Texas Health Care Association
Legislative Report
83rd Legislative Session
2013

Funding

MANAGED CARE

MEDICAID OVERSIGHT, REGULATORY ISSUES

ASSISTED LIVING

WORKGROUPS and ADVISORY COUNCILS

Funding

SB 1: General Appropriations Act
Author: Williams
Sponsor: Pitts
Effective Date: September 1, 2013

ARTICLE II

As per Rider 40, the legislature appropriated $23 million in GR for Fiscal year 2014 (Beginning September 1, 2013) and an additional $72 million in GR for Fiscal year 2015 (Beginning, September 1, 2014). This amount equates to a 2% increase in September 2013 and an additional 4% increase in September 2014.

Relevant Long Term Care Riders
DEPARTMENT OF AGING AND DISABILITY SERVICES
DADS RIDERS

4. Nursing Home Program Provisions
a. Nursing Home Income Eligibility Cap. It is the intent of the Legislature that the income eligibility cap for nursing home care shall be maintained at the federal maximum level of 300 percent of Supplemental Security Income (SSI).

b. Establishment of a Swing-bed Program. Out of the funds appropriated above for nursing home vendor payments, the department shall maintain a "swing-bed" program, in accordance with federal regulations, to provide reimbursement for skilled nursing patients who are served in hospital settings in counties with a population of 100,000 or less. If the swing beds are used for more than one 30-day length of stay per year per patient, the hospital must comply with the regulations and standards required for nursing home facilities.

c. Nursing Home Bed Capacity Planning. It is the intent of the Legislature that the department shall control the number of Medicaid beds, and decertify unused Medicaid beds, and reallocate some or all of the decertified Medicaid beds, taking into account a facility's occupancy rate.

d. Nursing Facility Competition. It is the intent of the Legislature that the department encourage competition among contracted nursing facilities.

8. Pediatric Care in Nursing Facilities. When using funds appropriated above in addition to consideration of expense in determining the appropriate placement for children who currently receive care in nursing facilities, the department shall, within the requirements of state and federal law, consider the requests of parents concerning

either a continued stay in a nursing facility providing skilled pediatric care or an alternate placement.

12. Reimbursement of Advisory Committees. Pursuant to Government Code §2110.004, reimbursement of expenses for advisory committee members, out of funds appropriated above, not to exceed $8,000 per fiscal year is limited to the following advisory committee:

Nursing Facility Administrators Advisory Committee
To the maximum extent possible, the department shall encourage the use of videoconferencing and teleconferencing and shall schedule meetings and locations to facilitate the travel of participants so that they may return the same day and reduce the need to reimburse members for overnight stays.

13. Survey of Nursing Facility Residents. Out of funds appropriated above, the Department of Aging and Disability Services is allocated the following:

a. up to $360,000 in All Funds, of which up to $180,000 is General Revenue Funds, in fiscal year 2014 to conduct surveys of nursing facility residents and individuals receiving other long-term services and supports. The surveys shall assess how satisfied individuals are with their quality of care and quality of life. Not later than January 15, 2015, the department shall submit a written report on the survey to the Legislature, Governor, and Health and Human Services Commissioner; and

b. up to $1,000,000 in All Funds, of which up to $500,000 is General Revenue Funds, to perform on-site case reviews of the care of nursing home residents and individuals receiving other long-term care services and supports. These reviews will identify preventable occurrences of adverse outcomes. The result of these reviews will be included in the report to the Legislature, Governor and Health and Human Services Commissioner described in (a) above.

14. Nursing Facility Beds for Medicaid Eligible Veterans. Contingent upon a request from the Texas Veterans Land Board, it is the intent of the Legislature that the Department of Aging and Disability Services maintain a program for Medicaid-eligible veterans that will enable individuals to be placed in State Veterans Homes if they so choose. It is further the intent of the Legislature that the department ensure the creation of sufficient certified beds to accommodate the requirements of such a program.

29. Appropriation: Medicaid Estate Recovery. Funds deposited to the credit of Medicaid Estate Recovery (General Revenue - Dedicated Account No. 5109) above the Biennial Revenue Estimate are hereby appropriated to the Department of Aging and Disability Services for community-based care to individuals who are on a waiting or interest list.

This appropriation is contingent upon the department submitting a plan which details the number of clients to be served, estimated expenditures by method of financing by year, as well as any other information requested by the Legislative Budget Board. The plan shall be submitted to the Legislative Budget Board, the Governor, and the Comptroller of Public Accounts 30 days prior to any expenditure of the funds.

30. Implementing a Person-centered Care Pilot Project for Nursing Facilities. Out of the funds appropriated above to the Department of Aging and Disability Services in Goal B, Regulation, Certification, Outreach, the agency shall allocate an amount not to exceed $250,000 in All Funds to:

a. Not later than January 31, 2014, in consultation with the Legislative Budget Board, implement a person-centered care pilot project modeled on the Rhode Island State Department of Health's Individualized Care Pilot Project that would use the nursing facility regulatory inspection process to improve nursing facility staffs' knowledge and implementation of person-centered care practices and culture change models of care in one or more regions of the state. The agency shall use and modify as necessary the information and materials contained in the electronic Individualized Care Pilot Tool Box developed by the Rhode Island Department of Health. The agency shall request approval from the Centers for Medicaid and Medicare Services for "pilot status" of the project for a defined period of time. To fulfill the educational component of the pilot project, the agency may use existing state staff or collaborate with an entity whose mission and purpose it is to train and implement culture change models of care and person-centered activities in long-term care facilities. The pilot project shall be operational no later than September 1, 2014.

b. Submit a report to the Legislative Budget Board and the Office of the Governor, no later than August 31, 2015. The report shall include, but not be limited to, an evaluation of the Person-centered Care pilot project that includes:
1) pre and post test measures of areas targeted for improvement,
2) the project's impact on nursing facility administrators and state survey staff knowledge and implementation of person-centered care practices,
3) agency recommendations for increasing the use and knowledge of person-centered care in nursing facilities, and
4) any other measure the agency determines is needed to determine the pilot's effectiveness at increasing the knowledge and implementation of person-centered care or culture change practices in Texas nursing facilities.

34. Services under a 1915(c) Waiver. It is the intent of the Legislature that, from the funds appropriated above, the Department of Aging and Disability Services shall provide services under a Section 1915(c) waiver program, other than a nursing facility waiver program to an individual, 21 years and younger, leaving a nursing facility if the individual:

a. meets the eligibility requirements for that Section 1915(c) waiver program; and
b. in order to leave the nursing facility, requires services that are available only under that Section 1915(c) waiver program.

35. Services under HCS Waiver Program. It is the intent of the Legislature that, from the funds appropriated above, if an individual 21 years and younger, seeking to leave an intermediate care facility for individuals with intellectual disabilities, has been offered services under the HCS (Home and Community-based Services) waiver program, the Department of Aging and Disability Services may provide services to the individual under another Section 1915(c) waiver program if the individual leaving the facility:
a. is determined to be ineligible for the services provided under the HCS waiver program; and
b. meets the eligibility requirements for and needs services provided under another Section 1915 waiver program.

38. Reporting on Nursing Facility Licensure. Out of funds appropriated above in Strategy B.1.1, Facility and Community-based Regulation, the Department of Aging and Disability Services shall submit a report summarizing the nursing facility licensure process, including criteria considered when determining whether to issue a new license within a given market area, and any recommendations to improve the effectiveness and efficiency of the process. The report shall be submitted to the Legislative Budget Board, the Office of the Governor, and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services by August 31, 2014.

53. Quality-Based Payment and Delivery Reforms in the Medicaid and Children's Health Insurance Programs. Out of funds appropriated to the Health and Human Services Commission (HHSC) in Goal B, Medicaid, and Goal C, Children's Health Insurance Program, HHSC may implement the following quality-based reforms in the Medicaid and CHIP programs:

a. develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used to implement quality-based payments for acute and long-term care services across delivery models and payment systems;

b. implement quality-based payment systems for compensating a health care provider or facility participating in the Medicaid and CHIP programs;

c. implement quality-based payment initiatives to reduce potentially preventable readmissions and potentially preventable complications; and

d. implement a bundled payment initiative in the Medicaid program, including a shared savings component for providers that meet quality-based outcomes. The executive commissioner may select high-cost and/or high-volume services to bundle and may consider the experiences of other payers and other state of Texas programs that purchase healthcare services in making the selection.

e. Under the Health and Human Services Commission's authority in 1 T.A.C. Sec. 355.307(c), the Commission may implement a Special Reimbursement Class for long term care commonly referred to as "small house facilities." Such a class may include a rate reimbursement model that is cost neutral and that adequately addresses the cost differences that exist in a nursing facility constructed and operated as a small house facility, as well as the potential for off-setting cost savings through decreased utilization of higher cost institutional and ancillary services. The payment increment may be based upon a provider incentive payment rate.

69. Pediatric Long Term Care Facility Rate Setting. It is the intent of the Legislature that the Executive Commissioner of HHSC shall develop and implement a Medicaid reimbursement methodology for the Pediatric Long Term Care facility rate class that includes a facility-specific prospective cost-based interim reimbursement rate and an annual cost-based retrospective cost settlement process. It is the intent of the Legislature that an annual settlement payment shall only be made for fiscal years in which the average daily census for the facility in that year was less than the average daily census of the prior fiscal year, except that no settlement shall be made for fiscal years in which the average daily census for the facility exceeded 85 percent or for fiscal years in which the facility's Medicaid revenues exceeded its Medicaid allowable costs.

72. Promote Innovative Nursing Home Care Models. From funds appropriated above in A.1.1 Strategy: Enterprise Oversight & Policy, the Health and Human Services Commission, with the Department of Aging and Disability Services, shall identify additional opportunities to encourage culture change in Texas nursing homes and to encourage the development of Green House Project homes and similar small house models, as an alternative to traditional skilled nursing facilities. The Health and Human Services Commission shall report its findings to the Governor, Lieutenant Governor, the Senate Finance Committee, the Senate Health and Human Services Committee, the House Appropriations Committee, and the House Human Services Committee by September 1, 2014.

85. Study and Report on Sepsis Infections in Medicaid. Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall study and submit a report to the Legislature of the health outcomes and fiscal impact of sepsis and septicemia on the Medicaid program. The report shall also investigate the use of evidence based protocols such as early goal directed therapy by health care facilities in

Texas and the success and prevalence of such protocols in reducing the incidence, mortality, and related costs in the Medicaid program. The report shall include recommendations from the commission for the implementation of a plan to improve the health of Texans and decrease costs in Medicaid by decreasing the impact of sepsis and septicemia. The commission shall submit the report by September 1, 2014.

Special Provisions of HHSC riders

40. Contingency for Nursing Facility Rate Increases. Contingent on passage of legislation (including but not limited to Senate Bill 7) by the Eighty-third Legislature, Regular Session, that carves nursing facility services into the Medicaid managed care service delivery model, in addition to amounts above, the Department of Aging and Disability Services is appropriated $23,446,624 in General Revenue Funds and $33,380,028 in Federal Funds in fiscal year 2014 and $72,734,490 in General Revenue Funds and $100,677,477 in Federal Funds in fiscal year 2015 in Strategy A.6.1, Nursing Facility Payments, and $1,662,179 in General Revenue Funds and $2,366,416 in Federal Funds in fiscal year 2014 and $5,163,429 in General Revenue Funds and $7,147,187 in Federal Funds in fiscal year 2015 in Strategy A.6.3, Hospice, to provide for a 2 percent rate increase to nursing facilities in fiscal year 2014 and an additional 4 percent rate increase to nursing facilities in fiscal year 2015. Percentage increases in both fiscal years are intended to be calculated based on the rates in effect on August 31, 2013.

Sec. 49. Workgroup on Nursing Facility Residents' Applied Income. Out of funds appropriated elsewhere in this Act to the Health and Human Services Commission, in Strategy A.1.1, Enterprise Oversight & Policy, the Executive commissioner of the Health and Human Services Commission shall appoint a workgroup on nursing facility residents' applied income by January 31, 2014. It is the intention of the Legislature that the members of the workgroup shall include, but are not limited to, representation from the Office of the Attorney General's Division of Medicaid Fraud Control and/or Consumer Protection, the Department of Aging and Disability Services Division of Long Term Regulatory, the Texas Health Care Association, the Texas Silver Haired Legislature, and The Texas Senior Advocacy Coalition. The purpose of the workgroup is to study the extent of misapplication of Medicaid nursing facility residents' applied income and to develop a set of recommendations to more effectively manage applied income payments to ensure those funds are used for their intended legal purposes. The workgroup shall report the results of its finding and recommendations to the chairs of the Senate Health and Human Services Committee and the House Human Services Committee by September 30, 2014.

Sec. 52. Fiscal Impact Analysis of Health and Medical Insurance for Eligible Employees of Contracted Long-Term Care Medicaid Providers. It is the intent of the Legislature that out of funds available, the Health and Human Services Commission in

coordination with the Legislative Budget Board shall determine the impact of the employer mandate in the Affordable Care Act on Medicaid long-term care providers through consideration of the following:

a. Current number of contracted long-term care Medicaid providers with 50 or more full-time equivalent employees;

b. Estimated percentage of employees that would qualify for the Medicaid exchange;

c. Estimated percentage of employees by wage rate who would enroll in a plan offered by their employer;

d. Estimated cost of providing health insurance per employee; and

e. Current number of employees and employee health insurance costs on current cost reports, requiring this information to be included on future cost reports.

It is the intent of the Legislature that the Health and Human Services Commission shall report these findings to the Governor and Legislative Budget Board no later than November 1, 2014, and HHSC shall take this impact into consideration when setting rates should additional funds become available through funds provided or additional state or federal Medicaid funds that become available.

HB 10: Relating to making emergency supplemental appropriations and providing direction and transfer authority regarding certain appropriations.
Author: Pitts
Sponsor: Williams

HB 10 added $4 Billion to the current biennium to payments for all Medicaid providers. This amount was needed to cover ongoing payments due to a shortfall in the 12-13 budget cycle.

Managed Care

SB 7: Relating to improving the delivery and quality of certain health and human services, including the delivery and quality of Medicaid acute care services and long-term care services and supports.
Author: Nelson
Sponsor: Raymond
Effective Date: September 1, 2013

SB 7 carves nursing facility benefits into the Medicaid Managed Care program. In SB 7 the commission shall ensure:

- The Commission is responsible for setting the minimum reimbursement rate paid to nursing facilities, including the staffing rate enhancement
- Nursing facility is paid not later than the 10th day after the date the facility submits a clean claim
- Appropriate utilization of services
- Reduction in potentially preventable events and unnecessary institutionalizations
- MCO's provide discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long term care settings
    - MCO's will assist in collecting applied income from recipients
    - Provides payment incentives to facilities for reduce acute care costs, encourage transformative efforts and promote resident-centered care culture through facility design and services

- Establish a portal compliant with state and federal regulations, including standard coding requirements, through which nursing facility providers may submit claims to any participating MCO
- Rules and procedures relating to the certification and decertification of nursing facilities is not affected
- MCO's offer nursing facility providers access to
    - Acute care professionals
    - Telemedicine when feasible

- Nursing facilities in the Medicaid program on Sept. 1, 2013 are allowed to participate in the STAR PLUS program through August 31, 2017
- HHSC will establish minimum performance standards and credentialing, an MCO may refuse to contract with a provider if those minimum standards are not met.
- An MCO may not require prior authorization for nursing facility residents in need of emergency hospital service

SB 7 requires the commission to develop a plan in preparation for implementing the requirements of STAR PLUS. The plan will be completed in two phases.

Phase one, initial contract planning phase. The commission will develop a contract template to be used by the commission when the commission contracts with MCO's to

provide nursing facility services under the STAR PLUS program. The template must include:

- Nursing home credentialing requirements
- Appeals process
- Termination provisions
- Prompt payment requirements and financial penalties for failure to meet prompt payment requirements
- A description of medical necessity criteria
- MCO's must provide recipients and and families freedom of choice in selecting a nursing facility
- A description of the MCO's role in discharge planning and imposing prior authorization requirements

Phase one must be completed no later than October 1, 2013

Phase two, the commission shall:

- Design and test the portal
- Establish and inform MCO's of the minimum technological/system requirements
- Establish operating policies through which providers may confirm recipients eligibility on a monthly basis
- Establish a manner in which MCO's assist the commission in collecting applied income or cost sharing.

Phase two must be completed no later than July 15, 2014

SB 7 establishes multiple advisory committees, including the STAR PLUS Nursing Facility Advisory Committee, Medicaid Managed Care Advisory Committee, and the STAR PLUS Quality Council.

SB 7 contains language preventing Managed Care Organizations from implementing significant, non-negotiated, across-the-board rate reductions, unless the MCO has prior approval from HHSC.

SB 7 includes an instructional provision that directs HHSC to seek a waiver or authorization from the appropriate federal agency to waive the 3-day hospital stay.

SB 7 reserves the right of the commission to establish an independent review process for final determination of provider appeals and denials.

SB 7 instructs the Commission to seek a waiver from CMS to ensure a significant portion (but no more than 80%) of accrued savings to Medicare program as a result of reduced hospitalizations, efficiency improvements to nursing facilities participating in Medicaid will be returned to the state and distributed to facilities in incentive payments.

Effective date of expansion to include nursing homes – Not before September 1, 2014

SB 348: Relating to a utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program.
Author: Schwerter
Sponsor: Kolkhorst
Effective date: September 1, 2013

SB 348 requires HHSC's Office of contract management to establish an annual utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. This bill focuses on Home and Community Based Services and Managed Care Organizations utilization review processes.

SB 1150, Relating to a provider protection plan that ensures efficiency and reduces administrative burdens on providers participating in a Medicaid managed care model or arrangement.
Author: Hinojosa
Sponsor: Guerra
Effective date: September 1, 2013

SB 1150 instructs HHSC to develop and implement a provider protection plan designed to reduce administrative burdens placed on providers participating in a Medicaid managed care model to ensure efficiency in provider enrollment and reimbursement. The provider protection plan must provide for:

- prompt payment and proper reimbursement of providers by managed care organizations;
- prompt and accurate adjudication of claims through:
  --provider education on the proper submission of clean claims and on appeals;
- acceptance of uniform through an electronic portal; and
- the establishment of standards for claims payments in accordance with a provider's contract;
- adequate and clearly defined provider network standards that are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards in effect on January 1, 2013, and that ensure choice among multiple providers to the greatest extent possible;
- a prompt credentialing process for providers;

- uniform efficiency standards and requirements for managed care organizations for the submission and tracking of preauthorization requests for services provided under the Medicaid program;
- establishment of an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:
    - submit electronic claims, prior authorization requests, claims appeals and reconsiderations, clinical data, and other documentation that the managed care organization requests for prior authorization and claims processing; and
    - obtain electronic remittance advice, explanation of benefits statements, and other standardized reports;
    - the measurement of the rates of retention by managed care organizations of significant traditional providers;

Health and Human Services Commission shall implement the provider protection plan by September 1, 2014.

MEDICAID OVERSIGHT, REGULATORY ISSUES

SB 8, relating to the provision and delivery of certain health and human services in this state, including the provision of those services through the Medicaid program and the prevention of fraud, waste, and abuse in that program and other programs.

Author: Nelson
Sponsor: Kolkhorst
Effective date: September 1, 2013

SB 8 addresses marketing activity, waste, fraud and abuse among Medicaid providers in instructs the commissioner of HHST to establish a data analysis to establish, employ, and oversee data analysis processes.

New restrictions are placed on marketing activity for Medicaid and CHIP providers, however a provider participating in the Medicaid STAR + PLUS program, may engage in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to educate a Medicaid client about available long-term care services and supports.

The commission shall establish a process by which providers may submit proposed marketing activities for review and prior authorization to ensure that providers are in compliance with the requirements of law.

The commission shall monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services.

The commission's OIG is responsible for the:

- prevention,
- detection,
- audit,
- inspection,
- review, and
- investigation of fraud, waste, and abuse.

The commission may obtain any information or technology necessary to enable the office to meet its responsibilities under this subchapter or other law.

The commission's office of inspector general shall employ and commission five peace officers at any given time for the purpose of assisting the office in carrying out the duties of the office relating to the investigation of fraud, waste, and abuse in the Medicaid program. Peace officers employed will be administratively attached to the Department of Public Safety.

The executive commissioner of the Health and Human Services Commission, shall establish criteria for the department or the commission's office of inspector general to:

- suspend a provider's billing privileges under the Medicaid program,
- revoke a provider's enrollment under the program, or
- deny a person's application to enroll as a provider under the program based on specific factors.

The executive commissioner of the Health and Human Services Commission shall require revocation of a provider's enrollment or denial of a person's application for enrollment as a provider under the Medicaid program if the person has been excluded or debarred from participation in a state or federally funded health care program as a result of:

- a criminal conviction or finding of civil or administrative liability for committing a fraudulent act, theft, embezzlement, or other financial misconduct under a state or federally funded health care program; or
- a criminal conviction for committing an act under a state or federally funded health care program that caused bodily injury to:
    - a person who is 65 years of age or older;
    - a person with a disability; or
    - a person under 18 years of age.

SB 1803, relating to investigations of and payment holds relating to allegations of fraud or abuse and investigations of and hearings on overpayments and other amounts owed by providers in connection with the Medicaid program or other health and human services programs.
Author: Huffman
Sponsor: Kolkhorst
Effective date: September 1, 2013

S.B. 1803 requires HHSC office of Inspector General to conduct a preliminary investigation, rather than an integrity review, to determine whether there is a sufficient basis to warrant a full investigation if HHSC receives a complaint or allegation of Medicaid fraud or abuse from any source.

The bill requires the notice of a payment hold, in addition to meeting federal requirements, to also include the specific basis for the hold, including:

- identification of the claims supporting the allegation at that point in the investigation and
- a representative sample of any documents that form the basis of the hold, and
- a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

S.B. 1803 requires the office of the inspector general, on timely request by a provider subject to a payment hold (other than a hold requested by the state's Medicaid fraud control unit), to file a request with the appeals division of HHSC, as an alternative to filing a request with the State Office of Administrative Hearings (SOAH), for an expedited hearing regarding the hold.

A provider may request an expedited administrative hearing regarding a payment hold not later than the 30th day after the date the provider receives notice from the OIG.

The bill requires SOAH and the executive commissioner of HHSC to jointly adopt rules that require a provider, before an expedited administrative hearing before SOAH regarding a hold, to advance security for the costs for which the provider is responsible.

S.B. 1803 authorizes a provider to appeal a final administrative order by filing a petition for judicial review in a district court in Travis County following an expedited administrative hearing.

The bill sets out provisions relating to scheduling and giving notice regarding the time and place of an initial informal resolution meeting.

S.B. 1803 requires the OIG to employ a medical director who is a licensed physician and a dental director who is a licensed dentist who preferably each have significant knowledge of the Medicaid program.
The bill requires the medical director and the dental director to ensure that:

- investigative findings based on the necessity or the quality of certain medical or dental services or care, as applicable, have been reviewed by a qualified expert as described by the Texas Rules of Evidence who preferably has significant knowledge of the Medicaid program rules and
- requirements before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties

SB 1803 requires the executive commissioner, in conjunction with the office of inspector general and in consultation with the state's Medicaid fraud control unit, to adopt rules for the office that:

- establish criteria for initiating a full fraud or abuse investigation,
- conducting the investigation, and
- collecting evidence;
- training requirements for Medicaid provider fraud or abuse investigators; criteria for determining, in accordance with state and federal law, when good cause exists to not impose a payment hold on a provider, discontinue a payment hold imposed on a provider,
- partially discontinue a payment hold imposed on a provider, and
- convert a full payment hold imposed on a provider to a partial payment hold.

The bill requires the executive commissioner to consider the following:

- a specific request by a law enforcement agency that the office not impose a payment hold on a provider or discontinue a payment hold imposed on a provider;
- a determination by the office that other available remedies implemented by the office or HHSC could more effectively or quickly protect Medicaid funds than imposing or continuing a payment hold;
- evidence submitted by a provider that convinces the office that a payment hold should be discontinued or partially imposed;
- a determination by the office that a Medicaid recipient's access to items or services will be jeopardized by the imposition of a payment hold;
- a determination by the office that a payment hold should be discontinued because the state's Medicaid fraud control unit or a law enforcement agency declines to cooperate in certifying that the unit or agency is continuing to investigate the credible allegation of fraud that is the basis of the payment hold;
- determination by the office that imposing a full or partial payment hold is not in the best interest of the Medicaid program; and

- a determination by the office that a partial payment hold will ensure that potentially fraudulent claims under the Medicaid program will not be continued to be paid.

S.B. 1803 authorizes a provider, if after a final determination HHSC or the office of inspector general seeks to recoup from the provider an overpayment or debt arising out of a fraud or abuse investigation in an amount that is less than $1 million, to appeal the determination not later than the 15th day after the date the provider receives a notice of HHSC's or the office's final determination by requesting in writing that HHSC or the office set an administrative hearing on the determination.

The bill requires HHSC, on receipt of a timely written request for an administrative hearing from the provider, to file a docketing request with SOAH or the appeals division of HHSC, as requested by the provider, for an administrative hearing on the final determination to recoup the overpayment or debt and any associated damages and penalties.

S.B. 1803 requires HHSC to employ a person whose salary is paid by HHSC and who is independent of the office of inspector general to attend the informal resolution meetings held regarding a payment hold or a recoupment of overpayment or debt as a neutral third-party observer. The bill requires the person to report to the executive commissioner on the proceedings and outcome of each informal resolution meeting.

HB 729, Relating to access to criminal history record information by certain hospitals and other facilities.
Author: Price
Sponsor: Deuell
Effective date: September 1, 2013

H.B. 729 allows certain entities, hospitals, nursing homes, to obtain criminal history record information from DPS regarding individuals who provide services at health care facilities.
H.B. 729 adds students doing their clinical training at a hospital to the list. For nursing homes, hospice programs, and long-term care facilities, the bill adds contract employees and volunteers to the list.

HB 908, Relating to the assessment of an elderly or disabled person's psychological status for purposes of an emergency order authorizing protective services.
Author: Nevarez
Sponsor: Uresti

Effective date: September 1, 2013

H.B. 908 adds licensed professional counselors to the list of those eligible to perform psychological assessments of disabled or elderly persons suffering from abuse, neglect, or exploitation, in order to ensure such persons have the same access to emergency protective services as those in urban counties.

HB 2383, Relating to the consideration of a life insurance policy in determining eligibility for medical assistance.
Author: Eiland
Sponsor: Duncan
Effective date: September 1, 2013

HB 2383 authorizes the owner of a life insurance policy with a face amount of more than $10,000 to enter into a life settlement contract under Chapter 1111A (Life Settlement Contracts), Insurance Code, for the benefit of a recipient of medical assistance long-term care services in exchange for direct payments to a health care provider for the provision of those services to that recipient or the state to offset the costs of providing those services to that recipient under the medical assistance program.

HB 2383 requires:

- proceeds of a life settlement contract entered into under this section be used for the payment of long-term care services and support
- authorizes the medical assistance program, to the extent feasible and allowed under federal law, to only act as the secondary payor for long-term care services and support provided to a person who is eligible for medical assistance and for whose benefit an owner of a life insurance policy has entered into a life settlement contract under this section.

Life settlement contracts must:

- provide that the lesser of five percent of the face amount of the life insurance policy or $5,000 is reserved and is payable to the owner's estate or a named beneficiary for funeral expenses;
- provide that the balance of proceeds under the life settlement contract that are unpaid on the death of the owner must be paid to the owner's estate or a named beneficiary; and
- specify the total amount payable for the benefit of the recipient of long-term care services and support under the life settlement contract.
- requires that all proceeds of a life settlement contract entered into under this section be held in an irrevocable state or federally insured account for the benefit of the recipient of long-term care services and support or for payment as otherwise required by this section.

Only a recipient of long-term care services and support for whose benefit an owner enters into a life settlement contract chooses the provider and type of services provided and paid for out of a secured account. Any attempt by a person to require the recipient to choose a specific provider is strictly prohibited.

HB 2383 requires life settlement companies to:

- maintain a surety bond executed and issued by an insurer authorized to issue surety bonds in this state;
- a policy of errors and omissions insurance; or
- a deposit in the amount of $500,000 in any combination of cash, certificates of deposit, or securities
- file with the Texas Department of Insurance

Requires TDI to educate on long-term care services and support under the medical assistance program about options for life insurance policies, including options that do not allow a life insurance policy to be considered as an asset or resource in determining eligibility for medical assistance.

Texas Health and Human Services Commission (executive commissioner) and Texas Department of Insurance, will adopt rules necessary to implement this law. Adopted rules must ensure that:

- proceeds from a life settlement contract are used to reimburse the provider of long-term care services and support or the state to offset the cost of medical assistance long-term care services and support;
- eligibility and need for medical assistance are determined without considering the balance of proceeds from a life settlement contract as provided in this section; and
- payments to a provider of long-term care services and support and applied income payments are made in accordance with this chapter.

Provides that the entry into a life settlement contract by an owner of a life insurance policy is not the only method by which the owner may avoid having the policy considered as an asset or resource in determining the eligibility of the owner for medical assistance.

HB 3196, relating to licensing, certification, and arbitration requirements for certain health facilities and to the allocation of Medicaid beds in those facilities.

Author: Price
Sponsor: Nelson
Effective date: September 1, 2013

H.B. 3196 adjusts the licensure fees for nursing facilities to align with the three-year licensure period. License fee may not exceed $375.
The bill authorizes the Texas Board of Human Services (board) to establish by rule license fees nursing facilities. The new license fee may not exceed $375, plus $15 for each unit of bed space and a background examination fee.

HB 3196 also increases the Alzheimer's certification period from one year to three years to be consistent with the three-year licensure cycle.
Finally, HB 3196 allows the executive commissioner of the Health and Human Services Commission to require applicants for a Medicaid bed waiver to provide a $500,000 performance bond, or other financial security, that will be forfeited to DADS if the applicant does not follow through with construction of a new nursing facility within the required time frame.

HHSC may not require an applicant for Medicaid beds in a nursing facility to obtain a performance bond from a specific insurance or surety agency, agent, or broker.

The executive commissioner will adopt criteria to exempt certain applicants for Medicaid beds from the requirements, including applicants that are licensed facilities with existing Medicaid bed allocations, criminal justice facilities, teaching facilities, and state veterans homes, and any other applicants that the executive commissioner finds good cause to exempt. The executive commissioner may modify the criteria for granting exemptions.

ASSISTED LIVING:

HB 33, relating to alternative methods of dispute resolution in certain disputes between the Department of Aging and Disability Services and an assisted living facility licensed by the department.
Author: Menendez
Sponsor: Uresti
Effective date: September 1, 2013

HB 33 requires the Health and Human Services Commission (HHSC) by rule to establish an informal dispute resolution process to address disputes between an assisted living facility and the Department of Aging and Disability Services (DADS) concerning a statement of violations prepared by DADS.

HB 33 requires:

- HHSC must complete the process within 90 days.

- Not later than the 10th business day after the date an assisted living facility requests an informal dispute resolution, DADS forward to the assisted living facility a copy of all information that is referred to in the disputed statement of violations or on which a citation is based in connection with the survey, inspection, investigation, or other visit, excluding:
    - the name of any complainant, witness, or informant;
    - any information that would reasonably lead to the identification of a complainant, witness, or informant;
    - information obtained from or contained in the records of the facility;
    - information that is publicly available; or
    - information that is confidential by law;

HB 33 requires HHSC to give full consideration to all factual arguments raised during the informal dispute resolution process that:

- are supported by references to specific information that the facility or DADS relies on to dispute or support findings in the statement of violations; and
- are provided by the proponent of the argument to HHSC and the opposing party;
- that informal dispute resolution staff give full consideration to the information provided by the assisted living facility and DADS;
- that ex parte communications concerning the substance of any argument relating to a survey, inspection, investigation, visit, or statement of violations under consideration not occur between the informal dispute resolution staff and the assisted living facility or DADS; and
- that the assisted living facility and DADS be given a reasonable opportunity to submit arguments and information supporting the position of the assisted living facility or DADS and to respond to arguments and information presented against them.

Assisted living facility requesting an informal dispute resolution must reimburse DADS for any costs associated with DADS's preparation, copying, and delivery of information requested by the facility.

HB 33 provides that a statement of violations prepared by DADS following a survey, inspection, investigation, or visit is confidential pending the outcome of the informal dispute resolution process. Information concerning the outcome of a survey, inspection, investigation, or visit to be posted on any website maintained by DADS while the dispute is pending if the posting clearly notes each finding that is in dispute.

HB 424, relating to the sex offender status of a person who becomes a resident of certain group home facilities.
Author: Burkette

Sponsor: Deuell
Effective date: September 1, 2013

H.B. 424 requires the director of a group home, and assisted living facilities, to ascertain whether the person is a registered sex offender. This bill requires the director to search a website maintained by the Department of Public Safety of the State of Texas that contains the sex offender database.

HB 424 requires the director, if based on information obtained the director ascertains that a person is a registered sex offender, not later than the third day after the date the person becomes a resident of the group home or assisted living facility, to provide notice that the person is a sex offender to the legal guardian of each current resident who has a legal guardian and directly to each other resident. Requires that the notice contain all of the information about the person that is available on the website.

This bill provides that a group home or its director is not liable under any law for damages arising from conduct required under this chapter.

Additionally, HB 424 requires the director of a group home and assisted living facility, to ascertain, whether any resident of the group home is a registered sex offender, and provide to the legal guardian of each current resident who has a legal guardian, and directly to each other resident, notice about each resident who is required to register. This check on current residents must occur no later than March 1, 2014,

HB 1971, Relating to a pilot program conducted by the Department of Aging and Disability Services to authorize certain accreditation surveys of assisted living facilities.
Author: John Davis
Sponsor: Deuell
Effective Date: September 1, 2013

HB 1971 allows DADS to create an ACCREDITATION SURVEY PILOT PROGRAM for Assisted Living facilities. The accreditation survey will fulfill the requirements of the life and safety code inspection. The programs goal is to implement this in at least one AL facility no later than August 31, 2014.

HB 3729, Relating to licensing requirements for newly constructed assisted living facilities.
Author: Coleman
Sponsor: Van de Putte
Effective: September 1, 2013

HB 3729 requires the Department of Aging and Disability Services (DADS) to, upon submission of a written request by the applicant, automatically issue a six-month

provisional license without conducting a life safety code inspection before issuance of the provisional license to a newly constructed facility if:

- the license applicant has submitted building plans to DADS for an early compliance review, rather than if the facility is in compliance with resident care standards;
- all local approvals, including a certificate of occupancy where required, have been obtained;
- a complete license application form is submitted within 30 days of receipt of all local approvals;
- the license fee has been paid;
- DADS determines that the license applicant or a person who owns the license applicant and controls the operations of the license applicant constructed another facility in this state that complies with DADS's life safety code standards; and
- the facility is in compliance with resident care standards based on an on-site health inspection.

WORKGROUPS AND ADVISORY COUNCILS CREATED THROUGH RIDER OR LEGISLATION DURING THE 83RD REQUIRING NURSING FACILITY REPRESENTATION:

Nursing Facility Advisory Committee – (must be appointed no later than 9/15/2013)
15 members, Speaker, Lt. Gov, Gov. each appoint 5:

Physician/Medical Director
Non-Profit member
For Profit member
Consumer Rep.
MCO Rep.

STAR-PLUS Quality Council (must be appointed no later than 10/1/2013)

Reps from HHSC agencies
Recipients of STARPLUS Medicaid Managed Care
Representatives of Advocacy group for IDD and Seniors
Representatives for service providers for individuals with disabilities
Representatives from MCO's

Medicaid Managed Care Advisory Council (appointed no later than 10/1/2013)

Hospitals
MCO's and participating health care providers
Primary care provider sand specialty care providers
State Agencies

Low Income recipients or consumer advocates
Recipients w/ disabilities, including recipients with IDD/physical disabilities/consumer
Parents of children with disabilities
Rural providers
Advocates for children with special health care needs
Pediatric health care providers
Long term services and supports, including nursing facility providers and direct care wkrs
Recipients who are 65 years of age or older
Recipients with mental illness
Non physician mental health providers
Entities with responsibilities for the delivery of long-term services and supports (ADRC's)

Workgroup on Nursing Facility Residents' Applied Income. (By January 31, 2014)
The Executive commissioner of the Health and Human Services Commission shall appoint a workgroup on nursing facility residents' applied income. Including:

Reps from Office of the Attorney General's Division of Medicaid Fraud Control and/or Consumer Protection
Department of Aging and Disability Services Division of Long Term Regulatory,
Texas Health Care Association,
Texas Silver Haired Legislature,
The Texas Senior Advocacy Coalition