the procedures by which complaints are filed with and resolved by the commission. The commission shall make the information available to the public and appropriate state governmental entities.

(b) The executive commissioner by rule shall establish methods by which consumers and service recipients are notified of the name, mailing address, and telephone number of the commission for directing complaints to the commission.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.410. PUBLIC ACCESS AND TESTIMONY. The executive commissioner shall develop and implement policies that provide the public with a reasonable opportunity to appear before the council or executive commissioner and to speak on any issue under the jurisdiction of the commission.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

Sec. 531.411. POLICYMAKING AND MANAGEMENT RESPONSIBILITIES. The executive commissioner, with the advice of the council, shall develop and the commission shall implement policies that clearly delineate the policymaking responsibilities of the executive commissioner from the management responsibilities of the commission and the staff of the commission.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 1.08, eff. Sept. 1, 2003.

#### SUBCHAPTER L. PROVISION OF SERVICES FOR CERTAIN CHILDREN WITH MULTIAGENCY NEEDS

Sec. 531.421. DEFINITIONS. In this subchapter:

(1) "Children with severe emotional disturbances" includes:

(A) children who are at risk of incarceration or placement in a residential mental health facility;

(B) children for whom a court may appoint the Department of Protective and Regulatory Services as managing conservator;

(C) children who are students in a special education program under Subchapter A, Chapter 29, Education Code; and

(D) children who have a substance abuse disorder or a developmental disability.

(2) "Community resource coordination group" means a coordination group established under a memorandum of understanding adopted under Section 531.055, as added by Chapter 114, Acts of the 77th Legislature, Regular Session, 2001.

(3) "Consortium" means the consortium that oversees the Texas Integrated Funding Initiative under Subchapter G, Chapter 531, as added by Chapter 446, Acts of the 76th Legislature, Regular Session, 1999.

(4) "Systems of care services" means a comprehensive state system of mental health services and other necessary and

related services that is organized as a coordinated network to meet the multiple and changing needs of children with severe emotional disturbances and their families.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.

Sec. 531.422. EVALUATIONS BY COMMUNITY RESOURCE COORDINATION GROUPS. (a) Each community resource coordination group shall evaluate the provision of systems of care services in the community that the group serves. Each evaluation must:

(1) describe and prioritize services needed by children with severe emotional disturbances in the community;

(2) review and assess the systems of care services that are available in the community to meet those needs;

(3) assess the integration of the provision of those services; and

(4) identify any barriers to the effective provision of those services.

(b) Each community resource coordination group shall create a report that includes the evaluation in Subsection (a) and makes related recommendations, including:

(1) suggested policy and statutory changes at agencies that provide systems of care services; and

(2) recommendations for overcoming barriers to the provision of systems of care services and improving the integration of those services.

(c) Each community resource coordination group shall submit the report described by Subsection (b) to the consortium. The consortium shall provide a deadline to each group for submitting the reports. The time frame for completing the reports must be coordinated with any regional reviews by the commission of the delivery of related services.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.

Sec. 531.423. SUMMARY REPORT BY TEXAS INTEGRATED FUNDING INITIATIVE CONSORTIUM. (a) The consortium shall create a summary report based on the evaluations in the reports submitted to the consortium by community resource coordination groups under Section 531.422. The consortium's report must include recommendations for policy and statutory changes at each agency that is involved in the provision of systems of care services and the outcome expected from implementing each recommendation.

(b) The consortium shall coordinate, where appropriate, the recommendations in the report created under this section with recommendations in the assessment developed under S.B. No. 491, Acts of the 78th Legislature, Regular Session, 2003, and with the continuum of care developed under S.B. No. 490, Acts of the 78th Legislature, Regular Session, 2003.

(c) The consortium may include in the report created under this section recommendations for the statewide expansion of sites participating in the Texas Integrated Funding Initiative under Subchapter G, Chapter 531, as added by Chapter 446, Acts of the 76th Legislature, Regular Session, 1999, and the integration of services provided at those sites with services provided by community resource coordination groups.

(d) The consortium shall provide a copy of the report created under this section to each agency for which the report makes a recommendation and to other agencies as appropriate.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.

Sec. 531.424. AGENCY IMPLEMENTATION OF RECOMMENDATIONS. An agency described by Section 531.423(a) shall, as appropriate, adopt rules, policy changes, and memoranda of understanding with other agencies to implement the recommendations in the report created under Section 531.423.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.166(a), eff. Sept. 1, 2003.