AN ACT

relating to improving the delivery and quality of certain health and human services, including the delivery and quality of Medicaid acute care services and long-term services and supports.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

ARTICLE 1. DELIVERY SYSTEM REDESIGN FOR THE PROVISION OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SECTION 1.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 534 to read as follows:

CHAPTER 534. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 534.001. DEFINITIONS. In this chapter:

(1) "Advisory committee" means the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053.

(2) "Basic attendant services" means assistance with the activities of daily living, including instrumental activities of daily living, provided to an individual because of a physical, cognitive, or behavioral limitation related to the individual's disability or chronic health condition.

(3) "Department" means the Department of Aging and Disability Services.

(4) "Functional need" means the measurement of an individual's services and supports needs, including the individual's intellectual, psychiatric, medical, and physical support needs.

(5) "Habilitation services" includes assistance provided to an individual with acquiring, retaining, or improving:

(A) skills related to the activities of daily living; and

(B) the social and adaptive skills necessary to enable the individual to live and fully participate in the community.

(6) "ICF-IID" means the Medicaid program serving individuals with intellectual and developmental disabilities who receive care in intermediate care facilities other than a state supported living center.

(7) "ICF-IID program" means a program under the Medicaid program serving individuals with intellectual and developmental disabilities who reside in and receive care from:

(A) intermediate care facilities licensed under Chapter 252, Health and Safety Code; or

(B) community-based intermediate care facilities operated by local intellectual and developmental disability authorities.

(8) "Local intellectual and developmental disability authority" means an authority defined by Section 531.002(11),

Health and Safety Code.

(9) "Managed care organization," "managed care plan," and "potentially preventable event" have the meanings assigned under Section 536.001.

(10) "Medicaid program" means the medical assistance program established under Chapter 32, Human Resources Code.

(11) "Medicaid waiver program" means only the following programs that are authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for the provision of services to persons with intellectual and developmental disabilities:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the home and community-based services (HCS) waiver program;

(C) the deaf-blind with multiple disabilities (DBMD) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(12) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

Sec. 534.002. CONFLICT WITH OTHER LAW. To the extent of a conflict between a provision of this chapter and another state law, the provision of this chapter controls.

SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM

Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH INTELLECTUAL AND

DEVELOPMENTAL DISABILITIES. In accordance with this chapter, the commission and the department shall jointly design and implement an acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities that supports the following goals:

(1) provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs;

(2) improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services;

(3) improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs;

(4) promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;

(5) promote individualized budgeting based on an assessment of an individual's needs and person-centered planning;

(6) promote integrated service coordination of acute care services and long-term services and supports;

(7) improve acute care and long-term services and supports outcomes, including reducing unnecessary institutionalization and potentially preventable events;

(8) promote high-quality care;

(9) provide fair hearing and appeals processes in accordance with applicable federal law;

(10) ensure the availability of a local safety net provider and local safety net services;

(11) promote independent service coordination and independent ombudsmen services; and

(12) ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.

Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. The commission and department shall, in consultation with the advisory committee, jointly implement the acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities in the manner and in the stages described in this chapter.

Sec. 534.053. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The Intellectual and Developmental Disability System Redesign Advisory Committee is established to advise the commission and the department on the implementation of the acute care services and long-term services and supports system redesign under this chapter. Subject to Subsection (b), the executive commissioner and the commissioner of the department shall jointly appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including:

(1) individuals with intellectual and developmental

disabilities who are recipients of services under the Medicaid waiver programs, individuals with intellectual and developmental disabilities who are recipients of services under the ICF-IID program, and individuals who are advocates of those recipients, including at least three representatives from intellectual and developmental disability advocacy organizations;

(2) representatives of Medicaid managed care and nonmanaged care health care providers, including:

(A) physicians who are primary care providers and physicians who are specialty care providers;

(B) nonphysician mental health professionals; and

(C) providers of long-term services and supports, including direct service workers;

(3) representatives of entities with responsibilities for the delivery of Medicaid long-term services and supports or other Medicaid program service delivery, including:

(A) representatives of aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(B) representatives of community mental health and intellectual disability centers;

(C) representatives of and service coordinators or case managers from private and public home and community-based services providers that serve individuals with intellectual and

developmental disabilities; and

(D) representatives of private and public ICF-IID providers; and

(4) representatives of managed care organizations contracting with the state to provide services to individuals with intellectual and developmental disabilities.

(b) To the greatest extent possible, the executive commissioner and the commissioner of the department shall appoint members of the advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid program recipients.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) The advisory committee must meet at least quarterly or more frequently if the presiding officer determines that it is necessary to address planning and development needs related to implementation of the acute care services and long-term services and supports system.

(e) A member of the advisory committee serves without compensation. A member of the advisory committee who is a Medicaid program recipient or the relative of a Medicaid program recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

(f) The advisory committee is subject to the requirements of Chapter 551.

(g) On January 1, 2024:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission shall submit a report to the legislature regarding:

(1) the implementation of the system required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with intellectual and developmental disabilities under the Medicaid program; and

(2) recommendations, including recommendations regarding appropriate statutory changes to facilitate the implementation.

(b) This section expires January 1, 2024.

Sec. 534.055. REPORT ON ROLE OF LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES AS SERVICE PROVIDERS. (a) The commission and department shall submit a report to the legislature not later than December 1, 2014, that includes the following information:

(1) the percentage of services provided by each local intellectual and developmental disability authority to individuals receiving ICF-IID or Medicaid waiver program services, compared to the percentage of those services provided by private providers;

(2) the types of evidence provided by local intellectual and developmental disability authorities to the department to demonstrate the lack of available private providers in areas of the state where local authorities provide services to more than 40 percent of the Texas home living (TxHmL) waiver program

clients or 20 percent of the home and community-based services (HCS) waiver program clients;

(3) the types and amounts of services received by clients from local intellectual and developmental disability authorities compared to the types and amounts of services received by clients from private providers;

(4) the provider capacity of each local intellectual and developmental disability authority as determined under Section 533.0355(d), Health and Safety Code;

(5) the number of individuals served above or below the applicable provider capacity by each local intellectual and developmental disability authority; and

(6) if a local intellectual and developmental disability authority is serving clients over the authority's provider capacity, the length of time the local authority has served clients above the authority's approved provider capacity.

(b) This section expires September 1, 2015.

SUBCHAPTER C. STAGE ONE: PROGRAMS TO IMPROVE SERVICE DELIVERY MODELS

Sec. 534.101. DEFINITIONS. In this subchapter:

(1) "Capitation" means a method of compensating a provider on a monthly basis for providing or coordinating the provision of a defined set of services and supports that is based on a predetermined payment per services recipient.

(2) "Provider" means a person with whom the commission contracts for the provision of long-term services and supports under the Medicaid program to a specific population based on

capitation.

Sec. 534.102. PILOT PROGRAMS TO TEST MANAGED CARE STRATEGIES BASED ON CAPITATION. The commission and the department may develop and implement pilot programs in accordance with this subchapter to test one or more service delivery models involving a managed care strategy based on capitation to deliver long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities.

Sec. 534.103. STAKEHOLDER INPUT. As part of developing and implementing a pilot program under this subchapter, the department shall develop a process to receive and evaluate input from statewide stakeholders and stakeholders from the region of the state in which the pilot program will be implemented.

Sec. 534.104. MANAGED CARE STRATEGY PROPOSALS; PILOT PROGRAM SERVICE PROVIDERS. (a) The department shall identify private services providers that are good candidates to develop a service delivery model involving a managed care strategy based on capitation and to test the model in the provision of long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities through a pilot program established under this subchapter.

(b) The department shall solicit managed care strategy proposals from the private services providers identified under Subsection (a). In addition, the department may accept and approve a managed care strategy proposal from any qualified entity that is a private services provider if the proposal provides for a comprehensive array of long-term services and supports, including

case management and service coordination.

(c) A managed care strategy based on capitation developed for implementation through a pilot program under this subchapter must be designed to:

(1) increase access to long-term services and supports;

(2) improve quality of acute care services and long-term services and supports;

(3) promote meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion and customized, integrated, competitive employment;

(4) promote integrated service coordination of acute care services and long-term services and supports;

(5) promote efficiency and the best use of funding;

(6) promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;

(7) promote employment assistance and supported employment;

(8) provide fair hearing and appeals processes in accordance with applicable federal law; and

(9) promote sufficient flexibility to achieve the goals listed in this section through the pilot program.

(d) The department, in consultation with the advisory committee, shall evaluate each submitted managed care strategy proposal and determine whether:

(1) the proposed strategy satisfies the requirements of this section; and

(2) the private services provider that submitted the proposal has a demonstrated ability to provide the long-term services and supports appropriate to the individuals who will receive services through the pilot program based on the proposed strategy, if implemented.

(e) Based on the evaluation performed under Subsection (d), the department may select as pilot program service providers one or more private services providers.

(f) For each pilot program service provider, the department shall develop and implement a pilot program. Under a pilot program, the pilot program service provider shall provide long-term services and supports under the Medicaid program to persons with intellectual and developmental disabilities to test its managed care strategy based on capitation.

(g) The department shall analyze information provided by the pilot program service providers and any information collected by the department during the operation of the pilot programs for purposes of making a recommendation about a system of programs and services for implementation through future state legislation or rules.

Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) The department, in consultation with the advisory committee, shall identify measurable goals to be achieved by each pilot program implemented under this subchapter. The identified goals must:

(1) align with information that will be collected

under Section 534.108(a); and

(2) be designed to improve the quality of outcomes for individuals receiving services through the pilot program.

(b) The department, in consultation with the advisory committee, shall propose specific strategies for achieving the identified goals. A proposed strategy may be evidence-based if there is an evidence-based strategy available for meeting the pilot program's goals.

Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION. (a) The commission and the department shall implement any pilot programs established under this subchapter not later than September 1, 2016.

(b) A pilot program established under this subchapter must operate for not less than 24 months, except that a pilot program may cease operation before the expiration of 24 months if the pilot program service provider terminates the contract with the commission before the agreed-to termination date.

(c) A pilot program established under this subchapter shall be conducted in one or more regions selected by the department.

Sec. 534.1065. RECIPIENT PARTICIPATION IN PROGRAM VOLUNTARY. Participation in a pilot program established under this subchapter by an individual with an intellectual or developmental disability is voluntary, and the decision whether to participate in a program and receive long-term services and supports from a provider through that program may be made only by the individual or the individual's legally authorized representative.

Sec. 534.107. COORDINATING SERVICES. In providing

long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities, a pilot program service provider shall:

(1) coordinate through the pilot program institutional and community-based services available to the individuals, including services provided through:

(A) a facility licensed under Chapter 252, Health and Safety Code;

(B) a Medicaid waiver program; or

(C) a community-based ICF-IID operated by local authorities;

(2) collaborate with managed care organizations to provide integrated coordination of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports;

(3) have a process for preventing inappropriate institutionalizations of individuals; and

(4) accept the risk of inappropriate institutionalizations of individuals previously residing in community settings.

Sec. 534.108. PILOT PROGRAM INFORMATION. (a) The commission and the department shall collect and compute the following information with respect to each pilot program implemented under this subchapter to the extent it is available:

(1) the difference between the average monthly cost per person for all acute care services and long-term services and

supports received by individuals participating in the pilot program while the program is operating, including services provided through the pilot program and other services with which pilot program services are coordinated as described by Section 534.107, and the average monthly cost per person for all services received by the individuals before the operation of the pilot program;

(2) the percentage of individuals receiving services through the pilot program who begin receiving services in a nonresidential setting instead of from a facility licensed under Chapter 252, Health and Safety Code, or any other residential setting;

(3) the difference between the percentage of individuals receiving services through the pilot program who live in non-provider-owned housing during the operation of the pilot program and the percentage of individuals receiving services through the pilot program who lived in non-provider-owned housing before the operation of the pilot program;

(4) the difference between the average total Medicaid cost, by level of need, for individuals in various residential settings receiving services through the pilot program during the operation of the program and the average total Medicaid cost, by level of need, for those individuals before the operation of the program;

(5) the difference between the percentage of individuals receiving services through the pilot program who obtain and maintain employment in meaningful, integrated settings during the operation of the program and the percentage of individuals

receiving services through the program who obtained and maintained employment in meaningful, integrated settings before the operation of the program;

(6) the difference between the percentage of individuals receiving services through the pilot program whose behavioral, medical, life-activity, and other personal outcomes have improved since the beginning of the program and the percentage of individuals receiving services through the program whose behavioral, medical, life-activity, and other personal outcomes improved before the operation of the program, as measured over a comparable period; and

(7) a comparison of the overall client satisfaction with services received through the pilot program, including for individuals who leave the program after a determination is made in the individuals' cases at hearings or on appeal, and the overall client satisfaction with services received before the individuals entered the pilot program.

(b) The pilot program service provider shall collect any information described by Subsection (a) that is available to the provider and provide the information to the department and the commission not later than the 30th day before the date the program's operation concludes.

(c) In addition to the information described by Subsection (a), the pilot program service provider shall collect any information specified by the department for use by the department in making an evaluation under Section 534.104(g).

(d) On or before December 1, 2016, and December 1, 2017, the

commission and the department, in consultation with the advisory committee, shall review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit a report to the legislature during the operation of the pilot programs. Each report must include recommendations for program improvement and continued implementation.

Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in cooperation with the department, shall ensure that each individual with an intellectual or developmental disability who receives services and supports under the Medicaid program through a pilot program established under this subchapter, or the individual's legally authorized representative, has access to a facilitated, person-centered plan that identifies outcomes for the individual and drives the development of the individualized budget. The consumer direction model, as defined by Section 531.051, may be an outcome of the plan.

Sec. 534.110. TRANSITION BETWEEN PROGRAMS. The commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid program benefits between a Medicaid waiver program or an ICF-IID program and a pilot program under this subchapter to protect continuity of care.

Sec. 534.111. CONCLUSION OF PILOT PROGRAMS; EXPIRATION. On September 1, 2018:

(1) each pilot program established under this subchapter that is still in operation must conclude; and

(2) this subchapter expires.

SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND CERTAIN OTHER SERVICES

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. Subject to Section 533.0025, the commission shall provide acute care Medicaid program benefits to individuals with intellectual and developmental disabilities through the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model and monitor the provision of those benefits.

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) The commission shall:

(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.

(b) The commission shall require that each managed care organization that contracts with the commission for the provision of basic attendant and habilitation services under the STAR + PLUS Medicaid managed care program in accordance with this section:

(1) include in the organization's provider network for the provision of those services:

(A) home and community support services agencies licensed under Chapter 142, Health and Safety Code, with which the department has a contract to provide services under the community living assistance and support services (CLASS) waiver program; and

(B) persons exempted from licensing under Section 142.003(a)(19), Health and Safety Code, with which the department has a contract to provide services under:

(i) the home and community-based services (HCS) waiver program; or

(ii) the Texas home living (TxHmL) waiver program;

(2) review and consider any assessment conducted by a local intellectual and developmental disability authority providing intellectual and developmental disability service coordination under Subsection (c); and

(3) enter into a written agreement with each local intellectual and developmental disability authority in the service area regarding the processes the organization and the authority will use to coordinate the services of individuals with intellectual and developmental disabilities.

(c) The department shall contract with and make contract payments to local intellectual and developmental disability authorities to conduct the following activities under this section:

(1) provide intellectual and developmental disability service coordination to individuals with intellectual and

developmental disabilities under the STAR + PLUS Medicaid managed care program by assisting those individuals who are eligible to receive services in a community-based setting, including individuals transitioning to a community-based setting;

(2) provide an assessment to the appropriate managed care organization regarding whether an individual with an intellectual or developmental disability needs attendant or habilitation services, based on the individual's functional need, risk factors, and desired outcomes;

(3) assist individuals with intellectual and developmental disabilities with developing the individuals' plans of care under the STAR + PLUS Medicaid managed care program, including with making any changes resulting from periodic reassessments of the plans;

(4) provide to the appropriate managed care organization and the department information regarding the recommended plans of care with which the authorities provide assistance as provided by Subdivision (3), including documentation necessary to demonstrate the need for care described by a plan; and

(5) on an annual basis, provide to the appropriate managed care organization and the department a description of outcomes based on an individual's plan of care.

(d) Local intellectual and developmental disability authorities providing service coordination under this section may not also provide attendant and habilitation services under this section.

(e) During the first three years basic attendant and

habilitation services are provided to individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program in accordance with this section, providers eligible to participate in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, or the community living assistance and support services (CLASS) waiver program on September 1, 2013, are considered significant traditional providers.

(f) A local intellectual and developmental disability authority with which the department contracts under Subsection (c) may subcontract with an eligible person, including a nonprofit entity, to coordinate the services of individuals with intellectual and developmental disabilities under this section. The executive commissioner by rule shall establish minimum qualifications a person must meet to be considered an "eligible person" under this subsection.

SUBCHAPTER E. STAGE TWO: TRANSITION OF LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM

Sec. 534.201. TRANSITION OF RECIPIENTS UNDER TEXAS HOME LIVING (TxHmL) WAIVER PROGRAM TO MANAGED CARE PROGRAM. (a) This section applies to individuals with intellectual and developmental disabilities who are receiving long-term services and supports under the Texas home living (TxHmL) waiver program on the date the commission implements the transition described by Subsection (b).

(b) Not later than September 1, 2017, the commission shall transition the provision of Medicaid program benefits to individuals to whom this section applies to the STAR + PLUS Medicaid

managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and habilitation services and of the pilot programs established under Subchapter C, subject to Subsection (c)(1).

(c) At the time of the transition described by Subsection (b), the commission shall determine whether to:

(1) continue operation of the Texas home living (TxHmL) waiver program for purposes of providing supplemental long-term services and supports not available under the managed care program delivery model selected by the commission; or

(2) provide all or a portion of the long-term services and supports previously available under the Texas home living (TxHmL) waiver program through the managed care program delivery model selected by the commission.

(d) In implementing the transition described by Subsection (b), the commission shall develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input provided by the advisory committee.

(e) The commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid program benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

(f) In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for

the organization to provide Medicaid program benefits under this section must contain a requirement that the organization implement a process for individuals with intellectual and developmental disabilities that:

(1) ensures that the individuals have a choice among providers;

(2) to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including the use of single-case agreements with out-of-network providers; and

(3) provides access to a member services phone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary, specialty, and other long-term services and supports.

Sec. 534.202. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) This section applies to individuals with intellectual and developmental disabilities who, on the date the commission implements the transition described by Subsection (b), are receiving long-term services and supports under:

(1) a Medicaid waiver program other than the Texas home living (TxHmL) waiver program; or

(2) an ICF-IID program.

(b) After implementing the transition required by Section 534.201 but not later than September 1, 2020, the commission shall transition the provision of Medicaid program benefits to

individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the transition of Texas home living (TxHmL) waiver program recipients to a managed care program delivery model under Section 534.201, subject to Subsections (c)(1) and (g).

(c) At the time of the transition described by Subsection (b), the commission shall determine whether to:

(1) continue operation of the Medicaid waiver programs or ICF-IID program only for purposes of providing, if applicable:

(A) supplemental long-term services and supports not available under the managed care program delivery model selected by the commission; or

(B) long-term services and supports to Medicaid waiver program recipients who choose to continue receiving benefits under the waiver program as provided by Subsection (g); or

(2) subject to Subsection (g), provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs or ICF-IID program through the managed care program delivery model selected by the commission.

(d) In implementing the transition described by Subsection (b), the commission shall develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input provided by the advisory committee.

(e) The commission shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid

program benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

(f) Before transitioning the provision of Medicaid program benefits for children under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to children with intellectual and developmental disabilities. Before transitioning the provision of Medicaid program benefits for adults with intellectual and developmental disabilities under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to adults with intellectual and developmental disabilities.

(g) If the commission determines that all or a portion of the long-term services and supports previously available under the Medicaid waiver programs should be provided through a managed care program delivery model under Subsection (c)(2), the commission shall, at the time of the transition, allow each recipient receiving long-term services and supports under a Medicaid waiver program the option of:

(1) continuing to receive the services and supports under the Medicaid waiver program; or

(2) receiving the services and supports through the

managed care program delivery model selected by the commission.

(h) A recipient who chooses to receive long-term services and supports through a managed care program delivery model under Subsection (g) may not, at a later time, choose to receive the services and supports under a Medicaid waiver program.

(i) In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization to provide Medicaid program benefits under this section must contain a requirement that the organization implement a process for individuals with intellectual and developmental disabilities that:

(1) ensures that the individuals have a choice among providers;

(2) to the greatest extent possible, protects those individuals' continuity of care with respect to access to primary care providers, including the use of single-case agreements with out-of-network providers; and

(3) provides access to a member services phone line for individuals or their legally authorized representatives to obtain information on and assistance with accessing services through network providers, including providers of primary, specialty, and other long-term services and supports.

Sec. 534.203. RESPONSIBILITIES OF COMMISSION UNDER SUBCHAPTER. In administering this subchapter, the commission shall ensure:

(1) that the commission is responsible for setting the minimum reimbursement rate paid to a provider of ICF-IID services

or a group home provider under the integrated managed care system, including the staff rate enhancement paid to a provider of ICF-IID services or a group home provider;

(2) that an ICF-IID service provider or a group home provider is paid not later than the 10th day after the date the provider submits a clean claim in accordance with the criteria used by the department for the reimbursement of ICF-IID service providers or a group home provider, as applicable; and

(3) the establishment of an electronic portal through which a provider of ICF-IID services or a group home provider participating in the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as appropriate, may submit long-term services and supports claims to any participating managed care organization.

SECTION 1.02. Subsection (a), Section 142.003, Health and Safety Code, is amended to read as follows:

(a) The following persons need not be licensed under this chapter:

(1) a physician, dentist, registered nurse, occupational therapist, or physical therapist licensed under the laws of this state who provides home health services to a client only as a part of and incidental to that person's private office practice;

(2) a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech therapist, medical social worker, or any other health care professional as

determined by the department who provides home health services as a sole practitioner;

(3) a registry that operates solely as a clearinghouse to put consumers in contact with persons who provide home health, hospice, or personal assistance services and that does not maintain official client records, direct client services, or compensate the person who is providing the service;

(4) an individual whose permanent residence is in the client's residence;

(5) an employee of a person licensed under this chapter who provides home health, hospice, or personal assistance services only as an employee of the license holder and who receives no benefit for providing the services, other than wages from the license holder;

(6) a home, nursing home, convalescent home, assisted living facility, special care facility, or other institution for individuals who are elderly or who have disabilities that provides home health or personal assistance services only to residents of the home or institution;

(7) a person who provides one health service through a contract with a person licensed under this chapter;

(8) a durable medical equipment supply company;

(9) a pharmacy or wholesale medical supply company that does not furnish services, other than supplies, to a person at the person's house;

(10) a hospital or other licensed health care facility that provides home health or personal assistance services only to

inpatient residents of the hospital or facility;

(11) a person providing home health or personal assistance services to an injured employee under Title 5, Labor Code;

(12) a visiting nurse service that:

(A) is conducted by and for the adherents of a well-recognized church or religious denomination; and

(B) provides nursing services by a person exempt from licensing by Section 301.004, Occupations Code, because the person furnishes nursing care in which treatment is only by prayer or spiritual means;

(13) an individual hired and paid directly by the client or the client's family or legal guardian to provide home health or personal assistance services;

(14) a business, school, camp, or other organization that provides home health or personal assistance services, incidental to the organization's primary purpose, to individuals employed by or participating in programs offered by the business, school, or camp that enable the individual to participate fully in the business's, school's, or camp's programs;

(15) a person or organization providing sitter-companion services or chore or household services that do not involve personal care, health, or health-related services;

(16) a licensed health care facility that provides hospice services under a contract with a hospice;

(17) a person delivering residential acquired immune deficiency syndrome hospice care who is licensed and designated as

a residential AIDS hospice under Chapter 248;

(18) the Texas Department of Criminal Justice;

(19) a person that provides home health, hospice, or personal assistance services only to persons receiving benefits under:

(A) the home and community-based services (HCS) waiver program;

(B) the Texas home living (TxHmL) waiver program; or

(C) Section 534.152, Government Code [~~enrolled in a program funded wholly or partly by the Texas Department of Mental Health and Mental Retardation and monitored by the Texas Department of Mental Health and Mental Retardation or its designated local authority in accordance with standards set by the Texas Department of Mental Health and Mental Retardation~~]; or

(20) an individual who provides home health or personal assistance services as the employee of a consumer or an entity or employee of an entity acting as a consumer's fiscal agent under Section 531.051, Government Code.

SECTION 1.03. Not later than October 1, 2013, the executive commissioner of the Health and Human Services Commission and the commissioner of the Department of Aging and Disability Services shall appoint the members of the Intellectual and Developmental Disability System Redesign Advisory Committee as required by Section 534.053, Government Code, as added by this article.

SECTION 1.04. (a) In this section, "health and human services agencies" has the meaning assigned by Section 531.001,

Government Code.

(b) The Health and Human Services Commission and any other health and human services agency implementing a provision of this Act that affects individuals with intellectual and developmental disabilities shall consult with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, Government Code, as added by this article, regarding implementation of the provision.

SECTION 1.05. The Health and Human Services Commission shall submit:

(1) the initial report on the implementation of the Medicaid acute care services and long-term services and supports delivery system for individuals with intellectual and developmental disabilities as required by Section 534.054, Government Code, as added by this article, not later than September 30, 2014; and

(2) the final report under that section not later than September 30, 2023.

SECTION 1.06. Not later than June 1, 2016, the Health and Human Services Commission shall submit a report to the legislature regarding the commission's experience in, including the cost-effectiveness of, delivering basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program under Section 534.152, Government Code, as added by this article.

SECTION 1.07. The Health and Human Services Commission and the Department of Aging and Disability Services shall implement any

pilot program to be established under Subchapter C, Chapter 534, Government Code, as added by this article, as soon as practicable after the effective date of this Act.

SECTION 1.08. (a) The Health and Human Services Commission and the Department of Aging and Disability Services shall:

(1) in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, Government Code, as added by this article, review and evaluate the outcomes of:

(A) the transition of the provision of benefits to individuals under the Texas home living (TxHmL) waiver program to a managed care program delivery model under Section 534.201, Government Code, as added by this article; and

(B) the transition of the provision of benefits to individuals under the Medicaid waiver programs, other than the Texas home living (TxHmL) waiver program, and the ICF-IID program to a managed care program delivery model under Section 534.202, Government Code, as added by this article; and

(2) submit as part of an annual report required by Section 534.054, Government Code, as added by this article, due on or before September 30 of 2018, 2019, and 2020, a report on the review and evaluation conducted under Paragraphs (A) and (B), Subdivision (1), of this subsection that includes recommendations for continued implementation of and improvements to the acute care and long-term services and supports system under Chapter 534, Government Code, as added by this article.

(b) This section expires September 1, 2024.

ARTICLE 2. MEDICAID MANAGED CARE EXPANSION

SECTION 2.01. Section 533.0025, Government Code, is amended by amending Subsections (a) and (b) and adding Subsections (f), (g), (h), and (i) to read as follows:

(a) In this section and Sections 533.00251, 533.002515, 533.00252, 533.00253, and 533.00254, "medical assistance" has the meaning assigned by Section 32.003, Human Resources Code.

(b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide medical assistance for acute care services through the most cost-effective model of Medicaid capitated managed care as determined by the commission. The [~~If the~~] commission shall require mandatory participation in a Medicaid capitated managed care program for all persons eligible for acute care [~~determines that it is more cost-effective, the commission may provide~~] medical assistance benefits, but may implement alternative models or arrangements, including a traditional fee-for-service arrangement, if the commission determines the alternative would be more cost-effective or efficient [~~for acute care in a certain part of this state or to a certain population of recipients using:~~

[~~(1) a health maintenance organization model, including the acute care portion of Medicaid Star + Plus pilot programs;~~

[~~(2) a primary care case management model;~~

[~~(3) a prepaid health plan model;~~

[~~(4) an exclusive provider organization model; or~~

[~~(5) another Medicaid managed care model or~~

~~arrangement~~].

(f) The commission shall:

(1) conduct a study to evaluate the feasibility of automatically enrolling applicants determined eligible for benefits under the medical assistance program in a Medicaid managed care plan chosen by the applicant; and

(2) report the results of the study to the legislature not later than December 1, 2014.

(g) Subsection (f) and this subsection expire September 1, 2015.

(h) If the commission determines that it is feasible, the commission may, notwithstanding any other law, implement an automatic enrollment process under which applicants determined eligible for medical assistance benefits are automatically enrolled in a Medicaid managed care plan chosen by the applicant. The commission may elect to implement the automatic enrollment process as to certain populations of recipients under the medical assistance program.

(i) Subject to Section 534.152, the commission shall:

(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with disabilities under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care

program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.

SECTION 2.02. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00251, 533.002515, 533.00252, 533.00253, and 533.00254 to read as follows:

Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS, INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this section and Sections 533.002515 and 533.00252:

(1) "Advisory committee" means the STAR + PLUS Nursing Facility Advisory Committee established under Section 533.00252.

(2) "Clean claim" means a claim that meets the same criteria for a clean claim used by the Department of Aging and Disability Services for the reimbursement of nursing facility claims.

(3) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to Medicaid recipients.

(4) "Potentially preventable event" has the meaning assigned by Section 536.001.

(b) Subject to Section 533.0025, the commission shall expand the STAR + PLUS Medicaid managed care program to all areas of this state to serve individuals eligible for acute care services and long-term services and supports under the medical assistance program.

(c) Subject to Section 533.0025 and notwithstanding any other law, the commission, in consultation with the advisory committee, shall provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. In implementing this subsection, the commission shall ensure:

(1) that the commission is responsible for setting the minimum reimbursement rate paid to a nursing facility under the managed care program, including the staff rate enhancement paid to a nursing facility that qualifies for the enhancement;

(2) that a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;

(3) the appropriate utilization of services consistent with criteria adopted by the commission;

(4) a reduction in the incidence of potentially preventable events and unnecessary institutionalizations;

(5) that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(6) that a managed care organization providing services under the managed care program:

(A) assists in collecting applied income from recipients; and

(B) provides payment incentives to nursing facility providers that reward reductions in preventable acute care

costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(7) the establishment of a portal that is in compliance with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization;

(8) that rules and procedures relating to the certification and decertification of nursing facility beds under the medical assistance program are not affected; and

(9) that a managed care organization providing services under the managed care program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board.

(d) Subject to Subsection (e), the commission shall ensure that a nursing facility provider authorized to provide services under the medical assistance program on September 1, 2013, is allowed to participate in the STAR + PLUS Medicaid managed care program through August 31, 2017.

(e) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care

program that are consistent with adopted federal and state standards. A managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by the commission under this section.

(f) A managed care organization may not require prior authorization for a nursing facility resident in need of emergency hospital services.

(g) Subsections (c), (d), (e), and (f) and this subsection expire September 1, 2019.

Sec. 533.002515. PLANNED PREPARATION FOR DELIVERY OF NURSING FACILITY BENEFITS THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) The commission shall develop a plan in preparation for implementing the requirement under Section 533.00251(c) that the commission provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. The plan required by this section must be completed in two phases as follows:

(1) phase one: contract planning phase; and

(2) phase two: initial testing phase.

(b) In phase one, the commission shall develop a contract template to be used by the commission when the commission contracts with a managed care organization to provide nursing facility services under the STAR + PLUS Medicaid managed care program. In addition to the requirements of Section 533.005 and any other applicable law, the template must include:

(1) nursing home credentialing requirements;

(2) appeals processes;

(3) termination provisions;

(4) prompt payment requirements and a liquidated damages provision that contains financial penalties for failure to meet prompt payment requirements;

(5) a description of medical necessity criteria;

(6) a requirement that the managed care organization provide recipients and recipients' families freedom of choice in selecting a nursing facility; and

(7) a description of the managed care organization's role in discharge planning and imposing prior authorization requirements.

(c) In phase two, the commission shall:

(1) design and test the portal required under Section 533.00251(c)(7);

(2) establish and inform managed care organizations of the minimum technological or system requirements needed to use the portal required under Section 533.00251(c)(7);

(3) establish operating policies that require that managed care organizations maintain a portal through which providers may confirm recipient eligibility on a monthly basis; and

(4) establish the manner in which managed care organizations are to assist the commission in collecting from recipients applied income or cost-sharing payments, including copayments, as applicable.

(d) This section expires September 1, 2015.

Sec. 533.00252. STAR + PLUS NURSING FACILITY ADVISORY

COMMITTEE. (a) The STAR + PLUS Nursing Facility Advisory Committee is established to advise the commission on the implementation of and other activities related to the provision of medical assistance benefits to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program under Section 533.00251, including advising the commission regarding its duties with respect to:

(1) developing quality-based outcomes and process measures for long-term services and supports provided in nursing facilities;

(2) developing quality-based long-term care payment systems and quality initiatives for nursing facilities;

(3) transparency of information received from managed care organizations;

(4) the reporting of outcome and process measures;

(5) the sharing of data among health and human services agencies; and

(6) patient care coordination, quality of care improvement, and cost savings.

(b) The governor, lieutenant governor, and speaker of the house of representatives shall each appoint five members of the advisory committee as follows:

(1) one member who is a physician and medical director of a nursing facility provider with experience providing the long-term continuum of care, including home care and hospice;

(2) one member who is a nonprofit nursing facility provider;

(3) one member who is a for-profit nursing facility provider;

(4) one member who is a consumer representative; and

(5) one member who is from a managed care organization providing services as provided by Section 533.00251.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) A member of the advisory committee serves without compensation.

(e) The advisory committee is subject to the requirements of Chapter 551.

(f) On September 1, 2016:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee established under Section 533.00254.

(2) "Health home" means a primary care provider practice, or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under the medical assistance program.

(3) "Potentially preventable event" has the meaning assigned by Section 536.001.

(b) Subject to Section 533.0025, the commission shall, in consultation with the advisory committee and the Children's Policy Council established under Section 22.035, Human Resources Code, establish a mandatory STAR Kids capitated managed care program tailored to provide medical assistance benefits to children with disabilities. The managed care program developed under this section must:

(1) provide medical assistance benefits that are customized to meet the health care needs of recipients under the program through a defined system of care;

(2) better coordinate care of recipients under the program;

(3) improve the health outcomes of recipients;

(4) improve recipients' access to health care services;

(5) achieve cost containment and cost efficiency;

(6) reduce the administrative complexity of delivering medical assistance benefits;

(7) reduce the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(8) require a health home; and

(9) coordinate and collaborate with long-term care service providers and long-term care management providers, if recipients are receiving long-term services and supports outside of the managed care organization.

(c) The commission may require that care management services made available as provided by Subsection (b)(7):

(1) incorporate best practices, as determined by the commission;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification methodology that identifies recipients who have the greatest need for services;

(4) provide a care needs assessment for a recipient that is comprehensive, holistic, consumer-directed, evidence-based, and takes into consideration social and medical issues, for purposes of prioritizing the recipient's needs that threaten independent living;

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transition of care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics determined appropriate by the commission; and

(8) use innovations in the provision of services.

(d) The commission shall provide medical assistance

benefits through the STAR Kids managed care program established under this section to children who are receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this subsection.

(e) The commission shall ensure that there is a plan for transitioning the provision of Medicaid program benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age.

(f) The commission shall seek ongoing input from the Children's Policy Council regarding the establishment and implementation of the STAR Kids managed care program.

Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE. (a) The STAR Kids Managed Care Advisory Committee is established to advise the commission on the establishment and implementation of the STAR Kids managed care program under Section 533.00253.

(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of:

(1) families whose children will receive private duty nursing under the program;

(2) health care providers;

(3) providers of home and community-based services, including at least one private duty nursing provider and one

pediatric therapy provider; and

(4) other stakeholders as the executive commissioner determines appropriate.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) A member of the advisory committee serves without compensation.

(e) The advisory committee is subject to the requirements of Chapter 551.

(f) On September 1, 2016:

(1) the advisory committee is abolished; and

(2) this section expires.

SECTION 2.03. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00285 to read as follows:

Sec. 533.00285. STAR + PLUS QUALITY COUNCIL. (a) The STAR + PLUS Quality Council is established to advise the commission on the development of policy recommendations that will ensure eligible recipients receive quality, person-centered, consumer-directed acute care services and long-term services and supports in an integrated setting under the STAR + PLUS Medicaid managed care program.

(b) The executive commissioner shall appoint the members of the council, who must be stakeholders from the acute care services and long-term services and supports community, including:

(1) representatives of health and human services agencies;

(2) recipients under the STAR + PLUS Medicaid managed

care program;

(3) representatives of advocacy groups representing individuals with disabilities and seniors who are recipients under the STAR + PLUS Medicaid managed care program;

(4) representatives of service providers for individuals with disabilities; and

(5) representatives of health maintenance organizations.

(c) The executive commissioner shall appoint the presiding officer of the council.

(d) The council shall meet at least quarterly or more frequently if the presiding officer determines that it is necessary to carry out the responsibilities of the council.

(e) Not later than November 1 of each year, the council in coordination with the commission shall submit a report to the executive commissioner that includes:

(1) an analysis and assessment of the quality of acute care services and long-term services and supports provided under the STAR + PLUS Medicaid managed care program;

(2) recommendations regarding how to improve the quality of acute care services and long-term services and supports provided under the program; and

(3) recommendations regarding how to ensure that recipients eligible to receive services and supports under the program receive person-centered, consumer-directed care in the most integrated setting achievable.

(f) Not later than December 1 of each even-numbered year,

the commission, in consultation with the council, shall submit a report to the legislature regarding the assessments and recommendations contained in any report submitted by the council under Subsection (e) during the most recent state fiscal biennium.

(g) The council is subject to the requirements of Chapter 551.

(h) A member of the council serves without compensation.

(i) On January 1, 2017:

(1) the council is abolished; and

(2) this section expires.

SECTION 2.04. Section 533.005, Government Code, is amended by amending Subsections (a) and (a-1) and adding Subsection (a-3) to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any [~~not later than the 45th day after the date a~~] claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii);[~~,~~] or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider

and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that the organization use advanced practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal; [~~and~~]

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider; and

(D) the managed care organization to allow a

provider with a claim that has not been paid before the time prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care organization:

(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to:

(i) [~~(A)~~] preventive care;

(ii) [~~(B)~~] primary care;

(iii) [~~(C)~~] specialty care;

(iv) [~~(D)~~] after-hours urgent care; [~~and~~]

(v) [~~(E)~~] chronic care;

(vi) long-term services and supports;

(vii) nursing services; and

(viii) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(B) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Paragraph (A) and specific data with respect to Paragraphs (A)(iii), (vi), (vii), and (viii) on the average length of time between:

(i) the date a provider makes a referral for the care or service and the date the organization approves or denies the referral; and

(ii) the date the organization approves a referral for the care or service and the date the care or service is initiated;

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that:

(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network

includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types; [~~and~~]

(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(iv) providers located throughout the region where the organization will provide health care services; and

(C) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health

conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under the Medicaid program;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care organization or

any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees; and

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in

accordance with Section 843.339, Insurance Code; [~~and~~]

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan; and

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reduction; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission.

(a-1) The requirements imposed by Subsections (a)(23)(A), (B), and (C) do not apply, and may not be enforced, on and after August 31, 2018 [~~2013~~].

(a-3) For purposes of Subsection (a)(25)(A), a provider reimbursement rate reduction is considered to have received the commission's prior approval unless the commission issues a written statement of disapproval not later than the 45th day after the date the commission receives notice of the proposed rate reduction from the managed care organization.

SECTION 2.05. Section 533.041, Government Code, is amended

by amending Subsection (a) and adding Subsections (c) and (d) to read as follows:

(a) The executive commissioner [~~commission~~] shall appoint a state Medicaid managed care advisory committee. The advisory committee consists of representatives of:

(1) hospitals;

(2) managed care organizations and participating health care providers;

(3) primary care providers and specialty care providers;

(4) state agencies;

(5) low-income recipients or consumer advocates representing low-income recipients;

(6) recipients with disabilities, including recipients with intellectual and developmental disabilities or physical disabilities, or consumer advocates representing those recipients [~~with a disability~~];

(7) parents of children who are recipients;

(8) rural providers;

(9) advocates for children with special health care needs;

(10) pediatric health care providers, including specialty providers;

(11) long-term services and supports [~~care~~] providers, including nursing facility [~~home~~] providers and direct service workers;

(12) obstetrical care providers;

(13) community-based organizations serving low-income children and their families; [~~and~~]

(14) community-based organizations engaged in perinatal services and outreach;

(15) recipients who are 65 years of age or older;

(16) recipients with mental illness;

(17) nonphysician mental health providers participating in the Medicaid managed care program; and

(18) entities with responsibilities for the delivery of long-term services and supports or other Medicaid program service delivery, including:

(A) independent living centers;

(B) area agencies on aging;

(C) aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;

(D) community mental health and intellectual disability centers; and

(E) the NorthSTAR Behavioral Health Program provided under Chapter 534, Health and Safety Code.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) To the greatest extent possible, the executive commissioner shall appoint members of the advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid program recipients.

SECTION 2.06. Section 533.042, Government Code, is amended to read as follows:

Sec. 533.042. MEETINGS. (a) The advisory committee shall meet at the call of the presiding officer at least semiannually, but no more frequently than quarterly.

(b) The advisory committee:

(1) [~~,~~] shall develop procedures that provide the public with reasonable opportunity to appear before the committee [~~committtee~~] and speak on any issue under the jurisdiction of the committee;[~~,~~] and

(2) is subject to Chapter 551.

SECTION 2.07. Section 533.043, Government Code, is amended to read as follows:

Sec. 533.043. POWERS AND DUTIES. (a) The advisory committee shall:

(1) provide recommendations and ongoing advisory input to the commission on the statewide implementation and operation of Medicaid managed care, including:

(A) program design and benefits;

(B) systemic concerns from consumers and providers;

(C) the efficiency and quality of services delivered by Medicaid managed care organizations;

(D) contract requirements for Medicaid managed care organizations;

(E) Medicaid managed care provider network adequacy;

(F) trends in claims processing; and

(G) other issues as requested by the executive commissioner;

(2) assist the commission with issues relevant to Medicaid managed care to improve the policies established for and programs operating under Medicaid managed care, including the early and periodic screening, diagnosis, and treatment program, provider and patient education issues, and patient eligibility issues; and

(3) disseminate or make available to each regional advisory committee appointed under Subchapter B information on best practices with respect to Medicaid managed care that is obtained from a regional advisory committee.

(b) The commission and the Department of Aging and Disability Services shall ensure coordination and communication between the advisory committee, regional Medicaid managed care advisory committees appointed by the commission under Subchapter B, and other advisory committees or groups that perform functions related to Medicaid managed care, including the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, in a manner that enables the state Medicaid managed care advisory committee to act as a central source of agency information and stakeholder input relevant to the implementation and operation of Medicaid managed care.

(c) The advisory committee may establish work groups that meet at other times for purposes of studying and making recommendations on issues the committee determines appropriate.

SECTION 2.08. Section 533.044, Government Code, is amended

to read as follows:

Sec. 533.044. OTHER LAW. (a) Except as provided by Subsection (b) and other provisions of this subchapter, the advisory committee is subject to Chapter 2110.

(b) Section 2110.008 does not apply to the advisory committee.

SECTION 2.09. Subchapter C, Chapter 533, Government Code, is amended by adding Section 533.045 to read as follows:

Sec. 533.045. COMPENSATION; REIMBURSEMENT. (a) Except as provided by Subsection (b), a member of the advisory committee is not entitled to receive compensation or reimbursement for travel expenses.

(b) A member of the advisory committee who is a Medicaid program recipient or the relative of a Medicaid program recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

SECTION 2.10. Section 32.0212, Human Resources Code, is amended to read as follows:

Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE. Notwithstanding any other law and subject to Section 533.0025, Government Code, the department shall provide medical assistance for acute care services through the Medicaid managed care system implemented under Chapter 533, Government Code, or another Medicaid capitated managed care program.

SECTION 2.11. (a) The senate health and human services committee and the house human services committee shall study and review:

(1) the requirement under Subsection (c), Section 533.00251, Government Code, as added by this article, that medical assistance program recipients who reside in nursing facilities receive nursing facility benefits through the STAR + PLUS Medicaid managed care program; and

(2) the implementation of that requirement.

(b) Not later than January 15, 2015, the committees shall report the committees' findings and recommendations to the lieutenant governor, the speaker of the house of representatives, and the governor. The committees shall include in the recommendations specific statutory, rule, and procedural changes that appear necessary from the results of the committees' study under Subsection (a) of this section.

(c) This section expires September 1, 2015.

SECTION 2.12. (a) The Health and Human Services Commission and the Department of Aging and Disability Services shall:

(1) review and evaluate the outcomes of the transition of the provision of benefits to recipients under the medically dependent children (MDCP) waiver program to the STAR Kids managed care program delivery model established under Section 533.00253, Government Code, as added by this article;

(2) not later than December 1, 2016, submit an initial report to the legislature on the review and evaluation conducted under Subdivision (1) of this subsection, including recommendations for continued implementation and improvement of the program; and

(3) not later than December 1 of each year after 2016

and until December 1, 2020, submit additional reports that include the information described by Subdivision (1) of this subsection.

(b) This section expires September 1, 2021.

SECTION 2.13. (a) Not later than October 1, 2013, the executive commissioner of the Health and Human Services Commission shall appoint the members of the STAR + PLUS Quality Council as required by Section 533.00285, Government Code, as added by this article.

(b) The STAR + PLUS Quality Council, in coordination with the Health and Human Services Commission, shall submit:

(1) the initial report required under Subsection (e), Section 533.00285, Government Code, as added by this article, not later than November 1, 2014; and

(2) the final report required under that subsection not later than November 1, 2016.

(c) The Health and Human Services Commission shall submit:

(1) the initial report required under Subsection (f), Section 533.00285, Government Code, as added by this article, not later than December 1, 2014; and

(2) the final report required under that subsection not later than December 1, 2016.

SECTION 2.14. Not later than June 1, 2016, the Health and Human Services Commission shall submit a report to the legislature regarding the commission's experience in, including the cost-effectiveness of, delivering basic attendant and habilitation services for individuals with disabilities under the STAR + PLUS Medicaid managed care program under Subsection (i), Section

533.0025, Government Code, as added by this article. The commission may combine the report required under this section with the report required under Section 1.06 of this Act.

SECTION 2.15. (a) The Health and Human Services Commission shall, in a contract between the commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act, require that the managed care organization comply with applicable provisions of Subsection (a), Section 533.005, Government Code, as amended by this article.

(b) The Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to require those managed care organizations to comply with applicable provisions of Subsection (a), Section 533.005, Government Code, as amended by this article. To the extent of a conflict between the applicable provisions of that subsection and a provision of a contract with a managed care organization entered into before the effective date of this Act, the contract provision prevails.

SECTION 2.16. Not later than September 15, 2013, the governor, lieutenant governor, and speaker of the house of representatives shall appoint the members of the STAR + PLUS Nursing Facility Advisory Committee as required by Section 533.00252, Government Code, as added by this article.

SECTION 2.17. (a) Not later than October 1, 2013, the Health and Human Services Commission shall:

(1) complete phase one of the plan required under Section 533.002515, Government Code, as added by this article; and

(2) submit a report regarding the implementation of phase one of the plan together with a copy of the contract template required by that section to the STAR + PLUS Nursing Facility Advisory Committee established under Section 533.00252, Government Code, as added by this article.

(b) Not later than July 15, 2014, the Health and Human Services Commission shall:

(1) complete phase two of the plan required under Section 533.002515, Government Code, as added by this article; and

(2) submit a report regarding the implementation of phase two to the STAR + PLUS Nursing Facility Advisory Committee established under Section 533.00252, Government Code, as added by this article.

SECTION 2.18. (a) The Health and Human Services Commission may not:

(1) implement Paragraph (B), Subdivision (6), Subsection (c), Section 533.00251, Government Code, as added by this article, unless the commission seeks and obtains a waiver or other authorization from the federal Centers for Medicare and Medicaid Services or other appropriate entity that ensures a significant portion, but not more than 80 percent, of accrued savings to the Medicare program as a result of reduced hospitalizations and institutionalizations and other care and efficiency improvements to nursing facilities participating in the medical assistance program in this state will be returned to this

state and distributed to those facilities; and

(2) begin providing medical assistance benefits to recipients under Section 533.00251, Government Code, as added by this article, before September 1, 2014.

(b) As soon as practicable after the implementation date of Section 533.00251, Government Code, as added by this article, the Health and Human Services Commission shall provide a portal through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims in accordance with Subdivision (7), Subsection (c), Section 533.00251, Government Code, as added by this article.

SECTION 2.19. (a) Not later than October 1, 2013, the executive commissioner of the Health and Human Services Commission shall appoint additional members to the state Medicaid managed care advisory committee to comply with Section 533.041, Government Code, as amended by this article.

(b) Not later than December 1, 2013, the presiding officer of the state Medicaid managed care advisory committee shall convene the first meeting of the advisory committee following appointment of additional members as required by Subsection (a) of this section.

SECTION 2.20. As soon as practicable after the effective date of this Act, but not later than January 1, 2014, the executive commissioner of the Health and Human Services Commission shall adopt rules and managed care contracting guidelines governing the transition of appropriate duties and functions from the commission and other health and human services agencies to managed care

organizations that are required as a result of the changes in law made by this article.

SECTION 2.21. The changes in law made by this article are not intended to negatively affect Medicaid recipients' access to quality health care. The Health and Human Services Commission, as the state agency designated to supervise the administration and operation of the Medicaid program and to plan and direct the Medicaid program in each state agency that operates a portion of the Medicaid program, including directing the Medicaid managed care system, shall continue to timely enforce all laws applicable to the Medicaid program and the Medicaid managed care system, including laws relating to provider network adequacy, the prompt payment of claims, and the resolution of patient and provider complaints.

ARTICLE 3. OTHER PROVISIONS RELATING TO INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SECTION 3.01. Subchapter B, Chapter 533, Health and Safety Code, is amended by adding Section 533.0335 to read as follows:

Sec. 533.0335. COMPREHENSIVE ASSESSMENT AND RESOURCE ALLOCATION PROCESS. (a) In this section:

(1) "Advisory committee" means the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, Government Code.

(2) "Department" means the Department of Aging and Disability Services.

(3) "Functional need," "ICF-IID program," and "Medicaid waiver program" have the meanings assigned those terms by Section 534.001, Government Code.

(b) Subject to the availability of federal funding, the department shall develop and implement a comprehensive assessment instrument and a resource allocation process for individuals with intellectual and developmental disabilities as needed to ensure that each individual with an intellectual or developmental disability receives the type, intensity, and range of services that are both appropriate and available, based on the functional needs of that individual, if the individual receives services through one of the following:

(1) a Medicaid waiver program;

(2) the ICF-IID program; or

(3) an intermediate care facility operated by the state and providing services for individuals with intellectual and developmental disabilities.

(b-1) In developing a comprehensive assessment instrument for purposes of Subsection (b), the department shall evaluate any assessment instrument in use by the department. In addition, the department may implement an evidence-based, nationally recognized, comprehensive assessment instrument that assesses the functional needs of an individual with intellectual and developmental disabilities as the comprehensive assessment instrument required by Subsection (b). This subsection expires September 1, 2015.

(c) The department, in consultation with the advisory committee, shall establish a prior authorization process for requests for supervised living or residential support services available in the home and community-based services (HCS) Medicaid waiver program. The process must ensure that supervised living or

residential support services available in the home and community-based services (HCS) Medicaid waiver program are available only to individuals for whom a more independent setting is not appropriate or available.

(d) The department shall cooperate with the advisory committee to establish the prior authorization process required by Subsection (c). This subsection expires January 1, 2024.

SECTION 3.02. Subchapter B, Chapter 533, Health and Safety Code, is amended by adding Sections 533.03551 and 533.03552 to read as follows:

Sec. 533.03551. FLEXIBLE, LOW-COST HOUSING OPTIONS. (a) To the extent permitted under federal law and regulations, the executive commissioner shall adopt or amend rules as necessary to allow for the development of additional housing supports for individuals with disabilities, including individuals with intellectual and developmental disabilities, in urban and rural areas, including:

(1) a selection of community-based housing options that comprise a continuum of integration, varying from most to least restrictive, that permits individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences;

(2) provider-owned and non-provider-owned residential settings;

(3) assistance with living more independently; and

(4) rental properties with on-site supports.

(b) The Department of Aging and Disability Services, in

cooperation with the Texas Department of Housing and Community Affairs, the Department of Agriculture, the Texas State Affordable Housing Corporation, and the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, Government Code, shall coordinate with federal, state, and local public housing entities as necessary to expand opportunities for accessible, affordable, and integrated housing to meet the complex needs of individuals with disabilities, including individuals with intellectual and developmental disabilities.

(c) The Department of Aging and Disability Services shall develop a process to receive input from statewide stakeholders to ensure the most comprehensive review of opportunities and options for housing services described by this section.

Sec. 533.03552. BEHAVIORAL SUPPORTS FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AT RISK OF INSTITUTIONALIZATION; INTERVENTION TEAMS. (a) In this section, "department" means the Department of Aging and Disability Services.

(b) Subject to the availability of federal funding, the department shall develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with intellectual and developmental disabilities and behavioral health needs who are at risk of institutionalization.

(c) Subject to the availability of federal funding, the department shall establish one or more behavioral health intervention teams to provide services and supports to individuals

with intellectual and developmental disabilities and behavioral health needs who are at risk of institutionalization. An intervention team may include a:

(1) psychiatrist or psychologist;

(2) physician;

(3) registered nurse;

(4) pharmacist or representative of a pharmacy;

(5) behavior analyst;

(6) social worker;

(7) crisis coordinator;

(8) peer specialist; and

(9) family partner.

(d) In providing services and supports, a behavioral health intervention team established by the department shall:

(1) use the team's best efforts to ensure that an individual remains in the community and avoids institutionalization;

(2) focus on stabilizing the individual and assessing the individual for intellectual, medical, psychiatric, psychological, and other needs;

(3) provide support to the individual's family members and other caregivers;

(4) provide intensive behavioral assessment and training to assist the individual in establishing positive behaviors and continuing to live in the community; and

(5) provide clinical and other referrals.

(e) The department shall ensure that members of a behavioral

health intervention team established under this section receive training on trauma-informed care, which is an approach to providing care to individuals with behavioral health needs based on awareness that a history of trauma or the presence of trauma symptoms may create the behavioral health needs of the individual.

SECTION 3.03. (a) The Health and Human Services Commission and the Department of Aging and Disability Services shall conduct a study to identify crisis intervention programs currently available to, evaluate the need for appropriate housing for, and develop strategies for serving the needs of persons in this state with Prader-Willi syndrome.

(b) In conducting the study, the Health and Human Services Commission and the Department of Aging and Disability Services shall seek stakeholder input.

(c) Not later than December 1, 2014, the Health and Human Services Commission shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the presiding officers of the standing committees of the senate and house of representatives having jurisdiction over the Medicaid program regarding the study required by this section.

(d) This section expires September 1, 2015.

SECTION 3.04. (a) In this section:

(1) "Medicaid program" means the medical assistance program established under Chapter 32, Human Resources Code.

(2) "Section 1915(c) waiver program" has the meaning assigned by Section 531.001, Government Code.

(b) The Health and Human Services Commission shall conduct a

study to evaluate the need for applying income disregards to persons with intellectual and developmental disabilities receiving benefits under the medical assistance program, including through a Section 1915(c) waiver program.

(c) Not later than January 15, 2015, the Health and Human Services Commission shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the presiding officers of the standing committees of the senate and house of representatives having jurisdiction over the Medicaid program regarding the study required by this section.

(d) This section expires September 1, 2015.

ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENT PROVISIONS

SECTION 4.01. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00256 to read as follows:

Sec. 533.00256. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002 and other appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:

(1) establish a clinical improvement program to identify goals designed to improve quality of care and care management and to reduce potentially preventable events, as defined by Section 536.001; and

(2) require managed care organizations to develop and implement collaborative program improvement strategies to address the goals.

(b) Goals established under this section may be set by geographic region and program type.

SECTION 4.02. Subsections (a) and (g), Section 533.0051, Government Code, are amended to read as follows:

(a) The commission shall establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization and the commission for the provision of health care services to recipients that is procured and managed under a value-based purchasing model. The performance measures and incentives must:

(1) be designed to facilitate and increase recipients' access to appropriate health care services; and

(2) to the extent possible, align with other state and regional quality care improvement initiatives.

(g) In performing the commission's duties under Subsection (d) with respect to assessing feasibility and cost-effectiveness, the commission may consult with participating Medicaid providers [~~physicians~~], including those with expertise in quality improvement and performance measurement[~~, and hospitals~~].

SECTION 4.03. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00511 to read as follows:

Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MANAGED CARE ORGANIZATIONS. (a) In this section, "potentially preventable event" has the meaning assigned by Section 536.001.

(b) The commission shall create an incentive program that automatically enrolls a greater percentage of recipients who did not actively choose their managed care plan in a managed care plan,

based on:

(1) the quality of care provided through the managed care organization offering that managed care plan;

(2) the organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization; and

(3) the organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by the commission, including measures based on potentially preventable events.

SECTION 4.04. Section 533.0071, Government Code, is amended to read as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, the commission shall:

(1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program;

(2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to

enrollees who leave the managed care program;

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A) where possible, decreasing the duplication of administrative reporting and process requirements for the managed care organizations and providers, such as requirements for the submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address information directly to the commission for correction in the state system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to the preauthorization process, lengths of hospital stays, filing deadlines, levels of care, and case management services;

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications; and

(E) providing a [~~single~~] portal through which

providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

(5) reserve the right to amend the managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes.

SECTION 4.05. Section 533.014, Government Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) Except as provided by Subsection (c), any [~~Any~~] amount received by the state under this section shall be deposited in the general revenue fund for the purpose of funding the state Medicaid program.

(c) If cost-effective, the commission may use amounts received by the state under this section to provide incentives to specific managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.

SECTION 4.06. Subsection (b), Section 536.002, Government Code, is amended to read as follows:

(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of physicians and other health care providers, representatives of health care facilities, representatives of managed care organizations, and

other stakeholders interested in health care services provided in this state, including:

(1) at least one member who is a physician with clinical practice experience in obstetrics and gynecology;

(2) at least one member who is a physician with clinical practice experience in pediatrics;

(3) at least one member who is a physician with clinical practice experience in internal medicine or family medicine;

(4) at least one member who is a physician with clinical practice experience in geriatric medicine;

(5) at least three members [~~one member~~] who are [~~is~~] or who represent [~~represents~~] a health care provider that primarily provides long-term [~~care~~] services and supports;

(6) at least one member who is a consumer representative; and

(7) at least one member who is a member of the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events who meets the qualifications prescribed by Section 98.052(a)(4), Health and Safety Code.

SECTION 4.07. Section 536.003, Government Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows:

(a) The commission, in consultation with the advisory committee, shall develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan and Medicaid

programs to implement quality-based payments for acute [~~and long-term~~] care services and long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems. Subject to Subsection (a-1), the [~~The~~] commission, in developing outcome and process measures under this section, must include measures that are based on [~~consider measures addressing~~] potentially preventable events and that advance quality improvement and innovation. The commission may change measures developed:

(1) to promote continuous system reform, improved quality, and reduced costs; and

(2) to account for managed care organizations added to a service area.

(a-1) The outcome measures based on potentially preventable events must:

(1) allow for rate-based determination of health care provider performance compared to statewide norms; and

(2) be risk-adjusted to account for the severity of the illnesses of patients served by the provider.

(b) To the extent feasible, the commission shall develop outcome and process measures:

(1) consistently across all child health plan and Medicaid program delivery models and payment systems;

(2) in a manner that takes into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness;

(3) that will have the greatest effect on improving

quality of care and the efficient use of services, including acute care services and long-term services and supports; [~~and~~]

(4) that are similar to outcome and process measures used in the private sector, as appropriate;

(5) that reflect effective coordination of acute care services and long-term services and supports;

(6) that can be tied to expenditures; and

(7) that reduce preventable health care utilization and costs.

SECTION 4.08. Subsection (a), Section 536.004, Government Code, is amended to read as follows:

(a) Using quality-based outcome and process measures developed under Section 536.003 and subject to this section, the commission, after consulting with the advisory committee and other appropriate stakeholders with an interest in the provision of acute care and long-term services and supports under the child health plan and Medicaid programs, shall develop quality-based payment systems, and require managed care organizations to develop quality-based payment systems, for compensating a physician or other health care provider participating in the child health plan or Medicaid program that:

(1) align payment incentives with high-quality, cost-effective health care;

(2) reward the use of evidence-based best practices;

(3) promote the coordination of health care;

(4) encourage appropriate physician and other health care provider collaboration;

(5) promote effective health care delivery models; and

(6) take into account the specific needs of the child health plan program enrollee and Medicaid recipient populations.

SECTION 4.09. Section 536.005, Government Code, is amended by adding Subsection (c) to read as follows:

(c) Notwithstanding Subsection (a) and to the extent possible, the commission shall convert outpatient hospital reimbursement systems under the child health plan and Medicaid programs to an appropriate prospective payment system that will allow the commission to:

(1) more accurately classify the full range of outpatient service episodes;

(2) more accurately account for the intensity of services provided; and

(3) motivate outpatient service providers to increase efficiency and effectiveness.

SECTION 4.10. Section 536.006, Government Code, is amended to read as follows:

Sec. 536.006. TRANSPARENCY. (a) The commission and the advisory committee shall:

(1) ensure transparency in the development and establishment of:

(A) quality-based payment and reimbursement systems under Section 536.004 and Subchapters B, C, and D, including the development of outcome and process measures under Section 536.003; and

(B) quality-based payment initiatives under

Subchapter E, including the development of quality of care and cost-efficiency benchmarks under Section 536.204(a) and efficiency performance standards under Section 536.204(b);

(2) develop guidelines establishing procedures for providing notice and information to, and receiving input from, managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, and other stakeholders, as appropriate, for purposes of developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1); [~~and~~]

(3) in developing and establishing the quality-based payment and reimbursement systems and initiatives described under Subdivision (1), consider that as the performance of a managed care organization or physician or other health care provider improves with respect to an outcome or process measure, quality of care and cost-efficiency benchmark, or efficiency performance standard, as applicable, there will be a diminishing rate of improved performance over time; and

(4) develop web-based capability to provide managed care organizations and health care providers with data on their clinical and utilization performance, including comparisons to peer organizations and providers located in this state and in the provider's respective region.

(b) The web-based capability required by Subsection (a)(4) must support the requirements of the electronic health information exchange system under Sections 531.907 through 531.909.

SECTION 4.11. Section 536.008, Government Code, is amended

to read as follows:

Sec. 536.008. ANNUAL REPORT. (a) The commission shall submit to the legislature and make available to the public an annual report [~~to the legislature~~] regarding:

(1) the quality-based outcome and process measures developed under Section 536.003, including measures based on each potentially preventable event; and

(2) the progress of the implementation of quality-based payment systems and other payment initiatives implemented under this chapter.

(b) As appropriate, the [~~The~~] commission shall report outcome and process measures under Subsection (a)(1) by:

(1) geographic location, which may require reporting by county, health care service region, or other appropriately defined geographic area;

(2) recipient population or eligibility group served;

(3) type of health care provider, such as acute care or long-term care provider;

(4) number of recipients who relocated to a community-based setting from a less integrated setting;

(5) quality-based payment system; and

(6) service delivery model.

(c) The report required under this section may not identify specific health care providers.

SECTION 4.12. Subsection (a), Section 536.051, Government Code, is amended to read as follows:

(a) Subject to Section 1903(m)(2)(A), Social Security Act

(42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal law, the commission shall base a percentage of the premiums paid to a managed care organization participating in the child health plan or Medicaid program on the organization's performance with respect to outcome and process measures developed under Section 536.003 that address[~~, including outcome measures addressing~~] potentially preventable events. The percentage of the premiums paid may increase each year.

SECTION 4.13. Subsection (a), Section 536.052, Government Code, is amended to read as follows:

(a) The commission may allow a managed care organization participating in the child health plan or Medicaid program increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to:

(1) achieve high-quality, cost-effective health care;

(2) increase the use of high-quality, cost-effective delivery models; [~~and~~]

(3) reduce the incidence of unnecessary institutionalization and potentially preventable events; and

(4) increase the use of alternative payment systems, including shared savings models, in collaboration with physicians and other health care providers.

SECTION 4.14. Section 536.151, Government Code, is amended by amending Subsections (a), (b), and (c) and adding Subsections (a-1) and (d) to read as follows:

(a) The executive commissioner shall adopt rules for

identifying:

(1) potentially preventable admissions and readmissions of child health plan program enrollees and Medicaid recipients, including preventable admissions to long-term care facilities;

(2) potentially preventable ancillary services provided to or ordered for child health plan program enrollees and Medicaid recipients;

(3) potentially preventable emergency room visits by child health plan program enrollees and Medicaid recipients; and

(4) potentially preventable complications experienced by child health plan program enrollees and Medicaid recipients.

(a-1) The commission shall collect data from hospitals on present-on-admission indicators for purposes of this section.

(b) The commission shall establish a program to provide a confidential report to each hospital in this state that participates in the child health plan or Medicaid program regarding the hospital's performance with respect to each potentially preventable event described under Subsection (a) [~~readmissions and potentially preventable complications~~]. To the extent possible, a report provided under this section should include all potentially preventable events [~~readmissions and potentially preventable complications information~~] across all child health plan and Medicaid program payment systems. A hospital shall distribute the information contained in the report to physicians and other health care providers providing services at the hospital.

(c) Except as provided by Subsection (d), a [~~A~~] report

provided to a hospital under this section is confidential and is not subject to Chapter 552.

(d) The commission may release the information in the report described by Subsection (b):

(1) not earlier than one year after the date the report is submitted to the hospital; and

(2) only after deleting any data that relates to a hospital's performance with respect to particular diagnosis-related groups or individual patients.

SECTION 4.15. Subsection (a), Section 536.152, Government Code, is amended to read as follows:

(a) Subject to Subsection (b), using the data collected under Section 536.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005, if applicable, the commission, after consulting with the advisory committee, shall to the extent feasible adjust child health plan and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, [~~in a manner that may reward or penalize a hospital~~] based on the hospital's performance with respect to exceeding, or failing to achieve, outcome and process measures developed under Section 536.003 that address the rates of potentially preventable readmissions and potentially preventable complications.

SECTION 4.16. Subsection (a), Section 536.202, Government Code, is amended to read as follows:

(a) The commission shall, after consulting with the

advisory committee, establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to physicians and other health care providers to develop health care interventions for child health plan program enrollees or Medicaid recipients, or both, that will:

(1) improve the quality of health care provided to the enrollees or recipients;

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

(4) increase the use of evidence-based best practices;

(5) increase appropriate physician and other health care provider collaboration; [~~and~~]

(6) contain costs; and

(7) improve integration of acute care services and long-term services and supports, including discharge planning from acute care services to community-based long-term services and supports.

SECTION 4.17. Chapter 536, Government Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENT SYSTEMS

Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with the advisory committee and other appropriate stakeholders representing nursing facility providers

with an interest in the provision of long-term services and supports, may develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. A quality-based payment system developed under this section must base payments to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the provider, and ensuring quality of care outcomes, including a reduction in potentially preventable events.

(b) The commission may develop a quality-based payment system for Medicaid long-term services and supports providers under this subchapter only if implementing the system would be feasible and cost-effective.

Sec. 536.252. EVALUATION OF DATA SETS. To ensure that the commission is using the best data to inform the development and implementation of quality-based payment systems under Section 536.251, the commission shall evaluate the reliability, validity, and functionality of post-acute and long-term services and supports data sets. The commission's evaluation under this section should assess:

(1) to what degree data sets relied on by the commission meet a standard:

(A) for integrating care;

(B) for developing coordinated care plans; and

(C) that would allow for the meaningful

development of risk adjustment techniques;

(2) whether the data sets will provide value for outcome or performance measures and cost containment; and

(3) how classification systems and data sets used for Medicaid long-term services and supports providers can be standardized and, where possible, simplified.

Sec. 536.253. COLLECTION AND REPORTING OF CERTAIN INFORMATION. (a) The executive commissioner shall adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term services and supports recipients.

(b) The commission shall establish a program to provide a report to each Medicaid long-term services and supports provider in this state regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits. To the extent possible, a report provided under this section should include applicable potentially preventable events information across all Medicaid program payment systems.

(c) Subject to Subsection (d), a report provided to a provider under this section is confidential and is not subject to Chapter 552.

(d) The commission may release the information in the report described by Subsection (b):

(1) not earlier than one year after the date the report is submitted to the provider; and

(2) only after deleting any data that relates to a provider's performance with respect to particular resource utilization groups or individual recipients.

SECTION 4.18. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall provide a portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims as required by Paragraph (E), Subdivision (4), Section 533.0071, Government Code, as amended by this article.

SECTION 4.19. Not later than September 1, 2013, the Health and Human Services Commission shall convert outpatient hospital reimbursement systems as required by Subsection (c), Section 536.005, Government Code, as added by this article.

ARTICLE 5. SPECIFIC PROVISIONS RELATING TO PREMIUMS UNDER THE MEDICAL ASSISTANCE PROGRAM

SECTION 5.01. Section 533.013, Government Code, is amended by adding Subsection (e) to read as follows:

(e) The commission shall pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practices. In pursuing premium rate-setting strategies under this section, the commission shall review and consider strategies employed or under consideration by other states. If necessary, the commission may request a waiver or other authorization from a federal agency to implement strategies identified under this subsection.

ARTICLE 6. ADDITIONAL PROVISIONS RELATING TO QUALITY AND DELIVERY OF HEALTH AND HUMAN SERVICES

SECTION 6.01. The heading to Section 531.024, Government Code, is amended to read as follows:

Sec. 531.024. PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES; DATA SHARING.

SECTION 6.02. Section 531.024, Government Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) To the extent permitted under applicable federal law and notwithstanding any provision of Chapter 191 or 192, Health and Safety Code, the commission and other health and human services agencies shall share data to facilitate patient care coordination, quality improvement, and cost savings in the Medicaid program, child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund.

SECTION 6.03. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.024115 to read as follows:

Sec. 531.024115. SERVICE DELIVERY AREA ALIGNMENT. Notwithstanding Section 533.0025(e) or any other law, to the extent possible, the commission shall align service delivery areas under the Medicaid and child health plan programs.

SECTION 6.04. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0981 to read as follows:

Sec. 531.0981. WELLNESS SCREENING PROGRAM. If cost-effective, the commission may implement a wellness screening program for Medicaid recipients designed to evaluate a recipient's

risk for having certain diseases and medical conditions for purposes of establishing a health baseline for each recipient that may be used to tailor the recipient's treatment plan or for establishing the recipient's health goals.

SECTION 6.05. Section 531.024115, Government Code, as added by this article:

(1) applies only with respect to a contract between the Health and Human Services Commission and a managed care organization, service provider, or other person or entity under the medical assistance program, including Chapter 533, Government Code, or the child health plan program established under Chapter 62, Health and Safety Code, that is entered into or renewed on or after the effective date of this Act; and

(2) does not authorize the Health and Human Services Commission to alter the terms of a contract that was entered into or renewed before the effective date of this Act.

SECTION 6.06. Section 533.0354, Health and Safety Code, is amended by adding Subsections (a-1), (a-2), and (b-1) to read as follows:

(a-1) In addition to the services required under Subsection (a) and using money appropriated for that purpose or money received under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), a local mental health authority may ensure, to the extent feasible, the provision of assessment services, crisis services, and intensive and comprehensive services using disease management practices for

children with serious emotional, behavioral, or mental disturbance not described by Subsection (a) and adults with severe mental illness who are experiencing significant functional impairment due to a mental health disorder not described by Subsection (a) that is defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), including:

(1) major depressive disorder, including single episode or recurrent major depressive disorder;

(2) post-traumatic stress disorder;

(3) schizoaffective disorder, including bipolar and depressive types;

(4) obsessive-compulsive disorder;

(5) anxiety disorder;

(6) attention deficit disorder;

(7) delusional disorder;

(8) bulimia nervosa, anorexia nervosa, or other eating disorders not otherwise specified; or

(9) any other diagnosed mental health disorder.

(a-2) The local mental health authority shall ensure that individuals described by Subsection (a-1) are engaged with treatment services in a clinically appropriate manner.

(b-1) The department shall require each local mental health authority to incorporate jail diversion strategies into the authority's disease management practices to reduce the involvement of the criminal justice system in managing adults with the following disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), who are not

described by Subsection (b):

(1) post-traumatic stress disorder;

(2) schizoaffective disorder, including bipolar and depressive types;

(3) anxiety disorder; or

(4) delusional disorder.

SECTION 6.07. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0284 to read as follows:

Sec. 32.0284. CALCULATION OF PAYMENTS UNDER CERTAIN SUPPLEMENTAL HOSPITAL PAYMENT PROGRAMS. (a) In this section:

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

(2) "Supplemental hospital payment program" means:

(A) the disproportionate share hospitals supplemental payment program administered according to 42 U.S.C. Section 1396r-4; and

(B) the uncompensated care payment program established under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315).

(b) For purposes of calculating the hospital-specific limit used to determine a hospital's uncompensated care payment under a supplemental hospital payment program, the commission shall ensure that to the extent a third-party commercial payment exceeds the Medicaid allowable cost for a service provided to a recipient and for which reimbursement was not paid under the medical assistance program, the payment is not considered a medical assistance

payment.

SECTION 6.08. Section 32.053, Human Resources Code, is amended by adding Subsection (i) to read as follows:

(i) To the extent allowed by the General Appropriations Act, the Health and Human Services Commission may transfer general revenue funds appropriated to the commission for the medical assistance program to the Department of Aging and Disability Services to provide PACE services in PACE program service areas to eligible recipients whose medical assistance benefits would otherwise be delivered as home and community-based services through the STAR + PLUS Medicaid managed care program and whose personal incomes are at or below the level of income required to receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq.

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

ARTICLE 7. FEDERAL AUTHORIZATIONS, FUNDING, AND EFFECTIVE DATE

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

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

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

(1) who are at least 21 years of age; and

(2) whose costs to receive care exceed cost limits under existing Medicaid waiver programs.

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

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

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

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 7 passed the Senate on March 25, 2013, by the following vote: Yeas 31, Nays 0; May 22, 2013, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 23, 2013, House granted request of the Senate; May 26, 2013, Senate adopted Conference Committee Report by the following vote: Yeas 30, Nays 1.

Secretary of the Senate

I hereby certify that S.B. No. 7 passed the House, with amendments, on May 21, 2013, by the following vote: Yeas 139, Nays 5, two present not voting; May 23, 2013, House granted request of the Senate for appointment of Conference Committee; May 26, 2013, House adopted Conference Committee Report by the following vote: Yeas 146, Nays 1, one present not voting.

Chief Clerk of the House

Approved:

Date

Governor