TEXAS INSIGHT
HEALTHCARE INTELLIGENCE

Health and Human Services

Medicaid and Managed Care Legislation

Source Documents

September 10, 2025

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

Below is a listing of Medicaid related bills reported by HHSC to be in active implementation. The information provided is the most current available from reliable sources.

STAR Health/Foster Care

House Bill 2809 (Rose)– (HB02809F.pdf) Requires DFPS to report attempted suicide attempts by youth in the DFPS managing conservatorship– Adds suicide attempt to the definition of a "significant change in medical condition"

Fiscal Impact: No significant fiscal implication to the State is anticipated.

The bill would add the number of children who attempted suicide while in managing conservatorship of the Department of Family and Protective Services to the yearly report. The bill would also add suicide attempt as a significant change in medical condition.

It is assumed that any costs to the Department of Family and Protective Services could be absorbed within existing resources.

Bill Analysis/Summary. According to the 2022 Report on Suicide and Suicide Prevention by the Statewide Behavioral Health Coordinating Council, the foster youth population in Texas has a higher rate of suicide than the rest of the youth population. The suicide rate for Texas' foster youth population increased by 335 percent in the five-year period between 2017 through 2021. According to the Centers for Disease Control and Prevention, a previous suicide attempt is one of the leading risk factors for death by suicide, and yet the Department of Family and Protective Services (DFPS) does not maintain records of suicide attempts by foster youth.

Currently, the annual report produced by DFPS does not include suicide attempts by children in the state's managing conservatorship and is not required to report attempts to families within a given period. Adding these requirements would improve our understanding of the magnitude of the issue, improve health outcomes, and allow for effective prevention.

H.B. 2809 would require DFPS to include suicide attempts by children in its managing conservatorship in the annual report of child protection statistics and to provide notice

to the parent of such a child who attempts suicide within a certain period. The annual report must be publicly accessible and published electronically by December 1st annually. Transparency into suicide attempt data can help the agency and the parents better understand risk factors and prevent any further attempts.

H.B. 2809 amends current law relating to required reporting by the Department of Family and Protective Services regarding youth in the managing conservatorship of the department who attempt suicide.

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

Senate Bill 855 (Sparks)– (SB00855F.pdf)Allows medical consenters to assume financial responsibility for certain out-of-network medical care provided to children in foster care– Managed Care Organization (MCO) would not be liable for cost of care or services

Fiscal Impact. No significant fiscal implication to the State is anticipated**.**

The bill would allow a person other than the Department of Family and Protective Service (DFPS), who is otherwise authorized to consent to medical care for a foster child, to assume financial responsibility for medical care provided to the foster child by an out-of-network provider. The bill would establish that DFPS is not liable for the cost of such care unless so ordered by a court. The bill would prohibit Medicaid managed care organizations from taking certain adverse actions related to such care and require STAR Health program managed care contracts between Medicaid managed care organizations and the Health and Human Services Commission (HHSC) to include provisions prohibiting such adverse actions.

The bill would take effect September 1, 2025.

According to DFPS and HHSC, amendments to contracts, policies, and procedures would be necessary to implement the provisions of the bill. It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. In October 2024, West Texas Together issued a report that addressed the critical shortage of healthcare providers serving foster youth in the Midland/Odessa area. The report revealed a critical shortage of healthcare providers in Midland/Odessa accepting Medicaid that serve foster youth. Of the 28 identified pediatric providers, only 10 accepted all clients, leading to long wait times and forcing families to travel for care. Behavioral health services are similarly constrained, with only 12 of 18 providers taking new clients and significant gaps in age-appropriate care and trauma-informed training. Furthermore, the region has only two ophthalmologists, one serving minors, and two speech therapists, both with over two-month wait times. These systemic barriers jeopardize timely, specialized care for foster youth, emphasizing the urgent need for enhanced healthcare access and support. In response to West Texas Together's report, the Health and Human Services Commission responded with differing information on contracted providers. This raised concerns regarding access to care for our most vulnerable youth and the accountability the state is assuming.

S.B. 855 seeks to provide a pathway for foster parents and youth to access care. This legislation amends the Family Code and the Government Code to allow the medical consenters of foster care children to access out-of-network providers for healthcare solutions. Additionally, this bill seeks to remove liability from the managed care organization for out-of-network care while ensuring Medicaid benefits are not limited for minors under conservatorship.

S.B. 855 amends current law relating to the authority of certain medical consenters to assume financial responsibility for certain out-of-network medical care provided to children in foster care.

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

Added Benefits

House Bill 26 (Hull)– (HB00026F.pdf) Requires HHSC to add nutritional counseling as an in-lieu-of service (ILOS)– Requires HHSC to implement an ILOS pilot for pregnant women to receive nutritional counseling and medically-tailored meals

Fiscal Impact. No significant fiscal implication to the State is anticipated.

The bill would require the Health and Human Services Commission (HHSC) to permit Medicaid managed care organizations to offer nutrition counseling and instruction services in lieu of services specified in the state Medicaid plan. The bill would allow HHSC to establish a pilot program to provide additional nutrition support services to certain pregnant Medicaid recipients in lieu of services specified in the state Medicaid plan, collect and analyze data on the impact to maternal and infant health outcomes that nutrition support services have on pilot program participants, and submit a written report that includes a summary of the pilot program outcomes and recommendations for legislative or other action.

The bill would take effect September 1, 2025.

According to HHSC, updates to claims and provider enrollment processes would be necessary to implement the provisions of the bill. This analysis assumes that these costs, costs related to the pilot program, and any other costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Currently, medical nutritional counseling is a Medicaid benefit provided to children with certain diseases who are referred for medically necessary nutritional counseling, a service offered by practicing licensed dietitians who are enrolled as Medicaid providers. However, the adult Medicaid population and children diagnosed with other diseases for whom nutritional counseling might improve health outcomes, decrease the risk of chronic disease, and decrease utilization of the healthcare system, are left without this same access to nutritional counseling. The federal Centers for Medicare and Medicaid Services (CMS) approves states to offer certain Medicaid services in lieu of other benefits if it can be demonstrated that the services are medically appropriate and more cost-effective than offering covered benefits. Currently, state law directs the Health and Human Services Commission (HHSC) to offer in-lieu-of services (ILOS) for mental health or substance use programs. ILOS are optional for Medicaid managed care organizations (MCOs) to provide, optional for Medicaid clients to participate in, and must be determined to be cost-effective with approval by CMS.

H.B. 26 seeks to direct HHSC to permit Medicaid MCOs to provide nutritional counseling and instruction services in lieu of other services if determined to be

medically appropriate and cost-effective. The bill excludes from nutritional counseling and instruction services any service that includes home-delivered meals, food prescriptions, or grocery support.

C.S.H.B. 26 amends current law current law relating to requiring contracts with Medicaid managed care organizations to permit the organizations to offer nutrition counseling and instruction services in lieu of other state Medicaid plan services.

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

House Report. House Bill 26 amends the Government Code to require a Medicaid managed care contract to contain language permitting the contracting managed care organization (MCO) to offer qualifying nutrition counseling and instruction services from a list of services approved by the state Medicaid managed care advisory committee and included in the contract in lieu of services specified in the state Medicaid plan. The bill also authorizes the Health and Human Services Commission to establish a pilot program that, if established, terminates August 31, 2030, under which Medicaid MCOs may offer and provide additional nutrition support services in lieu of services specified in the state Medicaid plan to pregnant Medicaid recipients who are diagnosed with a chronic health condition or disease that may contribute to a high-risk pregnancy or birth complications.

HB 26 would require Medicaid managed care contracts to include provisions permitting Medicaid managed care organizations (MCOs) to offer, in lieu of other services specified in the state Medicaid plan, medically appropriate, cost-effective, evidence-based nutrition counseling and instruction services that were approved by the state Medicaid managed care advisory committee.

The list of approved nutrition counseling and instruction services could not include home-delivered meals, food prescriptions, or grocery support.

If a state agency determined that a waiver or authorization from a federal agency was necessary to implement the bill, the agency would be required to request the waiver and could delay implementation until the waiver or authorization was granted.

The bill took effect September 1, 2025, and would apply to a contract entered into or renewed on or after the effective date.

House Bill 136 (Hull)– (HB00136F.pdf) Requires HHSC to add lactation consultation as a reimbursable Medicaid benefit

Fiscal impact. Estimated Two-year Net Impact to General Revenue Related Funds for HB136, As Engrossed: a negative impact of ($1,995,065) through the biennium ending August 31, 2027. Follow the link for detailed cost breakdown.

According to HHSC, necessary policy revisions and rate hearings associated with creating a new benefit can take approximately 12 to 18 months to complete; therefore, HHSC assumes that services would begin September 1, 2026.

This analysis assumes that HHSC would require $247,535 from the General Revenue Fund ($1,693,750 from All Funds) in fiscal year 2026 for development costs associated with establishing new provider types and $9,867 from the General Revenue Fund ($39,467 from All Funds) in subsequent fiscal years for ongoing system updates.

The additional annual caseload associated with the new benefit is estimated to be 54,861 in fiscal year 2027, increasing to 56,916 by fiscal year 2030, with an assumed per diem rate of $54.20 and an average of two lactation consultation sessions per utilizer. This analysis assumes a net client services cost of $1,789,640 from the General Revenue Fund ($4,455,165 from All Funds) in fiscal year 2027, including offsetting adjustments to managed care capitation rates due to decreased claims related to improved health outcomes for infants.

This analysis assumes that these costs would be partially offset by an estimated $38,983 to the General Revenue Fund in fiscal year 2027 from client services payments through managed care that are assumed to result in an increase to the General Revenue Fund from insurance premium tax revenue and revenue adjusted for assumed timing of payments and prepayments, resulting in increased revenue collections. Additionally, this analysis assumes an offset of $12,994 in fiscal year 2027 to be deposited to the credit of the Foundation School Fund, pursuant to Section 227.001(b), Insurance Code.

The total technology cost is estimated to be $1,693,750 from All Funds in fiscal year 2026 and $39,467 from All Funds in fiscal year 2027.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. House Bill 136 amends the Human Resources Code to require the Health and Human Services Commission (HHSC) to ensure the provision of Medicaid reimbursement for lactation consultation services provided by lactation consultants certified by an HHSC-approved international or national certification program. The bill requires the executive commissioner of HHSC to establish a separate provider type for lactation consultants for purposes of Medicaid provider enrollment and reimbursement.

CSHB 136 requires the Health and Human Services Commission (HHSC) to provide Medicaid reimbursement for lactation consultation services delivered by lactation consultants certified by an HHSC-approved international or national certification program. The bill also directs the HHSC executive commissioner to create a separate provider type for lactation consultants for purposes of Medicaid enrollment and reimbursement.

If a state agency determines that a waiver or authorization from a federal agency was necessary to implement the bill, the agency would be required to request the waiver and could delay implementation until the waiver or authorization was granted.
The bill took effect September 1, 2025.

House Bill 426 (Bernal)– (89(R) Text for HB 426) Requires HHSC to expand the allowable diagnoses for coverage of childhood cranial remolding orthosis in Medicaid– Requires HHSC to add childhood cranial remolding orthosis as a reimbursable benefit comparable to the amended Medicaid benefit

Fiscal Impact. Estimated Two-year Net Impact to General Revenue Related Funds for HB426,: a negative impact of ($2,265,870) through the biennium ending August 31, 2027.Follow the link for a detailed cost breakout

According to HHSC, necessary policy revisions and rate hearings associated with creating a new benefit can take approximately 12 to 18 months to complete; therefore, HHSC assumes that services would begin September 1, 2026.

The additional annual Medicaid caseload associated with the new benefit is estimated to be 3,114 in fiscal year 2027, increasing to 3,225 by fiscal year 2030, with an assumed annual cost of $1,864 per utilizer. The additional annual CHIP caseload associated with the new benefit is estimated to be 3 in fiscal year 2027 through 2030, with an assumed annual cost of $1,865 per utilizer. This analysis assumes a total client services cost of $2,333,647 from the General Revenue Fund ($5,809,427 from All Funds) in fiscal year 2027.

This analysis assumes that these costs would be partially offset by an estimated $50,833 to the General Revenue Fund in fiscal year 2027 from client services payments through managed care that are assumed to result in an increase to the General Revenue Fund from insurance premium tax revenue and revenue adjusted for assumed timing of payments and prepayments, resulting in increased revenue collections. Additionally, this analysis assumes an offset of $16,944 in fiscal year 2027 to be deposited to the credit of the Foundation School Fund, pursuant to Section 227.001(b), Insurance Code.

This analysis assumes that any administrative costs to HHSC associated with development and implementation of the new benefits could be absorbed using existing resources.

No significant technology cost is anticipated.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Concerns have been raised that insurers often consider cranial remolding orthoses cosmetic and do not provide coverage, even when prescribed for conditions like brachycephaly or plagiocephaly. Some have suggested that children with conditions such as craniosynostosis, often treated with surgery and orthoses, may not receive full coverage for additional helmets, limiting access to effective treatment. CSHB 426 would require the Health and Human Services Commission (HHSC) to ensure that medical assistance reimbursement was provided to cover in full the cost of a cranial remolding orthosis for a child who was a medical assistance recipient and had been diagnosed with either craniosynostosis or positional plagiocephaly or brachycephaly. To qualify, the child would be required to be between 3 and 18 months of age, have documented failure to respond to conservative therapy for at least two months, and meet at least one of the following clinical criteria:

- asymmetrical appearance confirmed by a right/left discrepancy of greater than six millimeters in a craniofacial anthropometric measurement; or
- brachycephalic or dolichocephalic disproportion in the comparison of head length to head width confirmed by a cephalic index of two standard deviations above or below the mean.

The bill prohibits the coverage from being less favorable than the coverage required for other orthotics under Medicaid. The bill would define "cranial remolding orthosis" as a custom-fitted or custom-fabricated medical device applied to the head to correct a deformity, improve function, or relieve symptoms of a structural cranial disease.

The bill also amends the Health and Safety Code to require the Children's Health Insurance Program (CHIP) to cover in full the cost of a cranial remolding orthosis for an enrollee in the same manner that Medicaid coverage was provided for that treatment.

If a state agency determines that a waiver or authorization from a federal agency was necessary to implement the bill, the agency would be required to request the waiver and could delay implementation until the waiver or authorization was granted.
The bill would take effect September 1, 2025.

Senate Bill 1044 (Parker)–(89(R) Text for SB 1044) Requires DSHS to add Duchenne muscular dystrophy to newborn screening– Requires HHSC to update interagency contract to reimburse for this additional screening

Fiscal Impact. No significant fiscal implication to the State is anticipated.

The Department of State Health Services (DSHS) is required to implement a provision of the bill only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, DSHS may, but is not required to, implement a provision of the bill using other appropriations available for that purpose. Additionally, the bill would authorize DSHS to implement changes made by the bill upon completion of a new laboratory.

To illustrate possible costs related solely to the new screening, the agency has noted that once additional laboratory space is operational, ramp-up activities for adding DMD to the Texas Newborn Screening Panel will take two years before testing can be implemented. DSHS estimates that the first year ramp up costs would be $710,320 and

$2,937,025 in the second year, all from the General Revenue Fund. DSHS would require 9.0 full-time equivalent positions (FTEs) in year 1 and 12.0 FTEs in year 2.

After the first two years, revenue from Medicaid reimbursements, based on a DMD test cost of $11.87, is estimated to total $4,053,400 in year 3, $4,912,721 in year 4, and $4,961,849 in year 5, which would be deposited into Account 709, Public Health Medicaid Reimbursements. Revenue from private pay insurance, based on a DMD test cost of $5.23, is estimated to total $780,272 in year 3, $1,576,149 in year 4, and $1,591,909 in year 5, which would be deposited into General Revenue-Dedicated Account 524, Public Health Services Fees.

The Health and Human Services Commission (HHSC) pays DSHS for Medicaid and Children's Health Insurance Program (CHIP) newborn testing through an interagency contract (IAC). HHSC would not have any costs until DSHS implements DMD testing.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Duchenne muscular dystrophy (DMD) is a universally fatal, rare pediatric disease resulting from an absence of dystrophinï¿½a protein vital for muscle structure, function, and preservation. Its genetic cause is an alteration (mutation) in the DMD gene that provides the code to make dystrophinï¿½that happens before birth and can be inherited or the result of a spontaneous new mutation. Without dystrophin, children with Duchenne experience progressive muscle deterioration and weakness, irreversibly losing the ability to walk, feed themselves, and breathe unassisted over time. Duchenne predominantly affects males, but, in rare cases, can also affect females. One of the most common fatal genetic disorders, DMD affects approximately one in every 3,500ï¿½5,000 male births worldwide. Premature death typically occurs in a patient's mid- to late 20s or third decade of life.

Despite advancements in treatment and physician education, the average age of diagnosis for DMD is five yearsï¿½an average of 2.5 years after parents or caregivers first notice the symptoms of the disease. This lag time in diagnosis has remained unchanged for over 20 years. Many families experience a lengthy, arduous journey to a diagnosis, involving months or years of unnecessary interventions and doctors' visits, with some parents reporting that concerns about their child's development are dismissed. Unfortunately, the diagnostic delay is worse for families of color and families from a low socioeconomic status. Because degeneration begins before birth, patients

with Duchenne experience irreversible muscle damage while waiting for a diagnosis. Broad adoption of newborn screening for DMD would prevent unnecessary testing, shorten the time to diagnosis, and help close the gap in racial and ethnic disparities, empowering families to make earlier and better informed treatment decisions.

S.B. 1044 adds screening for DMD to the newborn screening program conducted by the Texas Department of State Health Services (DSHS).

Committee Substitute

- Updated the implementation date from September 1, 2027, to "upon completion of the laboratory."
- Added that DSHS is required to "implement a provision of this act only if the legislature appropriates money specifically for that purpose."

S.B. 1044 amends current law relating to newborn screening tests for Duchenne muscular dystrophy.

Network Adequacy and Access to Care

House Bill 2516 (Guillen) – (HB02516F.pdf) Expands the Medicare supplement benefit plan coverage to individuals younger than 65 diagnosed with end stage renal disease or Amyotrophic Lateral Sclerosis (ALS)

Fiscal Impact. No significant fiscal implication to the State is anticipated. It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Concerns have been raised that individuals under age 65 who qualify for Medicare face barriers such as fewer options and higher premiums when attempting to obtain supplemental coverage to address significant out-of-pocket Medicare costs.
Digest

HB 2516 requires an entity that delivered or issued for delivery a Medicare supplement benefit plan in this state to individuals 65 years or older to offer the same coverage to individuals younger than 65 who were eligible for and enrolled in Medicare due to

disability, end stage renal disease, or amyotrophic lateral sclerosis. The bill would require an entity to provide any benefit, protection, policy, or procedure applicable to coverage and the same premium rate charged for a standardized Plan A, B, or D Medicare supplement benefit plan to applicable individuals younger than 65 in the same way it provided to 65-year-old individuals. A premium rate for a Medicare supplement benefit plan under the bill other than Plan A, B, or D could not exceed 200 percent of the premium rate charged for the same plan to an individual 65 years of age. An individual eligible for coverage under a Medicare supplement benefit plan under the bill could enroll any time during the six-month period beginning the first day of the first month the individual became enrolled for benefits under Medicare Part B. During an enrollment period, an entity could not:

- deny or condition the issuance or effectiveness of a Medicare supplement benefit plan or certificate that the entity offered and was available for issuance in this state;
- subject the applicant to medical underwriting or discriminate in the price of a Medicare supplement benefit plan or certificate because of the applicant's health status, claims experience, receipt of health care, or medical condition;
- impose a waiting period; or
- impose a limitation or exclusion of benefits based on a preexisting condition.

The insurance commissioner would be required to adopt rules necessary to administer the bill, including rules designating enrollment periods.

An individual eligible under the bill and enrolled in Medicare Part B due to disability, end stage renal disease, or amyotrophic lateral sclerosis on the effective date of the bill could apply for coverage under a Medicare supplement benefit plan between August 31, 2025, and March 2, 2026 or during a six-month period beginning on the date the application initially became available.

The bill took effect September 1, 2025, and would apply only to a Medicare supplement plan delivered, issued for delivery, or renewed on or after that date.

House Bill 3940 (Johnson) –(HB03940F.pdf) Members eligible for both Medicare and Medicaid, known as dually eligible individuals, may experience an impact to their Medicare services − Requires HHSC to notify medical providers, hospitals, birthing centers, and managed care organizations that a newborn not yet assigned a Medicaid ID number may use the mother's Medicaid ID

Fiscal Impact. No significant fiscal implication to the State is anticipated.

The bill requires the Health and Human Services Commission (HHSC) to provide an annual written notice to managed care organizations and health care providers of certain information regarding the use of Medicaid identification numbers with respect to newborn children.

The bill requires additional information about Medicaid benefits to be provided to parents of newborn children.

It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Concerns have been raised that many Medicaid-eligible newborns are not being automatically enrolled in coverage at birth as required by law and are experiencing delays in manual enrollment, leaving some newborns uninsured during critical early checkups.

HB 3940 would require the Health and Human Services Commission (HHSC) to annually provide a written notice to each managed care organization (MCO) and health care provider that regularly provided health care services to Medicaid recipients who were pregnant women or newborn children.

The bill requires the notice to remind providers and MCOs that when a newborn child of a Medicaid recipient had not yet been assigned a Medicaid ID, the provider could accept or use the recipient's Medicaid ID on any claim for reimbursement under Medicaid. The bill also requires the notice to encourage MCOs and providers to educate Medicaid recipients who were mothers or the prospective mothers of newborn children that the recipient's Medicaid ID could be used until their child was enrolled in Medicaid.

HB 3940 amends the resource information that a provider offering prenatal care to a pregnant woman during gestation or at the delivery of an infant was required to give to a newborn's parents to include information about Medicaid benefits for children, including eligibility requirements and the application process. The resource guide would

also have to include information on how to contact HHSC to report the child's birth for the purpose of enrolling the child in Medicaid.

The bill also requires that parents or caregivers receive written notice, developed by HHSC, informing them that their newborn child was automatically eligible for Medicaid. The notice would have to state that the woman's Medicaid ID could be used for reimbursement claims for services provided to the child until the child was enrolled in Medicaid and assigned a separate ID.

HB 3940 requires documentation in a newborn mother's health record that the woman received the required resource pamphlet and, if applicable, the resource guide and notice.

The bill took effect September 1, 2025.

Provider Credentialing or Licensing

House Bill 2038 (Oliverson)– (HB02038F.pdf) Allows for a provisional license to practice medicine to be issued by the Texas Medical Board

Fiscal Impact. Estimated Two-year Net Impact to General Revenue Related Funds for HB2038, As Passed 2nd House: a positive impact of $39,170 through the biennium ending August 31, 2027. The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

The bill amends the Texas Occupations Code to require the Texas Medical Board (TMB) to issue provisional licenses to practice medicine to certain foreign applicants who have been granted a medical degree, or a similar degree, and have been licensed in good standing in another country. TMB would have the choice to issue either a standard license or another provisional license to a provisional license holder if the licensee meets certain criteria. TMB would not be allowed to issue a license if the foreign applicant is a citizen of a country that is identified as either a national security risk or subject to prohibitions in the International Traffic in Arms Regulations. The provisional licenses would expire two years after the issuance of the provisional license.

The bill requires TMB to issue limited licenses to practice medicine to medical school graduates who have not matched into a residency program and authorizes a fee. these

graduates would be able to practice a limited scope of medicine under a supervising practice agreement with a sponsoring physician in counties with a population of less than 100,000.

The bill took effect September 1, 2025.

Based upon analysis provided by the Texas Medical Board (TMB), this estimate assumes that the agency will require 2.0 additional License and Permit Specialist positions ($57,851 each year with $17,309 in estimated benefits) to address the increased amount of licensure applications while maintaining current licensing processing times. This estimate assumes an additional annual cost of $23,370 for equipment and operating expenses related to the additional staffing position.

Based upon analysis provided by TMB and the Comptroller of Public Accounts, this estimate assumes that 200 individuals would apply each year for the foreign applicant provisional license and will pay a one-time application fee of $552 per applicant, resulting in $110,400 in annual revenue to the credit of the General Revenue Fund. Additionally, this estimate assumes that 170 individuals would apply each year for the graduate limited license and would pay a $220 application fee and a $267.50 registration fee for a license term of two years, resulting in annual revenue of $82,875 to the credit of the General Revenue Fund. This estimate assumes there will be no renewal applications and that all graduate limited licensees will enter into a residency program before they would need to renew their limited license.

No significant fiscal implication to units of local government is anticipated. See the link for detailed costs.

Bill Analysis/Summary. This legislation seeks to reduce barriers of entry for physicians to address the physician shortage the state currently faces.

In May of 2022, the Department of State Health Services issued the Physician Supply and Demand Projections 2021ï¿½2032, detailing the current shortage of physicians in Texas and how this shortage will continue to increase through 2032. The report found that current projections for medical education will not create a supply physicians great enough to meet projected demand. Texas is expected to be short 10,330 physicians by 2032[1]. Additionally, Texas is projected to be at a critical shortage of primary care physicians by 2036[2]. Furthermore, around 29 percent of Texas' current physicians

workforce is within retirement range and about 50 percent of Texas' medical school graduates left the state to finish their Graduate Medical Education elsewhere[3]. Texas ranks in the bottom half of states for primary care and physician availability, and 224 of Texas' 254 counties are health professional shortage areas[4].

H.B. 2038 amends the Occupations Code and Insurance Code to address the burdensome regulations that prevent physicians from providing care in Texas. This bill requires the Texas Medical Board to create pathways for new physicians to enter the market and serve Texans through the following ways: removing redundant residency requirements for qualified practicing international physicians, utilizing trained military veteran physicians by streamlining a long-term licensure pathway, and providing access to training and primary practice for medical school graduates who do not receive a residency match.

The committee substitute removes the section of the bill relating to veteran physicians. Additionally, a new provision is added to the section related to international physicians. This provision would prohibit a provisional license from being issued to a physician that is a citizen of a country identified as a national security risk.

H.B. 2038 amends current law relating to the issuance by the Texas Medical Board of certain licenses to practice medicine and the authority of an insured to select certain license holders under the insured's health policy, requires an occupational license, and authorizes fees.

House Bill 3151 (Hull)– (HB03151F.pdf). Adds Federally Qualified Health Centers (FQHC) as a provider type that qualifies for expedited credentialing under Medicaid

Fiscal Impact. No significant fiscal implication to the State is anticipated. It is assumed that any costs associated with the bill could be absorbed using existing resources.
No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Concerns have been raised that credentialing requirements for new clinics and providers vary across health plans and can result in delays that affect timely reimbursement, especially for federally qualified health centers (FQHCs) that rely on Medicaid and commercial insurance payments to sustain operations.

HB 3151 establishes that, for a health care provider to qualify for expedited credentialing and payment by a Medicaid managed care organization (MCO) for Medicaid reimbursement, the applicant provider would be required to be a member of one of the following that had a current contract with a Medicaid MCO:

- a federally qualified health center (FQHC) as defined by federal law; or
- an established medical group or professional practice designated by the U.S. Department of Health and Human Services Health Resources and Services Administration as an FQHC.

The bill would define "managed care plan" as a health benefit plan under which health care services were provided to enrollees through contracts with health care providers and that required enrollees to use participating providers or that provided a different level of coverage for enrollees who use participating providers.

The bill would apply to a health care provider who joined an established FQHC that had a contract with a managed care plan or a medical group or professional practice that had a contract with a managed care plan and became an FQHC.

Eligibility requirements. To qualify for expedited credentialing and payment as an FQHC, HB 3151 would require a health care provider to:

- be licensed, certified, or otherwise authorized to provide health care services in Texas by, and be in good standing with, the applicable state board;
- submit all documentation and other information required by the managed care plan issuer to begin the credentialing process required for the issuer to include the health care provider in the plan's network; and
- agree to comply with the terms of the managed care plan's participating provider contract with the applicant's FQHC.

The bill would require a managed care plan issuer to use an expedited credentialing process for an applicant who met the eligibility requirements, regardless of whether the applicant specifically requested expedited credentialing.

Expedited credentialing decision. The bill would require the managed care plan issuer to render a decision regarding the expedited credentialing of the applicant's application within 10 business days after the receipt of the applicant's completed application.

Payment for services during credentialing process. After an applicant had submitted the required information, the bill would require the managed care plan issuer, for payment purposes only, to treat the applicant as if the applicant was a participating provider in the plan's network when the applicant provided services to the plan's enrollees, including by:

- authorizing the applicant's FQHC to collect copayments from the enrollees for the applicant's services; and
- making payments, including payments for in-network benefits for services provided by the applicant during the credentialing process, to the applicant's FQHC for the applicant's services.

The bill would require the managed care plan issuer to ensure that the issuer's claims processing system could process claims from an applicant within 30 days after receipt of the completed application.

Directory entries. Pending the approval of a provider's application, HB 3151 would authorize the managed care issuer to exclude the applicant from the plan's directory, website, or other listing of participating providers.

Failure to meet credentialing requirements. The bill would specify that if on completion of the credentialing process, the managed care plan issuer determined that the applicant would not meet the issuer's credentialing requirements, the issuer would be authorized to recover from the applicant or the applicant's FQHC an amount equal to the difference between payments for in-network benefits and out-of-network benefits. The applicant or the applicant's FQHC also could retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

Enrollee held harmless. The bill would establish that an enrollee would be held harmless and would not be responsible for the difference between in-network copayments paid by the enrollee to a health care provider who was determined to be ineligible and the enrollee's managed care plan's charges for out-of-network services. The bill would prohibit the health care provider and the health care provider's FQHC from charging the enrollee for any portion of the health care provider's fee that was not paid or reimbursed by the plan.

Limitation on managed care plan issuer liability. The bill also would exempt a managed care plan issuer that complied with the bill from liability for damages arising

out of or in connection with, directly or indirectly, the payment by the issuer of an applicant as if the applicant was a participating provider in the plan's network.

If a state agency determined that a waiver or authorization from a federal agency was necessary to implement the bill, the agency would be required to request the waiver and could delay implementation until the waiver or authorization was granted.

The bill took effect September 1, 2025.

Senate Bill 1266 (Alvarado)– (SB01266F.pdf) Requires HHSC to implement improvements to the provider enrollment and credentialing processes; Requires HHSC to develop an electronic complaint and feedback submission process

Fiscal Impact. No significant fiscal implication to the State is anticipated.

The bill requires the Health and Human Services Commission (HHSC) to ensure that Medicaid providers have access to a support team for the Internet portal through which providers may enroll in Medicaid.

The bill requires HHSC to annually evaluate the performance of the support team, post the results of the evaluation on its website, and develop a procedure for Medicaid providers to submit complaints and feedback about enrollment and credentialing processes and support.

The bill establishes notification and process requirements that HHSC must meet before disenrolling a Medicaid provider.

The bill took effect September 1, 2025.

According to HHSC, the agency would incur one-time costs associated with implementation and ongoing costs for printing and postage; however, HHSC expects these costs to be minimal. It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Medicaid provider enrollment and revalidation (re-enrollment) have been significantly delayed for thousands of Texas Medicaid providers, with little explanation on the part of the certifying entity, the Texas Medicaid and Healthcare Partnership (TMHP). This has resulted in delayed care and significant costs to Medicaid providers. The Health and Human Services Commission (HHSC) has stated that, as of December 2024, there were nearly 9,000 Medicaid provider applications processing for more than 60 days. This is a result of a new provider enrollment system which was developed by a contractor without user testing.

S.B. 1266 will amend the Government Code so that the provider support team shepherding Medicaid providers through enrollment and re-enrollment processes is regularly-evaluated, with clear objectives for provider support. This legislation also requires both written and electronic notification of provider disenrollment, no less than 30 days before disenrollment. Currently providers only receive electronic notification.

S.B. 1266 creates the following requirements of HHSC:

- Establish a dedicated support team to assist Medicaid providers with enrollment and credentialing processes.
- Annually evaluate the performance of the dedicated support team that assists Medicaid providers with enrollment and credentialing.
- Create an electronic complaint and feedback system for Medicaid providers regarding the enrollment and credentialing processes and the support team assisting with those processes.
- Establish requirements before disenrolling a Medicaid provider during their enrollment revalidation period, including:

Both electronic and written notification at least 30 days before disenrollment; and
The opportunity for the provider to correct any deficiencies.

The committee substitute clarifies that HHSC may only disenroll a Medicaid provider for failing to complete the enrollment revalidation process. The committee substitute also clarifies that the provider support team does not need to be solely dedicated to that purpose so that existing full-time employees can be used for bill implementation.

S.B. 1266 amends current law relating to Medicaid provider enrollment and credentialing processes.

Medicaid Program Delivery

House Bill 388 (Harris Davila)– (HB00388F.pdf) Requires the Texas Department of Insurance (TDI) establish a uniform coordination of benefits questionnaire to obtain information from members.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. HB 388 requires the commissioner of insurance, in collaboration with appropriate stakeholders, to adopt rules establishing a uniform coordination of benefits questionnaire to be used by all health benefit plan issuers in the state by January 1, 2026.

Each health benefit plan issuer offering a health benefit plan with a coordination of benefits provision would be required to use the uniform coordination of benefits questionnaire and make it available to health care providers as appropriate.
The bill applies only to a health benefit plan that provided benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that was issued by:

- an insurance company;
- a group hospital service corporation;
- a health maintenance organization;
- an approved nonprofit health corporation that held a certificate of authority;
- a multiple employer welfare arrangement that held a certificate of authority;
- a stipulated premium company;
- a Lloyd's plan; or
- a reciprocal or interinsurance exchange.

The bill applies to:

- certain small employer health benefit plans;
- standard health benefit plans;

- basic coverage plans under the Texas Public School Employees Group Benefits Program;
- primary care coverage plans under Texas school employees uniform group health coverage;
- plans providing basic coverage under the Uniform Insurance Benefits Act for employees of the University of Texas system and the Texas A&M University system;
- alternative health benefit coverage offered by a subsidiary of the Texas Mutual Insurance Company;
- the state Medicaid program;
- the child health plan program;
- a regional or local health care program; and
- self-funded health benefit plans sponsored by professional employer organizations.

The bill would take effect September 1, 2025, and would apply only to the use of a coordination of benefits questionnaire on or after February 1, 2026.

House Bill 3211 (Dean)– (HB03211F.pdf) Adds requirements for vision care plans, which are not applicable to Medicaid and CHIP– Additional requirements that a contract between an MCO, including Medicaid and CHIP MCOs, and provider include electronic access to a fee schedule and use standardized codes and definitions.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Concerns have been raised that many vision benefit managers have restricted or closed provider panels, preventing unaffiliated optometrists or practices from participating in vision plans as in-network providers. Some have suggested that prohibiting these restrictions would create a more competitive environment and give patients an expanded range of eye care options.
Digest

CSHB 3211 prohibits a managed care plan from excluding an optometrist or a therapeutic optometrist as a participating practitioner in the plan if the optometrist or

therapeutic optometrist satisfied the plan's credentialing requirements and agreed to the plan's contractual terms.

The bill amends the definition of "vision care plan" to specify that it means a managed care plan.

CSHB 3211 requires a managed care plan to describe all reimbursable medical or vision care products or services covered under the plan using the standardized codes, names, and definitions published in the Healthcare Common Procedure Coding System, including Level I codes published by the American Medical Association and Level II codes published by the Centers for Medicare and Medicaid Services.

CSHB 3211 also requires a vision care plan issuer to include on its website a method for a licensed optometrist or therapeutic optometrist to submit an application for inclusion as a participating provider in the plan.

The application has to impose the same requirements on each optometrist and therapeutic optometrist and could only require an applicant to provide standardized applicable information prescribed by statutorily adopted rules or information specified on the Council for Affordable Quality Healthcare credentialing application.
Under CSHB 3211, an issuer would be required to:

- electronically deliver to the applicant a participating provider contract, including applicable reimbursement fee schedules, provider handbooks, and provider manuals no later than the 10th business day after the date the issuer received an eligible application; and
- complete the credentialing determination no later than the 30th business day after the date the issuer received an application and either approve or deny the application.

If an issuer denies an application, the issuer would have to deliver to the applicant a written explanation of the issuer's decision no later than the 10th business day after the date of the denial.

If an issuer approves an application, the issuer would have to include the credentialed and approved applicant as a participating provider in the plan no later than the 20th business day after an approved applicant accepted the delivered contract.
A vision care plan issuer would only be authorized to consider information included in an optometrist's or therapeutic optometrist's credentialing application in making a

credentialing determination and impose the same credentialing requirements on each applicant.

An issuer also is required to allow an optometrist or therapeutic optometrist to be a participating provider to the full extent of the optometrist's or therapeutic optometrist's license on all of the issuer's plans and other managed care plans with vision benefits that have enrollees located in this state and all of the issuer's vision panels. This section could not be construed to require an issuer to contract with an optometrist or a therapeutic optometrist for certain covered products or services as described by law.

An issuer would be prohibited from excluding an optometrist or a therapeutic optometrist from becoming a participating provider in the plan due to the aggregate number of optometrists or therapeutic optometrists on a vision panel in a geographic service area or due to the time, distance, and appointment availability for a patient to access a participating practitioner.

CSHB 3211 requires a contract between a managed care plan and an optometrist or therapeutic optometrist to include a fee schedule that included and individually identified each medical or vision care product or service covered under the plan and use the statutorily provided standardized codes, names, and definitions to describe all reimbursable medical or vision care products or services covered under the plan.
The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2025.

Senate Bill 926 (Hancock)– (SB00926F.pdf) Allows an MCO, including Medicaid and CHIP MCOs, to provide incentives to use services from a particular physician or provider– MCOs must comply with federal rules that ensure provider incentive plans are not for the purpose of limiting medically necessary services or lowering the quality of care.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary.

in order to have a well-functioning health care market, patients must be engaged in the process and should be rewarded for choosing lower-priced, higher-quality care. However, the bill sponsor has further informed the committee that current state law and Texas Department of Insurance regulations make it difficult for state-regulated plans to offer policies providing for such rewards, meaning patients with state-regulated health plans have little incentive to shop for higher-quality and lower-priced services, as they pay the same out-of-pocket amount regardless of which provider they choose. S.B. 926 would authorize health maintenance organizations and insurers offering preferred provider benefit plans to incentivize insureds or enrollees to use certain physicians or providers through modified deductibles, copayments, coinsurance, or other cost-sharing provisions. In addition, the bill makes changes to state law regulating physician rankings by health benefit plans.

Incentives to Use Certain Physicians or Providers

S.B. 926 amends the Insurance Code to authorize a health maintenance organization (HMO) or an insurer offering a preferred provider benefit plan to provide incentives for enrollees or insureds, as applicable, to use certain physicians or providers through modified deductibles, copayments, coinsurance, or other cost-sharing provisions. The bill establishes that an HMO or insurer that encourages an enrollee or insured, as applicable, to obtain a health care service from a particular physician or provider, including offering incentives to encourage enrollees or insureds to use specific physicians or providers, or that introduces or modifies a tiered network plan or assigns physicians or providers into tiers, has a fiduciary duty to the enrollee, group contract holder, insured, or policyholder, as applicable, to engage in that conduct only for the primary benefit of the enrollee, group contract holder, insured, or policyholder. The bill establishes that an HMO or insurer violates the fiduciary duty by offering incentives to encourage enrollees or insureds, as applicable, to use a particular physician or health care provider solely because the physician or provider directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with the HMO or insurer. The bill also establishes the following as conduct that violates the fiduciary duty:

- using a steering approach or a tiered network to provide a financial incentive as an inducement to limit medically necessary services, encourage receipt of lower quality medically necessary services, or violate state or federal law;
- failing to implement reasonable procedures to ensure that:

    - as applicable, participating providers or preferred providers that enrollees or insureds are encouraged to use within any steering approach or tiered network are not of materially lower quality than participating providers or preferred providers that enrollees or insureds are not encouraged to use; and
    - the HMO or insurer does not make materially false statements or representations about a physician's or health care provider's quality of care or costs; and
- failing to use objective, verifiable, and accurate information as the basis of any encouragement or incentive under these bill provisions.

The bill prohibits an encouragement or incentive from being based solely on cost or imposing a cost-sharing requirement for out-of-network emergency services that is greater than the cost-sharing requirement that would apply had the services been furnished by a participating provider or preferred provider, as applicable. The bill's provisions regarding incentives to use certain physicians or providers do not apply to a vision care plan, as defined by reference to statutory provisions relating to access to optometrists used under a managed care plan.

Physician Ranking by Health Benefit Plans

Physician Ranking Requirements Current law sets out certain conditions that must be met for a health benefit plan issuer, including a subsidiary or affiliate, to be authorized to rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians. S.B. 926 removes the conditions set out in current law, replaces them with new conditions applicable to such ranking or classification of physicians, and removes the specification that the conditions apply to the publication of such physician-specific information. The conditions prescribed by the bill differ from the conditions prescribed in current law as follows:

- the bill requires that the standards used by the issuer to rank or classify be developed or prescribed by an organization designated by the commissioner of insurance through rules adopted by the commissioner under related provisions added by the bill and subsequently described, whereas under current law the standards used by the issuer must conform to nationally recognized standards and guidelines as required by rules adopted by the

commissioner regarding physician ranking under current law and subsequently described;

- the bill requires the ranking or classification and any methodology used to rank or classify to be disclosed to each affected physician at least 45 days before the date the ranking or classification is released, published, or distributed by the issuer and to identify the products or networks offered by the issuer for which the ranking or classification will be used, whereas under current law the standards and measurements to be used by the issuer must be disclosed to each affected physician before any evaluation period used by the issuer; and
- the bill newly requires that each affected physician be given an easy-to-use process to identify:
    - before the release, publication, or distribution of the ranking or classification, any discrepancy between the standards and the ranking or classification proposed by the issuer; and
    - after the release, publication, or distribution of the ranking or classification, any objectively and verifiably false information contained in the ranking or classification.

Moreover, with respect to the aforementioned easy-to-use process for an affected physician to identify certain discrepancies or false information, the bill requires that if a physician submits information sufficient to establish a verifiable discrepancy or objectively and verifiably false information contained in the ranking or classification or a violation of applicable provisions relating to standards for physician rankings, the issuer must remedy the discrepancy, false information, or violation by the later of the release, publication, or distribution of the ranking or classification or the 30th day after the date the issuer receives the information. Current law, in contrast, requires each affected physician to be afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that, at a minimum, includes due process protections that conform to the following protections:

- the issuer provides at least 45 days' written notice to the physician of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the issuer in its rating, tiering, ranking, or comparison decision;
- in addition to any written fair reconsideration process, the issuer, upon a request for review that is made within 30 days of receiving that notice,

provides a fair reconsideration proceeding, at the physician's option, by teleconference at an agreed upon time or in person, at an agreed upon time or between the hours of 8 a.m. and 5 p.m. Monday through Friday;

- the physician has the right to provide information at a requested fair reconsideration proceeding for determination by a decision-maker, have a representative participate in the fair reconsideration proceeding, and submit a written statement at the conclusion of the fair reconsideration proceeding; and
- the issuer provides a written communication of the outcome of a fair reconsideration proceeding prior to any publication or dissemination of the rating, ranking, tiering, or comparison, which communication must include the specific reasons for the final decision.

Commissioner Rules

Under current law the commissioner, in adopting rules regarding physician rankings by health benefit plans, must either consider the standards, guidelines, and measures prescribed by certain nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care or, if no such national organizations have established standards or guidelines regarding an issue, consider the standards, guidelines, and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship. S.B. 926 removes both of those considerations and provides instead that, in adopting rules for the designation of an organization whose standards for physician ranking or classification may be used by a health benefit plan issuer, the commissioner may only designate an organization that meets the following criteria:

- the organization is a national medical specialty society or is a bona fide organization that is unbiased toward or against any medical provider or health benefit plan issuer; and
- the standards developed or prescribed by the organization that are to be used in rankings or classifications meet the following criteria:
    - emphasize quality of care;
    - are nationally recognized, in widely circulated peer-reviewed medical literature, expert-based physician consensus quality standards, or leading objective clinical evidence-based scholarship;
    - have a publicly transparent methodology;

- if based on clinical outcomes, are risk-adjusted; and
- are compatible with an easy-to-use process in which a physician or person acting on behalf of the physician may report data, evidentiary, factual, or mathematical discrepancies, errors, omissions, or faulty assumptions for investigation and, if appropriate, correction.

The bill defines "national medical specialty society" as a national organization that has a majority of members who are physicians, that represents a specific physician medical specialty, and that is represented in the house of delegates of the American Medical Association.

Sanctions S.B. 926 requires the commissioner to prohibit a health benefit plan issuer from using a physician ranking or classification system otherwise authorized under applicable state law for not less than 12 consecutive months if the commissioner determines that the issuer has engaged in a pattern of discrepancies, falsehoods, or violations regarding rankings or classifications, as established by information submitted by physicians under the bill's provisions.

The bill is effective September 1, 2025.

Senate Bill 963 (Hughes)

(SB00963F.pdf)--Allows a Medicaid MCO to inform Medicaid recipients about the availability of private health benefit plan coverage

Fiscal Impact. No significant fiscal implication to the State is anticipated.

The bill prohibits the Texas Health and Human Services Commission (HHSC) from establishing marketing guidelines that prevent Medicaid managed care organizations from informing individuals about certain health care plans.

The bill directs HHSC to require through the marketing guidelines that Medicaid managed care organizations providing this information also inform individuals about the potential deductibles, copayments, and other cost-sharing requirements, and the bill would prohibit Medicaid managed care organizations providing this information or their affiliates from offering material or financial gain as an actual or implied incentive for enrolling in a qualified health plan.

It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Managed Care Organizations (MCOs) report that current guidelines from the Health and Human Services Commission restrict their ability to inform enrollees who may not qualify for Medicaid about health plan options available through Healthcare.gov. These limitations create confusion and prevent MCOs from providing essential information to members who no longer qualify for Medicaid but may be eligible for subsidized coverage in the individual marketplace.

The individual coverage marketplace has grown significantly in Texas, with enrollment nearly quadrupling in just four years. This expansion has contributed to a decline in the state's uninsured rate, highlighting the importance of ensuring eligible but enrolled populations are aware of their coverage options.

What The Bill Does:

- S.B. 963 prevents HHSC from establishing marketing guidelines that prohibit an MCO from informing a recipient about the availability of qualified health plans offered through healthcare.gov.
- The bill ensures clarity for MCOs so they can appropriately educate members transitioning out of Medicaid about affordable marketplace coverage options.
- By allowing MCOs to provide clear and direct information, Texas can continue to reduce the uninsured rate and increase access to health coverage.

Why It Matters:

- Many Texans transitioning out of Medicaid are unaware of their eligibility for premium tax credits and cost-sharing reductions available in the marketplace.
- Supporting awareness of individual market options helps ensure continuity of care and prevents gaps in coverage.
- S.B. 963 aligns Texas with best practices for promoting health care access while maintaining a strong private insurance market.
- Texas should support increasing coverage through ensuring eligible but unenrolled populations are aware of options like individual marketplace coverage with discounted options through premium tax credits

S.B. 963 amends current law relating to allowing Medicaid managed care organizations to engage in marketing about the availability of certain private health benefit plan coverage.

Senate Bill 1307 (Cook)– (SB01307F.pdf) Requires TDI to collaborate with HHSC on a reference guide to educate the public on health care coverage in Texas.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. the Texas Department of Insurance (TDI) has detailed online resources for the public to reference when making health insurance decisions, but the resources are not consolidated, making it difficult for the public to access and comprehend. The Health and Human Services Commission (HHSC) publishes and maintains an aggregated reference guide for Medicaid and CHIP, providing straightforward and easily digestible information about these programs. The bill sponsor has also informed the committee that this guide has proven to be a valuable resource in simplifying the Medicaid and CHIP process and that creating a cumulative guide of resources from TDI would similarly help streamline health plan selection and provide the public with accurate information to make the best health care choice possible. S.B. 1307 requires TDI to consult with HHSC to develop a biennial reference guide designed to educate the public about health care coverage in Texas.

S.B. 1307 amends the Insurance Code to require the Texas Department of Insurance (TDI) to consult with the Health and Human Services Commission to develop a biennial reference guide designed to educate the public about health coverage in Texas. The bill requires the reference guide to include the following information:

- the biennial period covered by the current edition;
- definitions of the term "health insurance" and terms used to describe other forms of health coverage;
- sources from which consumers may obtain health coverage, including through employers, and an explanation of how coverage may be obtained from each of those sources;
- a guide to consumer rights and resources related to health coverage;
- a health coverage shopping guide that includes:

    - an explanation of discount cards and other noninsurance health coverage products and a comparison of those products to health insurance;
    - an explanation and comparison of common types of short-term or disease-specific health coverage;
    - an explanation and comparison of preferred provider benefit plans, exclusive provider benefit plans, health maintenance organizations, and point-of-service plans;
    - an explanation of provider networks and the differences between in-network providers and out-of-network providers;
    - an explanation of the Affordable Care Act marketplace plan categories of bronze, silver, gold, and platinum;
    - an explanation of the out-of-pocket costs of health coverage, including premiums, deductibles, copayments, and coinsurance; and
    - information on how to recognize health coverage scams;
- an explanation of the effect of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 on consumers' health coverage;
- a basic overview of federal, state, and local programs that may assist consumers to obtain health care services;
- methods for a consumer to resolve disputes with a health coverage issuer or administrator;
- methods to seek assistance from TDI for a complaint regarding a health coverage plan or product; and
- the areas of health coverage regulated by TDI and those regulated by federal law, including the federal Employee Retirement Income Security Act of 1974.

The bill requires TDI to publish the reference guide on TDI's website and in a printed form available to the public on request. TDI must publish the first reference guide not later than January 1, 2026

Modernization

House Bill 3812 (Bonnen)– (HB03812F.pdf) Prohibits a physician who conducts utilization review to hold a license to practice administrative medicine; Updates insurance code prior authorization requirements and exemptions, including an annual report submission on exemptions.

Fiscal Impact. Estimated Two-year Net Impact to General Revenue Related Funds for HB3812, As Engrossed: an impact of $0 through the biennium ending August 31, 2027. The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

The bill would amend the Texas Insurance Code to require health maintenance organizations and insurers to provide annual, detailed reports to the Texas Department of Insurance (TDI) pertaining to healthcare services concerning exemptions granted for specific services, determination to rescind or deny exemptions, and independent reviews of determinations, including instances where physicians requested such reviews.

The bill would take effect September 1, 2025.

Based upon analysis provided by the Texas Department of Insurance (TDI), this estimate assumes that the agency would require a new reporting system database to implement the provisions of the bill. The agency anticipates that with approximately 3,000 health care services per health plan and the number of health maintenance organizations and insurers required to annually report, the volume of the data submitted will be significant. This estimate assumes that the agency would be required to build a dedicated reporting system to handle this volume of reports with an initial build cost of $900,000 and an annual cost of $150,000.

This estimate assumes any appropriations made to implement the provisions of the bill would be appropriated from the Texas Department of Insurance Operating Account Fund 36. This account is a self-leveling account, and any expenditure increases would be reflected in the annual adjustment of the maintenance tax rates for insurance carriers. Therefore, the overall revenue into the account will equal expenses.

Based upon analysis provided by the Texas Department of Insurance, this estimate assumes the agency would require a new reporting database to implement the provisions of the bill. The new reporting database would be built utilizing a third party vendor to have online reporting, centralized storage, and report generating functionalities.

No significant fiscal implication to units of local government is anticipated.

Follow the link for a detailed cost estimate .

Bill Analysis/Summary. Some have suggested that revising provisions related to the service review process for physician exemptions from prior authorization requirements could help address concerns that the evaluation window for which services can be reviewed is too short and may prevent providers from reaching the authorization approval rate threshold for which they can qualify for an exemption.

CSHB 3812 would amend provisions relating to health care provider preauthorization requirements.

Exemption from preauthorization requirements. CSHB 3812 would extend the evaluation period during which an HMO or insurer was required to evaluate whether a physician or provider qualified for an exemption from preauthorization requirements from once every six months to once every year. The bill also would add to the conditions for exemption from preauthorization requirements to provide that the physician or provider had to have provided the particular health care service at least five times during the evaluation period.

If there were fewer than five claims for a particular health care service submitted by the physician or provider during the most recent evaluation period, the HMO or insurer would be required to review all the claims for that service submitted by the physician or provider during the most recent evaluation period.

In conducting an evaluation for an exemption, an HMO or insurer, or its affiliate, is required to include all preauthorization requests submitted by a physician or provider, considering all health insurance policies and health benefit plans issued or administered by the health maintenance organization or insurer.

For the purposes of the bill, a person is considered an "affiliate" of another if the person directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with the other person.

The bill specifies that a physician or provider's right to review an adverse determination regarding a preauthorization exemption would include the right to review an HMO's or insurer's denial of an exemption.

Report to TDI. Each HMO and insurer is required to submit to the Texas Department of Insurance (TDI) an annual written report for each health care service subject to a preauthorization requirement exemption on the:

- exemptions granted by the HMO or insurer for the service;
- determinations by the HMO or insurer to rescind or deny an exemption for the service, including the number of exemptions denied or rescinded by the HMO or insurer; and
- independent reviews of determinations conducted by an independent review organization, including the number of determinations made by the HMO or insurer for which a physician or provider requested an independent review and the outcome of each independent review.

The report would be considered public information subject to disclosure under the Public Information Act. TDI would be required to ensure that the report did not contain any identifying information before disclosing the report.

Utilization reviews. The bill would prohibit a physician under whose direction a utilization review agent conducted a utilization review from holding a license to practice administrative medicine.

The prohibition of HMOs or insurers from conducting a retrospective review of a health care service would be replaced with a prohibition from conducting a utilization review or requiring another review similar to preauthorization of a health care service.

A preauthorization exemption before the bill's effective date could not be rescinded before the first anniversary of the last day of the most recent evaluation period for the exemption.

The bill took effect September 1, 2025, and applies only to utilization review conducted on or after that date.

House Bill 5195 (Capriglione)– (HB05195F.pdf) Modernization of state agency systems, including website and online form updates.

Fiscal Impact. No significant fiscal implication to the State is anticipated.

The bill mandates that state agencies assess their online platforms and consider certain guidelines to improve user accessibility, navigation, and service efficiency. The bill also

instructs the Department of Information Resources to provide guidance, technical assistance, efficiency reporting, and best practices to promote consistency across agency websites.

This analysis assumes that any costs associated with the bill could be absorbed withing existing agency resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Concerns have been raised that many current state agency websites are outdated and inefficient, making them difficult for small business owners to navigate. Some have suggested that the state should begin modernizing its agency websites to make online licensing and reporting processes easier.

House Bill 5195 amends the Government Code to require each state agency to assess its website and online service portals to identify areas for improvement in user accessibility, navigation, and digital service efficiency. The bill authorizes the Department of Information Resources (DIR) to establish a working group to facilitate information sharing and support consistency across agencies and requires DIR to do the following:

- provide guidance and technical assistance for use by state agencies in standardizing agency modernization planning efforts;
- develop and disseminate best practices for user-centered design, digital accessibility, and service integration; and
- submit a report to the legislature detailing the status of the digital modernization planning efforts and identifying common priorities and challenges.

The bill requires each state agency, in coordination with DIR and the Legislative Budget Board, to review biennially the implementation of the agency's digital modernization efforts and to submit the findings of the review to DIR. The bill requires DIR to submit a report on the findings to the governor, lieutenant governor, and speaker of the house.

Senate Bill 1188 (Kolkhorst)– (SB01188F.pdf) Requires HHSC, Texas Medical Board, and TDI to adopt rules with requirements for storage, content, and management of electronic health records

Fiscal Impact. No significant fiscal implication to the State is anticipated.

According to the Health and Human Services Commission, implementing the provisions of the bill can be accomplished utilizing existing resources, assuming the Electronic Health Records (EHR) requirements are implemented in a timely manner and that the definition of EHR does not apply to non-acute care settings.

According to the Comptroller of Public Accounts, the number of violations that would result in civil penalties and the amount of those penalties is unknown, therefore, the fiscal impact to the state cannot be determined.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Senate Bill 1188 amends the Health and Safety Code to set out provisions regarding electronic health record requirements, including a requirement for electronic health records that contain patient information to be physically maintained in the United States or a U.S. territory and accessible only to certain individuals for health care purposes. The bill establishes provisions relating to the use of artificial intelligence for diagnostic purposes, access to a minor's electronic
health records, record requirements regarding biological sex, and related investigations, disciplinary actions, and injunctive relief.

SB 1188 establishes certain provisions on electronic health records, including the responsibilities of covered entities under current provisions on medical records privacy and documentation related to biological sex and sexual development disorders.

Definitions. The bill includes a health care practitioner as a "covered entity" under Health and Safety Code sec. 181.001(b)(2). The following entities are not covered entities under the bill:

- a licensed home and community support services agency;
- a licensed nursing facility;
- a continuing care facility;
- a licensed assisted living facility;
- a licensed intermediate care facility;
- a licensed day activity and health services facility; or
- a provider under the Texas Home Living or Home and Community-Based Services Waiver Program.

The bill defines "female" as an individual whose reproductive system was developed to produce ova and "male" as an individual whose reproductive system was developed to produce sperm.

A "sexual development disorder" means a congenital condition associated with atypical development of internal or external genital structures. The term would include a chromosomal, gonadal, and anatomic abnormality.

Documentation of biological sex on health records. The Health and Human Services Commission (HHSC), Texas Medical Board (TMB), and Texas Department of Insurance (TDI) are required to jointly ensure that:

- each electronic health record prepared or maintained by a covered entity included a separate space for the entity to document an individual's biological sex as either male or female based on the individual's observed biological sex recorded by a health care practitioner at birth and information on any sexual development disorder of the individual, whether identified at birth or later in the individual's life; and
- any algorithm or decision assistance tool included in an electronic health record to assist a health care practitioner in making medical treatment decisions included an individual's biological sex as recorded in the space described above.

This provision does not prohibit an electronic health record from including spaces for recording other information related to an individual's biological sex or gender identity.

Powers and duties of covered entities. A covered entity can amend on an electronic health record an individual's biological sex as recorded in the space described above only if the amendment was to correct a clerical error or the individual was diagnosed with a sexual development disorder and the amendment changed the individual's listed biological sex to the opposite biological sex. If a covered entity amends an individual's biological sex, the covered entity would be required to include in the individual's electronic health record information on the individual's sexual development disorder in the designated space on the individual's health record.

SB 1188 requires covered entities to:

- ensure each electronic health record system the entity used to store electronic health records of minors allowed a minor's parent, managing conservator, or guardian to obtain complete and unrestricted access to the minor's electronic

health record immediately upon request, unless access to all or part of the record was restricted under state or federal law or by a court order;

- ensure that the electronic health record information of the state's residents, other than open data, was accessible only to individuals requiring the information to perform duties within the scope of their employment related to treatment, payment, or health care operations;
- implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of electronic health record information;
- ensure each electronic health record maintained for an individual included the option for a health care practitioner to collect and record communications between two or more covered entities related to the individual's metabolic health and diet in the treatment of a chronic disease or illness; and
- ensure that electronic health records under the control of the entity that contained patient information were physically maintained in the United States or a U.S. territory.

A covered entity cannot collect, store, or share any information regarding an individual's credit score or voter registration status in the individual's electronic health record.

Certain provisions related to maintenance of records in the United States, access to health record information, and safeguards for the protection of electronic health record information apply to the storage of an electronic health record on or after January 1, 2026, regardless of the date on which the record was prepared.

Violations. HHSC or the appropriate regulatory agency is required to conduct an investigation of any credible allegation of a violation of the bill by a covered entity. The appropriate regulatory agency could take disciplinary action against a covered entity that violated the bill three or more times in the same manner as if the covered entity violated an applicable licensing or regulatory law. The disciplinary action could include license, registration, or certification suspension or revocation for a period determined appropriate.

The attorney general can institute an action for injunctive relief to restrain a relevant violation and an action for civil penalties against a covered entity for a violation of the bill. An applicable civil penalty may not exceed:

- $5,000 for each violation that was committed negligently in a single year, regardless of how long the violation continued during that year;

- $25,000 for each violation that was committed knowingly or intentionally in a single year, regardless of how long the violation continued during that year; or
- $250,000 for each violation in which the covered entity knowingly or intentionally used protected health information for financial gain.

Artificial intelligence. The bill requires a health care practitioner who uses artificial intelligence for diagnostic purposes to review all records created with artificial intelligence to ensure that the data was accurate and properly managed. The practitioner would have to disclose use of such technology to patients.

General provisions. The HHSC executive commissioner, TMB, TDI, the Texas Department of Licensing and Regulation, and each regulatory agency subject to the bill is required to enter into a memorandum of understanding and, as necessary, adopt rules to implement the bill.

If a state agency determines that a waiver or authorization from a federal agency is necessary to implement the bill, the agency is required to request the waiver and could delay implementation until the waiver or authorization is granted.

The bill took effect September 1, 2025

Senate Bill 815 (Schwertner)– (SB00815F.pdf) Regulates the use of artificial intelligence (AI) in utilization review in health benefit plans, including Medicaid and CHIP MCOs; Prohibits the use of an automated decision-making system from whole or partly making an adverse determination, but does not prohibit use of AI for administrative support or fraud-detection functions.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. As artificial intelligence (AI) technology rapidly expands, its adoption by health insurers has outpaced the establishment of necessary guardrails, leaving consumers unprotected. While artificial intelligence has significant potential to support the healthcare system, there is limited data on its usage or accuracy, and

consumer protections remain absent. AI relies on algorithms to perform tasks, an approach that minimizes the unique needs of patients. Without safeguards, algorithms risk being designed to prioritize the interests of health insurance companies over patients. Reports of AI use by insurers are increasing, with applications ranging from processing documentation to reviewing claims and prior authorization requests.

The use of AI puts patients at risk. A lack of transparency leaves them vulnerable to faulty algorithms or missing critical details. The Texas Department of Insurance (TDI) also lacks clear authority to monitor and enforce compliance, highlighting the need for regulatory guidance and oversight.

S.B. 815 adds a new section to the Insurance Code that prohibits the use of artificial intelligence algorithms as the sole basis to deny, delay, or modify health care services, in whole or in part, for medical necessity reasons. The bill gives TDI the ability to audit and inspect a health benefit plan's use of AI for utilization review in order to ensure compliance with the prohibition.

S.B. 815 amends current law relating to the use of certain automated systems in, and certain adverse determinations made in connection with, the health benefit claims process.

Managed Care Oversight

House Bill 142 (Noble)– (HB00142F.pdf) Allows disclosure of Office of Inspector General (OIG) information obtained while conducting administrative oversight activities– Expands the work of the OIG Recovery Audit Contractor (RAC) beyond fee-for-service and into managed care.

Fiscal Impact. Estimated Two-year Net Impact to General Revenue Related Funds for HB142, As Passed 2nd House: a positive impact of $4,060,855 through the biennium ending August 31, 2027.

The Texas Health and Human Services Commission (HHSC) is required to implement the provisions of the bill only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the agency may, but is not required to, implement the bill using other appropriations available for that purpose.

The bill makes changes to the administration and duties of the Texas Health and Human Services Commission's (HHSC) Office of Inspector General (OIG), including the process for retainment of qualified expert witnesses, the disclosure of information to other entities during investigations, the prohibition of certain criminal history background checks, and reviews of certain Medicaid overpayments and underpayments. The bill would require that the Recovery Audit Contractor program (RAC) identify underpayments and overpayments within the Medicaid managed care program, extending beyond the current reviews of Fee-for-Service (FFS) payments. The bill would require OIG to ensure that a RAC initiates recovery efforts for overpayments from either the provider or the managed care organization (MCO) involved in the overpayments. Under the bill, RACs may not initiate a review of a claim unless OIG or its designee determines that the review would be cost-effective and approves the review, and at least one year must have passed since the date the claim was received. RACs also may not initiate a review if an MCO has notified the OIG that the MCO is auditing the claim already. The bill would require the HHSC executive commissioner to adopt a process for appeals related to overpayments, and the executive commissioner may work with the OIG to adopt rules to implement the bill. The bill clarifies that HHSC is only required to implement the bill if the legislature appropriates funds for this purpose; otherwise, HHSC may implement using other funds but is not required to.

This analysis assumes an overall positive impact to GR for the FY 2026-27 biennium because the net savings that are assumed in FY 2027 (due to Medicaid recoveries) are greater than the costs assumed in FY 2026.

Based on information provided by HHSC, this analysis assumes that the agency will require additional staff resources to implement provisions of the bill, including attorneys, contract specialists, management analysts, nurses, physicians, program specialists, and project managers. The analysis assumes an additional 3.2 full-time equivalents (FTEs) in the first year of implementation (FY 2026) and 17.7 FTEs thereafter. Attorneys will be involved in resolving contractual disputes that may arise between providers and MCOs, and contract specialists will be involved in resolving additional provider complaints and providing technical assistance to the RAC, OIG, and the RAC appeals contractor. Management analysts will support compliance with federal and state RAC policies and guide RAC activities in managed care. Nurses and physicians will provide technical assistance to the RAC appeals contractor. Project managers will provide additional coordination for RAC activities in managed care. Personnel related

costs are estimated to total $505,683 in All Funds in FY 2026 and $2,890,008 in All Funds in FY 2027.

The agency expects to incur additional costs related to its RAC appeals contractor in FY 2029 ($281,304 in All Funds) and FY 2030 ($281,304 in All Funds). In addition, the agency will incur one-time costs for recovery collections in FY 2026 ($800,000 in All Funds) and FY 2027 ($300,000 in All Funds). The agency assumes there will be additional ongoing costs related to recovery collections in FY 2027 through FY 2030 ($475,200 in All Funds in FY 2027, $864,000 in FY 2028, $1,440,000 in FY 2029, and $1,440,000 in FY 2030). Recovery collections activities will involve procuring a third-party vendor to establish provider accounts receivables, to receive payments from providers, and to communicate collection activities and status with providers.

The agency also assumes additional ongoing costs for second level appeals ($381,580 in FY 2027, $693,782 in FY 2028, $1,156,304 in FY 2029, and $1,156,304 in FY 2030).

The additional non-staff costs above are assumed at a 50% GR, 50% administrative federal Medicaid matching rate.

The agency also assumes there will be significant recovered Medicaid revenue to the state as a result of the audits of overpayments in managed care. The analysis assumes that by FY 2029, the recoveries could reach approximately $88.48 million/year. This figure is based on FY 2024 data on overpayments in the Fee-for-Service (FFS) system, and an assumption that there are 1.5 times more providers in managed care as there are in FFS. The estimate assumes a per-claim recovery rate of approximately $5,276, based on averages in FFS, and an assumption of 22,537 claims per year for managed care. The agency assumes that various constraints will bring total recoveries down by 25% from that potential. The agency assumes that recoveries would therefore total $29,199,255 in FY 2027, $53,089,554 in FY 2028, $88,482,591 in FY 2029, and $88,484,591 in FY 2030.

Out of these recovered funds, the agency must pay a contingency fee of 12.5% to the RAC contractor (this is allocated as a cost to Other Fund 8044 in the tables above). The agency estimates these fees to be $3,649,906 in FY 2027, $6,636,194 in FY 2028, $11,060,323 in FY 2029, and $11,060,323 in FY 2030. Therefore, when recoveries are reduced by these fees, the resulting savings to the state would be the following: $25,549,349 in FY 2027; $46,453,360 in FY 2028; $77,422,268 in FY 2029; and

$77,424,268 in FY 2030. This analysis assumes that savings from Medicaid recoveries would be allocated to GR and federal funds methods of finance using the standard Medicaid FMAP match rate (59.84% federal match in FY 2026, 59.83% federal match assumed in FY 2027-2030). Therefore, some funds would reflect savings to GR Match for Medicaid, and other funds would reflect savings to Federal Funds.

It is assumed that any other costs related to the bill could be absorbed using existing resources.

The agency assumes that the primary technology cost associated with the bill would be incurred by procuring a deconfliction database to ensure against the potential for duplicate recovery efforts for the same case. This analysis assumes one-time costs for the database ($5,000,000 in All Funds in FY 2026 and $3,711,000 in All Funds in FY 2027), as well as ongoing costs for the database operations ($1,273,500 in All Funds in each of FYs 2027-2030).

No significant fiscal implication to units of local government is anticipated.

The bill makes no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill. Follow the link for cost detail.

Bill Analysis/Summary. H.B. 142 is an omnibus bill for the Office of the Inspector General (OIG). Current law presents multiple barriers to OIG's oversight and enforcement capabilities. There are conflicting statutory provisions regarding expert witness procurement, limitations on conducting criminal background checks on certain healthcare providers, and outdated requirements for reviewing Medicaid claims. Additionally, inefficiencies in fraud reporting, restrictions on information-sharing, and redundant statutory language further impede the OIG's ability to carry out its mission effectively.

H.B. 142 strengthens the OIG's ability to combat fraud, waste, and abuse in Texas health programs by addressing inefficiencies and inconsistencies in current law. It clarifies the OIG's authority to retain expert witnesses under Section 2152.005, aligning with other state agencies to expand access to specialized medical expertise.

H.B. 142 allows name-based criminal history checks for Medicaid providers while keeping fingerprint restrictions, ensuring better vetting without added burdens. It also

modernizes the fraud hotline, reducing inefficiencies in handling 33,000 annual reports, of which less than two percent lead to recoveries.

Additionally, it clarifies data-sharing rules, enabling the OIG to collaborate with law enforcement and other states to detect Medicaid fraud. It repeals outdated random Medicaid claim reviews, shifting focus to data-driven fraud detection. Finally, the bill fixes redundant statutory language from previous legislation, ensuring clarity in health agency laws.

In summary the bill:

- Clarifies OIG's ability to hire expert witnesses, aligning with other state agencies to attract more qualified medical professionals.
- Allows OIG to conduct name-based criminal history checks on Medicaid and CHIP providers, improving provider screening without added costs.
- Gives OIG flexibility in how fraud, waste, and abuse reports are received, improving efficiency while reducing low-value reports.
- Allows OIG to share fraud-related data with law enforcement and other states, helping detect Medicaid fraud across state lines.
- Eliminates the outdated random claims review requirement, freeing up resources for data-driven fraud detection instead.
- Corrects redundant statutory language from previous legislation.

Committee Substitute:

C.S.H.B. 142 incorporates the language from Senator Hughes' S.B. 2458 that was voted out of the Senate Committee on Health and Human Services earlier this month 9-0.

S.B. 2458 strengthens OIG'S ability to recover improper Medicaid payments by expanding the Recovery Audit Contractor Program to include managed care claims, which make up about 97 percent of Texas Medicaid claims. The bill ensures recoveries do not duplicate existing managed care efforts and applies only if funding is available. This expansion is expected to generate $25.5 million in FY 27, $46.5 million in FY 28, and $77.4 million in FY 29.

C.S.H.B. 142 amends current law relating to the Health and Human Services Commission's office of inspector general, the review of certain Medicaid claims, and the recovery of certain overpayments under Medicaid.

House Bill 4224 (Hull)– (HB04224F.pdf) Requires providers to prominently post on their website and at any facility instructions for how to request health records and to contact the licensing authority to file a consumer complaint.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Health and Safety Code sec. 181.001 defines a "covered entity" as a person or organization that, for any type of gain or on a pro bono basis, handles protected health information, including collecting, analyzing, storing, or transmitting it. The term includes health care providers, researchers, website operators, and their employees or contractors who access or use such information.

Health and Safety Code sec. 181.103 requires the attorney general to maintain a website that provides information on consumer privacy rights related to protected health information under federal and state law. The website also must include a list of regulating agencies, complaint procedures, and agency contact information.

Concerns have been raised that consumers may not know how to access their medical records or file complaints when covered entities do not provide information about the request process, which may hinder patients from exercising their rights under HIPAA to obtain protected health information.

House Bill 4224 amends the Health and Safety Code, for purposes of statutory provisions governing access to and use of protected health information with respect to medical records privacy, to require an applicable covered entity to prominently post on the entity's website and at any entity facility detailed instructions for a consumer to request the consumer's health care records from the entity, contact the disciplinary or licensing authority for the entity, and file a consumer complain

Teleservices

House Bill 1700 (Fairly)– (HB01700F.pdf) Requires standardization of formats and record retention related to patient consent to treatment, data collection, and data sharing when they utilize telehealth, telemedicine or teledentistry.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. During the COVID-19 pandemic, a lack of clarity arose as to how health professionals should implement the state and federal requirements for collecting consent to share, consent to treat, records retention, and other documentation when performing a virtual service, especially when the services were provided via audio-only platforms. According to a study by the House Committee on Public Health following the 87th Regular Session, medical record documentation and retention requirements for telemedicine and in-person services needed to be further addressed. H.B. 1700 seeks to address this issue by requiring each agency with regulatory authority over a health professional providing certain telehealth services to adopt rules necessary to standardize formats for, and retention of records relating to, a patient's consent to treatment, data collection, and data sharing.

H.B. 1700 amends current law relating to certain records of a health professional providing a telemedicine medical service, teledentistry dental service, or telehealth service.

House Bill 1700 amends the Occupations Code to require each agency with regulatory authority over a health professional providing a telemedicine medical service, teledentistry dental service, or telehealth service to adopt rules necessary to standardize formats for and retention of records related to a patient's consent to treatment, data collection, and data sharing.

Nursing Facilities

Senate Bill 457 (Kolkhorst)– (SB00457F.pdf) Establishes a patient care expense ratio that requires 80% of payments made to certain nursing facilities be spent on

patient care expenses; HHSC to develop a process that allows for successor liability agreements in the event of a Change of Ownership (CHOW) to allow providers to continue receiving Medicaid payments during the CHOW process.

Fiscal Impact. Estimated Two-year Net Impact to General Revenue Related Funds for SB457, Conference Committee Report: a negative impact of ($1,751,447) through the biennium ending August 31, 2027.

The bill makes no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

The bill requires applications for license or renewal of a license of a nursing facility and related institution to include the name of each person with direct or indirect ownership interest of five percent or more in the facility or the real property on which the facility is located, and to describe the ownership interest. The bill would require a license holder to notify the Health and Human Services Commission (HHSC) of changes made to the ownership interest information included in the application.

The bill requires the executive commissioner of HHSC to, by rule, establish an annual patient care expense ratio applicable to the reimbursement of nursing facility providers. With certain exceptions, the bill permits HHSC to recoup all or part of the medical assistance reimbursement amount paid to a nursing facility that is subject to the expense ratio if the facility fails to spend the reimbursement amount in accordance with the expense ratio.

The bill requires HHSC to ensure that a nursing facility providing Medicaid services to recipients continues to receive Medicaid reimbursement uninterrupted while a change in ownership application is pending, provided the facility under the new ownership meets certain requirements.

The bill took effect September 1, 2025.

According to HHSC, 3.5 additional full-time equivalents (FTE) are needed to process an anticipated increase in applications. This analysis assumes HHSC would need additional License and Permit Specialist IV positions to process increased applications and screen additional individuals that are required to be disclosed in the application. This analysis assumes a total of 3.0 FTEs are needed in fiscal year 2026 through 2030 to implement

the provisions of the bill. Personnel-related costs, including salaries, travel, and overhead are estimated to total $396,652 from All Funds in fiscal year 2026 and $366,904 from All Funds in fiscal year 2027.

It is assumed all other costs associated with the bill can be absorbed within existing resources.

The total technology cost is estimated to be $1,465,083 from All Funds in fiscal year 2026. Costs are primarily related to software licenses and one-time modifications to the Texas Unified Licensure Information Portal to accommodate the changes to applications required by the bill.

No significant fiscal implication to units of local government is anticipated.

Follow the link for cost detail.

Dental Services

Senate Bill 527 (Schwertner)– (SB00527F.pdf) Requires health benefit plans to cover general anesthesia in connection with certain pediatric dental services– HHSC and MCOs are already in compliance.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. Recently, pediatric patients are experiencing delays in dental care because medical insurance will not cover general anesthesia for dental procedures. Dentists argue that insurers often require the pediatric patient to be swollen with an infection to the face and head and be acutely ill before the anesthesia coverage is permitted for the dental procedure to take place. Over 30 states have a form of required general anesthesia coverage for pediatric dental patients. The lack of general anesthesia coverage for dental procedures is prohibiting care for our youngest Texans. S.B. 527 would close this gap in coverage, requiring that if a health insurance plan

covers general anesthesia for other medically necessary procedures it cannot discriminate against general anesthesia for dental procedures.

S.B. 527 amends current law relating to health benefit coverage for general anesthesia in connection with certain pediatric dental services.

Senate Bill 527 amends the Insurance Code to prohibit a health benefit plan that provides coverage for general anesthesia from excluding from coverage medically necessary general anesthesia services in connection with dental services provided to a covered individual who is younger than 13 years of age and unable to undergo the dental service without general anesthesia due to a documented physical, mental, or medical reason, provided that the anesthesia is performed by a qualified provider of anesthesia services.

House Bill 4070 (Johnson)– (HB04070F.pdf) Adds restrictions on designing or manufacturing an orthodontic device that the provider has not examined in-person– Increases record keeping timelines from five years to seven years.

Fiscal Impact. No significant fiscal implication to the State is anticipated.
It is assumed that any costs associated with the bill could be absorbed using existing resources.

No significant fiscal implication to units of local government is anticipated.

Bill Analysis/Summary. In Texas, some companies sell orthodontic devices directly to consumers without confirmation of an in-person dental examination. The bill author has informed the committee that, without such an examination, a patient can be pursuing orthodontics without evaluation to determine the proper treatment and can incur significant damage to their teeth as a result, since some devices may not be an adequate treatment option if an individual has gum disease, short roots, or other dental conditions. H.B. 4070 seeks to protect patients from unsafe medical practices by establishing requirements for a person selling an orthodontic device or providing a service related to the design or manufacture of such a device to patients in Texas, including an in-person examination requirement.

H.B. 4070 amends current law relating to the sale, design, and manufacture of orthodontic devices.

House Bill 4070 amends the Health and Safety Code to set out requirements for a person who sells an orthodontic device or provides a service related to the design or manufacture of an orthodontic device to patients in Texas. Among other provisions, the bill requires such a person to either be a dentist who has provided applicable services to the patient or has received confirmation from a dentist who has provided those services to the patient. The bill also prohibits a person from selling an orthodontic device or providing a service related to the design or manufacture or such a device unless the patient has received an in-person intraoral dental examination and a head and neck examination, a review of recently performed appropriate diagnostic imaging, a prescription for an orthodontic device issued by the applicable dentist, counsel by the applicable dentist regarding available orthodontic treatment options and the risks associated with those treatments, and a review of the patient's medical and dental health histories.

2026-27 General Appropriations Act: Key Provisions

Rider 23– Attendant wage increases and impacts to the attendant care rate enhancement programs

23. Base Wage Increase for Personal Attendant Services.

(a) Included in the amounts appropriated above in Goal A, Medicaid Client Services, Strategy D.2.3, Behavioral Health Waiver & Amendment, and Strategy F.1.2, Non-Medicaid Services, is $470,883,027 from the General Revenue Fund and $716,822,548 from Federal Funds ($1,187,705,575 from All Funds) in fiscal year 2026 and $494,762,919 from the General Revenue Fund and $753,159,237 from Federal Funds ($1,247,922,156 from All Funds) in fiscal year 2027 to increase the base wage for personal attendant services to $13.00 per hour, increase the associated payroll costs, taxes, and benefits percentage to 15.0 percent for services provided in residential settings and 14.0 percent for services provided in non-residential settings, and increase the associated administrative rate by $0.24 per hour.
(b) The Health and Human Services Commission (HHSC) shall utilize any funds that were previously expended for the attendant compensation rate enhancement programs for the base wage increase described in subsection (a) and shall discontinue the attendant compensation rate enhancement programs for community care services, intermediate care facility services, and intellectual and developmental disability services.

(c) Out of funds appropriated in Strategy B.1.1, Medicaid & CHIP Contracts and Administration, HHSC shall continue to collect biennial cost reports from providers to monitor the average hourly wage and associated payroll costs, taxes, and benefits. HHSC shall calculate for each provider the total amount that was paid to the provider that is attributable to the direct care wages, payroll costs, taxes, and benefits, the amount expended by the provider for that purpose, and the ratio of expenses to revenue to determine a direct care wage and benefits expense ratio. HHSC shall report to the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House of Representatives, and the Office of the Governor on an annual basis by November 1 of each year on the findings, including a list of providers whose calculated direct care staff wage and benefits expense ratio is less than 0.90.

Rider 24-- Certain Medicaid maternal fetal medicine radiological services

24. Rate Increase for Certain Maternal Fetal Medicine Radiological Services. Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, is $2,742,390 from the General Revenue Fund and $4,113,590 from Federal Funds ($6,855,980 from All Funds) in fiscal year 2026 and $2,713,310 from the General Revenue Fund and $4,069,980 from Federal Funds ($6,783,290 from All Funds) in fiscal year 2027 to increase the Medicaid reimbursement rate for maternal fetal medicine radiological services by 10 percent.

To the extent possible, HHSC shall ensure any funds identified in this rider that are included in Medicaid managed care capitation rates are distributed by the managed care organizations to the providers delivering the services that are receiving a rate increase pursuant to this rider.

Rider 25– – Medicaid nursing facility services

25. Rate Increase for Nursing Facilities. Contingent on enactment of Senate Bill 457, or similar legislation relating to the regulation of certain nursing facilities, including licensing requirements and Medicaid participation and reimbursement requirements, by the Eighty-ninth Legislature, Regular Session, 2025, subsections (c) and (d) of this provision shall not take effect.

(a) Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, are the following amounts: (1) $78,359,051 from the General Revenue Fund and $116,758,109 from Federal Funds ($195,117,160 from All Funds) in fiscal year 2026 and $82,477,647 from the General Revenue Fund and $122,843,855 from

Federal Funds ($205,321,502 from All Funds) in fiscal year 2027 to increase the dietary rate for nursing facilities; and (2) $26,119,684 from the General Revenue Fund and $38,919,370 from Federal Funds ($65,039,054 from All Funds) in fiscal year 2026 and $27,492,549 from the General Revenue Fund and $40,947,952 from Federal Funds ($68,440,501 from All Funds) in fiscal year 2027 to increase the administrative rate for nursing facilities

(b) The Health and Human Services Commission (HHSC) shall only expend the funds in subsection (a)(1) to provide reimbursement rate increases that will increase the dietary subcomponent and subsection (a)(2) to provide reimbursement rate increases that will increase the facility and operations subcomponents. (c) HHSC shall implement the rate increases in a manner that will enable HHSC to ensure that at least 90 percent of the funds appropriated in subsection (a)(1) are expended for dietary and nutrition expenses and 90 percent of the facility and operations funds appropriated in subsection (a)(2) are expended for facility and operational costs. For purposes of these funds, "facility and operational costs" means costs related to fixed capital and general and administrative costs, but does not include:
(1) professional and facility malpractice or liability insurance expenses;
(2) advertising expenses;
(3) travel and seminar expenses;
(4) association and other dues;
(5) facility owner, partner, or stockholder salaries, wages, and/or benefits;
(6) professional service fees;
(7) management consultant fees;
(8) management fees; or
(9) total central office overhead expenses or individual central office line items.

(d) HHSC shall return to the Comptroller of Public Accounts any amount recouped from a provider who does not utilize the funds in accordance with the stated purpose. HHSC may not expend funds appropriated for nursing facility services in Medicaid managed care in lieu of payments that are currently authorized by the Centers for Medicare and Medicaid Services for the Quality Improvement Payment Program; and HHSC may not expend funds appropriated for nursing facility services in Medicaid fee-for-service that would not result in receipt of Federal Funds.

To receive reimbursement rate increases appropriated under subsection (a), nursing facilities must report to HHSC on their cost report, as specified by HHSC, to demonstrate that at least 90.0 percent of the funds were expended for the purpose of dietary and nutrition expenses and facility and operational costs, as defined above.

Rider 30– Certain Medicaid ABA services

30. Rate Increase for Applied Behavior Analysis Services and Report on Autism Services. Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, is $5,549,400 from the General Revenue Fund and $8,268,826 from Federal Funds ($13,818,226 from All Funds) in fiscal year 2026 and $6,947,212 from the General Revenue Fund and $10,347,316 from Federal Funds ($17,294,528 from All Funds) in fiscal year 2027 to increase the Medicaid reimbursement rate for certain applied behavior analysis services to $14.50 per unit in both Medicaid fee-for-service and managed care models.

HHSC shall report to the Legislative Budget Board and Governor by September 1, 2026, the following:
(a) The compliance by managed care organizations in increasing reimbursement rates pursuant to this rider;
(b) The number of monthly utilizers of pediatric autism services in Medicaid; and
(c) An analysis on whether the utilization of autism services aligns with the actual need for services, considering the incidence rates of autism within the general population and the projected rates of individuals potentially eligible for autism services in Medicaid.

Rider 31– Certain nursing facilities serving people with IDD

31. Rate Increase for Intellectual Developmental Disability Nursing Facilities.

(a) Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, is $779,805 from the General Revenue Fund and $1,169,708 from Federal Funds ($1,949,513 from All Funds) in fiscal year 2026 and $810,997 from the General Revenue Fund and $1,216,496 from Federal Funds ($2,027,493 from All Funds) in fiscal year 2027 to revise the reimbursement methodology for an Intellectual Developmental Disability (IDD) nursing facility special reimbursement class, in which 90.0 percent of residents have a Preadmission Screening and Resident Review positive screen for IDD, to match that of the allowable Medicare equivalent.

(b) It is the intent of the Legislature that, out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission conduct an annual review, by August 31 of each year, of reimbursement rates for Intellectual Developmental Disability nursing facility services delivered under Medicaid.

Rider 34– Improve credentialing processes in STAR Health (single process for credentialling)

34. Credentialing for Providers within the STAR Health Managed Care Program. Out of funds appropriated above in Strategy B.1.1. Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall, directly or through contract, analyze and make all necessary improvements to the process for credentialing health care providers, particularly those health care providers that provide and bill for mental and behavioral health services, within the STAR Health managed care program. Specifically, HHSC shall implement any changes needed to accomplish the expeditious credentialing and enrollment of health care providers, including:

(a) A single process to permit credentialing across managed care organizations; and
(b) Any other process, policy, or other efficiencies to streamline access to qualified health care providers.

Rider 35– Nutritional counseling and instructional services as in-lieu-of services (HB26 related)

35. Nutritional Support Services. Out of funds appropriated above, the Health and Human Services Commission (HHSC) may permit a managed care organization to offer nutritional support services in lieu of a service or setting covered under the state plan. The nutritional support services must be clinically appropriate and a cost-effective substitute for a covered Medicaid service.

In determining nutritional support services to include in the contract with managed care organizations, HHSC shall take into consideration nutrition counseling and instruction services, tailored to health risk or demonstrated outcome improvement.

Rider 36– Annual review of "Pediatric Care Center" rates

36. Rate Review for Pediatric Care Center Services. It is the intent of the Legislature that, out of funds appropriated above in Strategy B.1.1, Medicaid and CHIP Contracts and Administration, the Health and Human Services Commission shall, not later than August 31 of each year, conduct a review of reimbursement rates for pediatric care center services delivered to children under Medicaid.

Rider 38 – Evaluate feasibility of creating a diabetes prevention program reporting

38. Diabetes Prevention Program.

(a) Out of amounts appropriated above to the Health and Human Services Commission (HHSC) that are available for that purpose, the commission shall conduct a study, in consultation with the Department of State Health Services, to evaluate the cost-effectiveness and feasibility of implementing and administering a diabetes prevention program for Medicaid recipients, including alternative interventions for Medicaid recipients at risk of developing Type 2 diabetes.

(b) Not later than November 1, 2026, HHSC shall submit to the Governor, the Legislative Budget Board, the Senate Finance Committee, the House Appropriations Committee, and each standing committee of the Legislature with jurisdiction over health and human services a written report containing the findings of the study conducted under this rider and any recommendations for legislative or other action based on those findings.

Rider 39– Reallocation of Medicaid dental provider rates

39. Medicaid Dental Reimbursement Rate Reallocation.

(a) Out of amounts appropriated above in Strategy A.1.1, Medicaid Client Services, the Health and Human Services Commission (HHSC) shall:

(1) for each procedure code under which a dental service provided to a Medicaid recipient is billed:

(A) other than a procedure code described by Paragraph (B) of this subdivision, reduce the reimbursement rate for the dental service to the amount in effect for the dental service on February 28, 2025; and

(B) if the procedure code was impacted by policy changes resulting from HHSC's biennial review of dental services reimbursement rates that took effect March 1, 2025, maintain the reimbursement rate implemented under the policy; and

(2) subject to Subsection (b) of this rider, after adjusting the reimbursement rates as prescribed by Subdivision (1), implement a uniform reimbursement rate increase for the following procedure codes: D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1351, D1510, D1516, D1517, D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2751, D2930, D3120,

D3220, D3310, D3320, D3330, D7140, D7240, D9248, D2931, D7111, D7210, D7220, D7230, D2750, D2752, D2790, D2933, D2934, D2940, and D9243.

(b) In implementing the uniform reimbursement rate increase described by Subsection (a)(2) of this rider, HHSC shall limit the percentage of the rate increases as necessary to ensure any overall increase in the amount of estimated expenditures on an annual basis is equivalent to the overall increase in amount of estimated expenditures that would have resulted from implementation of policy changes that took effect March 1, 2025, including changes in reimbursement rates, following HHSC's biennial review of dental services reimbursement rates.

Rider 76-- Requires HHSC to use an HTW short eligibility application form, if allowed by federal law

76. Healthy Texas Women Short Form Application. It is the intent of the Legislature that the Health and Human Services Commission shall, to the extent allowable by federal law, implement a short form application for the Healthy Texas Women program, limiting the required elements conforming to the application for Family Planning Only populations in accordance with 42 CFR 435.907(c)(2).

Rider 95 − Funding for services provided by mobile stroke units and reimbursement for tissue plasminogen activator (tPA)

95. Stroke Treatment and Response.

(a) Included in amounts appropriated above in Strategy D.1.10, Additional Specialty Care, is $2,500,000 from the General Revenue Fund in fiscal year 2026 and $2,500,000 from the General Revenue Fund in fiscal year 2027 for the Health and Human Services Commission (HHSC) to provide funding for services provided by mobile stroke units.

(b) It is the intent of the Legislature that, out of funds appropriated above in Goal A, Medicaid Client Services, HHSC shall reimburse for tissue plasminogen activator (tPA) for treatment of stroke.

Special Provision 31– – Requires development of service coordination protocols in STAR Health

Sec. 31. STAR Health Services Coordination. Not later than August 31, 2026, the Health and Human Services Commission shall, in collaboration with the STAR Health managed care organization and the Department of Family and Protective Services, develop written protocols to operationalize the service coordination requirements in the STAR Health Medicaid managed care contract. The written protocols should, at a minimum, define a process through which a STAR Health service coordinator participates in the development of the Child's Plan of Service and defines the service coordinator's role in facilitating access to all STAR Health covered services identified in the plan.

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