BILL ANALYSIS

Senate Research Center

S.B. 7
By: Nelson; Patrick
Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 7 improves the coordination of Medicaid long-term care services and supports with acute care services, redesigns the long-term care services and supports system to more efficiently serve individuals with intellectual and developmental disabilities, and expands on quality-based payment initiatives to promote high-quality, efficient care throughout Medicaid.

S.B. 7 amends current law 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.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) in SECTION 1.01 (Section 534.152, Government Code), SECTION 2.20, SECTION 3.02 (Section 533.03551, Health and Safety Code), and SECTION 4.17 (Section 536.253, Government Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 4.14 (Section 536.151, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

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. Amends Subtitle I, Title 4, Government Code, by adding Chapter 534, 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. Defines "advisory committee," "basic attendant services," "department," "functional need," "habilitation services," "ICF-IID," "ICF-IID program," "local intellectual and developmental disability authority," "managed care organization," "managed care plan," "potentially preventable event," "Medicaid program," "Medicaid waiver program," and "state supported living center" in this chapter.

Sec. 534.002. CONFLICT WITH OTHER LAW. Provides that 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. Requires the Texas Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS), in accordance with this chapter, to 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. Requires HHSC and DADS, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee (redesign advisory committee), to 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) Establishes the redesign advisory committee to advise HHSC and DADS on the implementation of the acute care services and long-term services and supports system redesign under this chapter. Requires the executive commissioner of HHSC (executive commissioner) and the commissioner of DADS, subject to Subsection (b), to jointly appoint members of the redesign 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 physicians who are primary care providers and physicians who are specialty care providers; nonphysician mental health professionals; and 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 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; representatives of community mental health and intellectual disability centers; 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 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) Requires the executive commissioner and the commissioner of DADS, to the greatest extent possible, to appoint members of the redesign advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid program recipients.

(c) Requires the executive commissioner to appoint the presiding officer of the redesign advisory committee.

(d) Requires the redesign advisory committee to 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) Provides that a member of the redesign advisory committee serves without compensation. Provides that a member of the redesign 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 (GAA).

(f) Provides that the redesign advisory committee is subject to the requirements of Chapter 551 (Open Meetings).

(g) Provides that, on January 1, 2024, the redesign advisory committee is abolished, and this section expires.

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Requires HHSC, not later than September 30 of each year, to submit a report to the legislature regarding 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 recommendations, including recommendations regarding appropriate statutory changes to facilitate the implementation.

(b) Provides that this section expires January 1, 2024.

Sec. 534.055. REPORT ON ROLE OF LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES AS SERVICE PROVIDERS. (a) Requires HHSC and DADS to 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 DADS 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) (relating to requiring the executive commissioner, in establishing a local mental retardation authority's role as a qualified service provider of ICF-MR and related waiver programs under Section 533.035(e-1), to require the local mental retardation authority to base the local authority's provider capacity on certain information), 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) Provides that this section expires September 1, 2015.

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

Sec. 534.101. DEFINITIONS. Defines "capitation" and "provider" in this subchapter.

Sec. 534.102. PILOT PROGRAMS TO TEST MANAGED CARE STRATEGIES BASED ON CAPITATION. Authorizes HHSC and DADS to 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. Requires DADS, as part of developing and implementing a pilot program under this subchapter, to 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) Requires DADS to 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) Requires DADS to solicit managed care strategy proposals from the private services providers identified under Subsection (a). Authorizes DADS, in addition, to 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) Requires that a managed care strategy based on capitation developed for implementation through a pilot program under this subchapter 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) Requires DADS, in consultation with the redesign advisory committee, to evaluate each submitted managed care strategy proposal and determine whether the proposed strategy satisfies the requirements of this section, and 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) Authorizes DADS, based on the evaluation performed under Subsection (d), to select as pilot program service providers one or more private services providers.

(f) Requires DADS, for each pilot program service provider, to develop and implement a pilot program. Requires the pilot program service provider, under a

pilot program, to 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) Requires DADS to analyze information provided by the pilot program service providers and any information collected by DADS 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) Requires DADS, in consultation with the redesign advisory committee, to identify measurable goals to be achieved by each pilot program implemented under this subchapter. Requires that the identified goals align with information that will be collected under Section 534.108(a), and be designed to improve the quality of outcomes for individuals receiving services through the pilot program.

(b) Requires DADS, in consultation with the redesign advisory committee, to propose specific strategies for achieving the identified goals. Authorizes a proposed strategy to 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) Requires HHSC and DADS to implement any pilot programs established under this subchapter not later than September 1, 2016.

(b) Requires that a pilot program established under this subchapter 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 HHSC before the agreed-to termination date.

(c) Requires that a pilot program established under this subchapter be conducted in one or more regions selected by DADS.

Sec. 534.1065. RECIPIENT PARTICIPATION IN PROGRAM VOLUNTARY. Provides that 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 is authorized to be made only by the individual or the individual's legally authorized representative.

Sec. 534.107. COORDINATING SERVICES. Requires a pilot program service provider, in providing long-term services and supports under the Medicaid program to individuals with intellectual and developmental disabilities, to:

(1) coordinate through the pilot program institutional and community-based services available to the individuals, including services provided through a facility licensed under Chapter 252 (Intermediate Care Facilities for the Mentally Retarded), Health and Safety Code, a Medicaid waiver program, or 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) Requires HHSC and DADS to 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) Requires the pilot program service provider to collect any information described by Subsection (a) that is available to the provider and provide the information to DADS and HHSC not later than the 30th day before the date the program's operation concludes.

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

(d) Requires HHSC and DADS, on or before December 1, 2016, and December 1, 2017, in consultation with the redesign advisory committee, to 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. Requires that each report include recommendations for program improvement and continued implementation.

Sec. 534.109. PERSON-CENTERED PLANNING. Requires HHSC, in cooperation with DADS, to 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. Provides that the consumer direction model, as defined by Section 531.051 (Consumer Direction of Certain Services for Person with Disabilities and Elderly Persons), may be an outcome of the plan.

Sec. 534.110. TRANSITION BETWEEN PROGRAMS. Requires HHSC to 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. Provides that on September 1, 2018, each pilot program established under this subchapter that is still in operation is required to conclude and 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. Requires HHSC, subject to Section 533.0025, to 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) Requires HHSC to 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 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) Requires HHSC to require that each managed care organization that contracts with HHSC 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 (Home and Community Support Services), Health and Safety Code, with which DADS 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) (relating to providing that a person that provides home health, hospice, or personal assistance services only to persons enrolled in a program funded wholly or partly by the Texas Department of Mental Health and Mental Retardation (TXMHMR) and monitored by TXMHMR or its designated local authority in accordance with standards set by TXMHMR need not be licensed under this chapter), Health and Safety Code, with which DADS has a contract to provide services under the HCS waiver program; or 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) Requires DADS to 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 DADS 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 DADS a description of outcomes based on an individual's plan of care.

(d) Prohibits local intellectual and developmental disability authorities providing service coordination under this section from also providing attendant and habilitation services under this section.

(e) Provides that 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 HCS waiver program, the TxHmL waiver program, or the community living assistance and

support services (CLASS) waiver program on September 1, 2013, are considered significant traditional providers.

(f) Authorizes a local intellectual and developmental disability authority with which DADS contracts under Subsection (c) to subcontract with an eligible person, including a nonprofit entity, to coordinate the services of individuals with intellectual and developmental disabilities under this section. Requires the executive commissioner by rule to establish minimum qualifications a person is required to 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) Provides that this section applies to individuals with intellectual and developmental disabilities who are receiving long-term services and supports under the TxHmL waiver program on the date HHSC implements the transition described by Subsection (b).

(b) Requires HHSC, not later than September 1, 2017, to 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 HHSC 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) Requires HHSC, at the time of the transition described by Subsection (b), to determine whether to:

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

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

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

(e) Requires HHSC to 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) Requires that a contract between a managed care organization and HHSC for the organization to provide Medicaid program benefits under this section, in addition to the requirements of Section 533.005, 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) Provides that this section applies to individuals with intellectual and developmental disabilities who, on the date HHSC implements the transition described by Subsection (b), are receiving long-term services and supports under a Medicaid waiver program other than the TxHmL waiver program or an ICF-IID program.

(b) Requires HHSC, after implementing the transition required by Section 534.201 but not later than September 1, 2020, to 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 HHSC based on cost-effectiveness and the experience of the transition of TxHmL waiver program recipients to a managed care program delivery model under Section 534.201, subject to Subsections (c)(1) and (g).

(c) Requires HHSC, at the time of the transition described by Subsection (b), to determine whether to:

(1) continue operation of the Medicaid waiver programs or ICF-IID program only for purposes of providing, if applicable, supplemental long-term services and supports not available under the managed care program delivery model selected by HHSC; or 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 HHSC.

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

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

(g) Requires HHSC, at the time of the transition, if HHSC 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), to 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 HHSC.

(h) Prohibits a recipient who chooses to receive long-term services and supports through a managed care program delivery model under Subsection (g) from, at a later time, choosing to receive the services and supports under a Medicaid waiver program.

(i) Requires that a contract between a managed care organization and HHSC for the organization to provide Medicaid program benefits under this section, in addition to the requirements of Section 533.005, to 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. Requires HHSC, in administering this subchapter, to ensure:

(1) that HHSC 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 DADS 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, is authorized to submit long-term services and supports claims to any participating managed care organization.

SECTION 1.02. Amends Section 142.003(a), Health and Safety Code, to provide that certain persons need not be licensed under this chapter, including a person that provides home health, hospice, or personal assistance services only to persons receiving benefits under the HCS waiver program, the TxHmL waiver program, or Section 534.152, Government Code, rather than a person that provides home health, hospice, or personal assistance services only to persons enrolled in a program funded wholly or partly by TXMHMR and monitored by TXMHMR or its designated local authority in accordance with standards set by TXMHMR.

SECTION 1.03. Requires the executive commissioner and the commissioner of DADS, not later than October 1, 2013, to appoint the members of the redesign advisory committee as required by Section 534.053, Government Code, as added by this article.

SECTION 1.04. (a) Defines "health and human services agencies" in this section.

(b) Requires HHSC and any other health and human services agency implementing a provision of this Act that affects individuals with intellectual and developmental disabilities to consult with redesign advisory committee established under Section 534.053, Government Code, as added by this article, regarding implementation of the provision.

SECTION 1.05. Requires HHSC to submit 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 the final report under that section not later than September 30, 2023.

SECTION 1.06. Requires HHSC, not later than June 1, 2016, to submit a report to the legislature regarding HHSC'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. Requires HHSC and DADS to 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) Requires HHSC and DADS to:

(1) in consultation with the 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 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 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 Subdivisions (1)(A) and (B) 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) Provides that this section expires September 1, 2024.

ARTICLE 2. MEDICAID MANAGED CARE EXPANSION

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

(a) Defines "medical assistance" in this section and Sections 533.00251, 533.002515, 533.00252, 533.00253, and 533.00254.

(b) Requires the Health and Human Services Commission (HHSC) or an agency operating part of the state Medicaid managed care program, as appropriate, except as otherwise provided by this section and notwithstanding any other law, to provide medical assistance for acute care services through the most cost-effective model of Medicaid capitated managed care as determined by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to require mandatory participation in a Medicaid capitated managed care program for all persons eligible for acute care medical assistance benefits, but is authorized to implement alternative models or arrangements, including a traditional fee-for-service arrangement, if HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, determines the alternative would be more cost-effective or efficient. Deletes existing text authorizing HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, determines that it is more cost-effective, to provide medical assistance for acute care in a certain part of this state or to a certain population of recipients using a health maintenance organization model, including the acute care portion of Medicaid STAR + PLUS pilot programs, a primary care case management model, a prepaid health plan model, an exclusive provider organization model, or another Medicaid managed care model or arrangement.

(f) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to 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 report the results of the study to the legislature not later than December 1, 2014.

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

(h) Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, determines that it is feasible, to, 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. Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to elect to implement the automatic enrollment process as to certain populations of recipients under the medical assistance program.

(i) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, subject to Section 534.152, to:

(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. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.00251, 533.002515, 533.00252, 533.00253, and 533.00254, as follows:

Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS, INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) Defines "advisory committee," "clean claim," "nursing facility," and "potentially preventable event" in this section and Sections 533.002515 and 533.00252.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, subject to Section 533.0025, to 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) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, subject to Section 533.0025 and notwithstanding any other law, in consultation with the STAR + PLUS Nursing Facility Advisory Committee (SPNF advisory committee), to provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in implementing this subsection, to ensure:

(1) that HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, 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 HHSC or an agency operating part of the state Medicaid managed care program, as appropriate;

(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;

(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; and

(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 acute care professionals and telemedicine,

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

(d) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, subject to Subsection (e), to 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) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to 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. Authorizes a managed care organization to refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, under this section.

(f) Prohibits a managed care organization from requiring prior authorization for a nursing facility resident in need of emergency hospital services.

(g) Provides that 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) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to develop a plan in preparation for implementing the requirement under Section 533.00251(c) that HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. Requires that the plan required by this section be completed in two phases as follows:

(1) phase one: contract planning phase; and

(2) phase two: initial testing phase.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in phase one, to develop a contract template to be used by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, when HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, contracts with a managed care organization to provide nursing facility services under the STAR + PLUS Medicaid managed care program. Requires that the template, in addition to the requirements of Section 533.005 and any other applicable law, 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) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in phase two, to:

(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 HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in collecting from recipients applied income or cost-sharing payments, including copayments, as applicable.

(d) Provides that this section expires September 1, 2015.

Sec. 533.00252. STAR + PLUS NURSING FACILITY ADVISORY COMMITTEE. (a) Establishes the SPNF advisory committee to advise HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, 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 HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, regarding its duties with respect to developing quality-based outcomes and process measures for long-term services and supports provided in nursing facilities; developing quality-based long-term care payment systems and quality initiatives for nursing facilities; transparency of information received from managed care organizations; the reporting of outcome and process measures; the sharing of data among health and human services agencies; and patient care coordination, quality of care improvement, and cost savings.

(b) Requires the governor, lieutenant governor, and speaker of the house of representatives to each appoint five members of the SPNF 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) Requires the executive commissioner to appoint the presiding officer of the SPNF advisory committee.

(d) Provides that a member of the SPNF advisory committee serves without compensation.

(e) Provides that the SPNF advisory committee is subject to the requirements of Chapter 551.

(f) Provides that, on September 1, 2016, the SPNF advisory committee is abolished and this section expires.

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) Defines "advisory committee," "health home" and "potentially preventable event" in this section.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, subject to Section 533.0025, in consultation with the STAR Kids Managed Care Advisory Committee (STAR Kids advisory committee) and the Children's Policy Council established under Section 22.035 (Children's Policy Council), Human Resources Code, to establish a mandatory STAR Kids capitated managed care program tailored to provide medical assistance benefits to children with disabilities. Requires that the managed care program developed under this section:

(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 management providers, if recipients are receiving long-term services and supports outside of the managed care organization; and

(c) Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to require that care management services made available as provided by Subsection (b)(7):

(1) incorporate best practices, as determined by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate;

(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 recipient quality of life, recipient satisfaction, and other financial and clinical metrics determined appropriate by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate; and

(8) use innovations in the provision of services.

(d) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to 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 waiver program (MDCP). Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to ensure that the STAR Kids managed care program provides all of the benefits provided under MDCP to the extent necessary to implement this subsection.

(e) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to ensure 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. Requires that the plan ensure that coordination between the programs begins when a recipient reaches 18 years of age.

(f) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to 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) Provides that the STAR Kids advisory committee is established to advise HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, on the establishment and implementation of the STAR Kids managed care program under Section 533.00253.

(b) Requires the executive commissioner to appoint the members of the STAR Kids advisory committee. Requires the STAR Kids advisory committee to 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) Requires the executive commissioner to appoint the presiding officer of the STAR Kids advisory committee.

(d) Provides that a member of the STAR Kids advisory committee serves without compensation.

(e) Provides that the STAR Kids advisory committee is subject to the requirements of Chapter 551.

(f) Provides that on September 1, 2016, the STAR Kids advisory committee is abolished and this section expires.

SECTION 2.03. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00285, as follows:

Sec. 533.00285. STAR + PLUS QUALITY COUNCIL. (a) Provides that The STAR + PLUS Quality Council is established to advise HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, 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) Requires the executive commissioner to 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) Requires the executive commissioner to appoint the presiding officer of the council.

(d) Requires the council to 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) Requires the council in coordination with HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, not later than November 1 of each year, to 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) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in consultation with the council, not later than December 1 of each even-numbered year, to 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) Provides that the council is subject to the requirements of Chapter 551.

(h) Provides that a member of the council serves without compensation.

(i) Provides that on January 1, 2017, the council is abolished and this section expires.

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

(a) Requires that a contract between a managed care organization and HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, for the organization to provide health care services to recipients contain:

(1)-(6) Makes no change to these subdivisions;

(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 claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim, rather than under a managed care plan not later than the 45th day after the date a claim for payment 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 HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, or 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)-(14) Makes no change to these subdivisions;

(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 certain requirements, including that the managed care organization 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)-(19) Makes no change to these subdivisions;

(20) a requirement that the managed care organization:

(A) develop and submit to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, 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) preventive care;

(ii) primary care;

(iii) specialty care;

(iv) after-hours urgent care;

(v) 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 HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, submit to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, 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 HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, before the organization begins to provide health care services to recipients, that:

(A) Makes no change to this paragraph;

(B) the organization's provider network includes a certain number and variety of providers. including a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(C) Makes no change to this paragraph;

(22)-(24) Makes no change to these subdivisions;

(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 HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to make the reduction; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate.

(a-1) Provides that the requirements imposed by Subsections (a)(23)(A) (relating to requiring that a contract between a managed care organization and HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, for the organization to provide health care services to recipients contain, 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 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) (relating to requiring that a contract between a managed care organization and HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, for the organization to provide health care services to recipients contain, 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 that adheres to the applicable preferred drug list adopted by the commission under Section 531.072), and (C) (relating to requiring that a contract between a managed care organization and HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, for the organization to provide health care services to recipients contain, 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 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) do not apply, and prohibits them from being enforced, on and after August 31, 2018, rather than on and after August 31, 2013.

(a-3) Provides that for purposes of Subsection (a)(25)(A), a provider reimbursement rate reduction is considered to have received the prior approval of HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, unless HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, issues a written statement of disapproval not later than the 45th day after the date HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, receives notice of the proposed rate reduction from the managed care organization.

SECTION 2.05. Amends Section 533.041, Government Code, by amending Subsection (a) and adding Subsections (c) and (d), as follows:

(a) Requires the executive commissioner, rather than HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to appoint a state Medicaid managed care advisory committee (Medicaid advisory committee). Provides that the Medicaid advisory committee consists of representatives of:

(1) Makes no change to this subdivision;

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

(3) primary care providers and specialty care providers;

(4) Makes no change to this subdivision;

(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, rather than consumer advocates representing recipients with a disability;

(7)-(10) Makes no change to these subdivisions;

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

(12)-(14) Makes nonsubstantive changes;

(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 (Community Services), Health and Safety Code.

(c) Requires the executive commissioner to appoint the presiding officer of the Medicaid advisory committee.

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

SECTION 2.06. Amends Section 533.042, Government Code, as follows:

Sec. 533.042. MEETINGS. (a) Creates this subsection from existing text. Requires the Medicaid advisory committee to meet at the call of the presiding officer at least semiannually, but no more frequently than quarterly.

(b) Provides that the Medicaid advisory committee:

(1) is required to develop procedures that provide the public with reasonable opportunity to appear before the Medicaid advisory committee and speak on any issue under the jurisdiction of the Medicaid advisory committee and is subject to Chapter 551. Makes nonsubstantive changes.

SECTION 2.07. Amends Section 533.043, Government Code, as follows:

Sec. 533.043. POWERS AND DUTIES. (a) Creates this subsection from existing text. Requires the Medicaid advisory committee to:

(1) provide recommendations and ongoing advisory input to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, 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)-(3) Makes no change to these subdivisions.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, and DADS to ensure coordination and communication between the Medicaid advisory committee, regional Medicaid managed care advisory committees appointed by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, under Subchapter B, and other advisory committees or groups that perform functions related to Medicaid managed care, including the redesign advisory committee established under Section 534.053, in a manner that enables the Medicaid 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) Authorizes the Medicaid advisory committee to establish work groups that meet at other times for purposes of studying and making recommendations on issues the Medicaid advisory committee determines appropriate.

SECTION 2.08. Amends Section 533.044, Government Code, as follows:

Sec. 533.044. OTHER LAW. (a) Creates this subsection from existing text. Provides that except as provided by Subsection (b) and other provisions of this subchapter, the

Medicaid advisory committee is subject to Chapter 2110 (State Agency Advisory Committees).

(b) Provides that Section 2110.008 (Duration of Advisory Committees) does not apply to the Medicaid advisory committee.

SECTION 2.09. Amends Subchapter C, Chapter 533, Government Code, by adding Section 533.045, as follows:

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

(b) Entitles a member of the Medicaid advisory committee who is a Medicaid program recipient or the relative of a Medicaid program recipient to a per diem allowance and reimbursement at rates established in GAA.

SECTION 2.10. Amends Section 32.0212, Human Resources Code, to require HHSC or an agency operating part of the medical assistance program, as appropriate, notwithstanding any other law and subject to Section 533.0025, Government Code, to 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) Requires the senate health and human services committee and the house human services committee to study and review:

(1) the requirement under Section 533.00251(c), 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) Requires the committees, not later than January 15, 2015, to report the committees' findings and recommendations to the lieutenant governor, the speaker of the house of representatives, and the governor. Requires the committees to 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) Provides that this section expires September 1, 2015.

SECTION 2.12. (a) Requires HHSC and DADS to:

(1) review and evaluate the outcomes of the transition of the provision of benefits to recipients under MDCP 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) Provides that this section expires September 1, 2021.

SECTION 2.13. (a) Requires the executive commissioner of HHSC, not later than October 1, 2013, to appoint the members of the STAR + PLUS Quality Council as required by Section 533.00285, Government Code, as added by this article.

(b) Requires the STAR + PLUS Quality Council, in coordination with HHSC, to 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) Requires HHSC to 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. Requires HHSC, not later than June 1, 2016, to submit a report to the legislature regarding the HHSC'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 Section 533.0025(i), Government Code, as added by this article. Authorizes HHSC to combine the report required under this section with the report required under Section 1.06 of this Act.

SECTION 2.15. (a) Requires HHSC, in a contract between HHSC 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, to require that the managed care organization comply with applicable provisions of Section 533.005(a), Government Code, as amended by this article.

(b) Requires HHSC to 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 Section 533.005(a), Government Code, as amended by this article. Provides that 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. Requires the governor, lieutenant governor, and speaker of the house of representatives, not later than September 15, 2013, to appoint the members of the SPNF advisory committee as required by Section 533.00252, Government Code, as added by this article.

SECTION 2.17. (a) Requires HHSC, not later than October 1, 2013, to:

(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 SPNF advisory committee established under Section 533.00252, Government Code, as added by this article.

(b) Requires HHSC, not later than July 15, 2014, to:

(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 SPNF advisory committee established under Section 533.00252, Government Code, as added by this article.

SECTION 2.18. (a) Prohibits HHSC from:

(1) implementing Section 533.00251(c)(6)(B), Government Code, as added by this article, unless HHSC 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) Requires HHSC, as soon as practicable after the implementation date of Section 533.00251, Government Code, as added by this article, to provide a portal through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims in accordance with Section 533.00251(c)(7), Government Code, as added by this article.

SECTION 2.19. (a) Requires the executive commissioner of HHSC, not later than October 1, 2013, to appoint additional members to the Medicaid advisory committee to comply with Section 533.041, Government Code, as amended by this article.

(b) Requires the presiding officer of the Medicaid advisory committee, not later than December 1, 2013, to convene the first meeting of the Medicaid advisory committee following appointment of additional members as required by Subsection (a) of this section.

SECTION 2.20. Requires the executive commissioner of HHSC, as soon as practicable after the effective date of this Act, but not later than January 1, 2014, to adopt rules and managed care contracting guidelines governing the transition of appropriate duties and functions from HHSC 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. Provides that the changes in law made by this article are not intended to negatively affect Medicaid recipients' access to quality health care. Requires HHSC, 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, to 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. Amends Subchapter B, Chapter 533, Health and Safety Code, by adding Section 533.0335, as follows:

Sec. 533.0335. COMPREHENSIVE ASSESSMENT AND RESOURCE ALLOCATION PROCESS. (a) Defines "advisory committee," "department," "functional need," "ICF-IID program," and "Medicaid waiver program" in this section.

(b) Requires DADS, subject to the availability of federal funding, to 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) Requires DADS, in developing a comprehensive assessment instrument for purposes of Subsection (b), to evaluate any assessment instrument in use by DADS. Authorizes DADS, in addition, to 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). Provides that this subsection expires September 1, 2015.

(c) Requires DADS, in consultation with the redesign advisory committee, to establish a prior authorization process for requests for supervised living or residential support services available in the HCS Medicaid waiver program. Requires that the process ensure that supervised living or residential support services available in HCS Medicaid waiver program are available only to individuals for whom a more independent setting is not appropriate or available.

(d) Requires DADS to cooperate with the redesign advisory committee to establish the prior authorization process required by Subsection (c). Provides that this subsection expires January 1, 2024.

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

Sec. 533.03551. FLEXIBLE, LOW-COST HOUSING OPTIONS. (a) Requires the executive commissioner of HHSC, to the extent permitted under federal law and regulations, to 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 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, provider-owned and non-provider-owned residential settings, assistance with living more independently, and rental properties with on-site supports.

(b) Requires DADS, in cooperation with the Texas Department of Housing and Community Affairs, the Department of Agriculture, the Texas State Affordable Housing Corporation, and the redesign advisory committee established under Section 534.053, Government Code, to 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) Requires DADS to 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) Defines "department" in this section.

(b) Requires DADS, subject to the availability of federal funding, to 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) Requires DADS, subject to the availability of federal funding, to 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. Authorizes an intervention team to include a psychiatrist or psychologist, physician, registered nurse, pharmacist or representative of a pharmacy, behavior analyst, social worker, crisis coordinator, peer specialist, and family partner.

(d) Requires a behavioral health intervention team established by DADS, in providing services and supports, to use the team's best efforts to ensure an individual remains in the community and avoids institutionalization; focus on stabilizing the individual and assessing the individual for intellectual, medical, psychiatric, psychological, and other needs; provide support to the individual's family members and other caregivers; provide intensive behavioral assessment and training to assist the individual in establishing positive behaviors and continuing to live in the community; and provide clinical and other referrals.

(e) Requires DADS to 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) Requires HHSC and DADS to 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) Requires HHSC and DADS, in conducting the study, to seek stakeholder input.

(c) Requires HHSC, not later than December 1, 2014, to 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) Provides that this section expires September 1, 2015.

SECTION 3.04. (a) Defines "Medicaid program" and "Section 1915(c) waiver program" in this section.

(b) Requires HHSC to 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) Requires HHSC, not later than January 15, 2015, to 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) Provides that this section expires September 1, 2015.

ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENT PROVISIONS

SECTION 4.01. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00256, as follows:

Sec. 533.00256. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee (QBP 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, to 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 require managed care organizations to develop and implement collaborative program improvement strategies to address the goals.

(b) Authorizes goals established under this section to be set by geographic region and program type.

SECTION 4.02. Amends Sections 533.0051(a) and (g), Government Code, as follows:

(a) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization and HHSC for the provision of health care services to recipients that is procured and managed under a value-based purchasing model. Requires that the performance measures and incentives be designed to facilitate and increase recipients' access to appropriate health care services, and to the extent possible, align with other state and regional quality care improvement initiatives.

(g) Authorizes HHSC, or an agency operating part of the state Medicaid managed care program, as appropriate, in performing HHSC's duties under Subsection (d) (relating to requiring HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to assess the feasibility and cost-effectiveness of including certain provisions) with respect to assessing feasibility and cost-effectiveness, to consult with participating Medicaid providers, including those with expertise in quality improvement and performance measurement, rather than to consult with physicians, including those with expertise in quality improvement and performance measurement, and hospitals.

SECTION 4.03. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00511, as follows:

Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MANAGED CARE ORGANIZATIONS. (a) Defines "potentially preventable event" in this section.

(b) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to 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 the quality of care provided through the managed care organization offering that managed care plan; the organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization; and the organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, including measures based on potentially preventable events.

SECTION 4.04. Amends Section 533.0071, Government Code, as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to make every effort to improve the administration of contracts with managed care organizations. Requires HHSC, or an agency operating part of the state Medicaid managed care program, as appropriate, to improve the administration of these contracts, to:

(1)-(3) Makes no change to these subdivisions;

(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)-(D) Makes no change to these paragraphs; and

(E) providing a portal through which providers in any managed care organization's provider network are authorized to submit acute care services and long-term services and supports claims, rather than providing a single portal through which providers in any managed care organization's provider network are authorized to submit claims; and

(5) Makes no change to this subdivision.

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

(b) Requires that any amount received by the state under this section (Profit Sharing), except as provided by Subsection (c), be deposited in the general revenue fund for the purpose of funding the state Medicaid program.

(c) Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if cost-effective, to 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. Amends Section 536.002(b), Government Code, as follows:

(b) Requires the executive commissioner to appoint the members of the QBP advisory committee. Requires the QBP advisory committee to consist of certain 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 certain members of whom at least three members who are or who represent a health care provider that primarily provides long-term services and supports, rather than at least one member who is or who represents a health care provider that primarily provides long-term care services.

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

(a) Requires HHSC, in consultation with the QBP advisory committee, to 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 care services and long-term services and supports, rather than for acute and long-term care services, across all delivery models and payment systems, including fee-for-service and managed care payment systems. Requires HHSC, subject to Subsection (a-1), in developing outcome and process measures under this section, to include measures that are based on potentially preventable events and that advance quality improvement and innovation, rather than to consider measures addressing potentially preventable events. Authorizes HHSC to change measures developed to promote continuous system reform, improved quality, and reduced costs, and to account for managed care organizations added to a service area.

(a-1) Requires that the outcome measures based on potentially preventable events allow for rate-based determination of health care provider performance compared to statewide norms, and be risk-adjusted to account for the severity of the illnesses of patients served by the provider.

(b) Requires HHSC, to the extent feasible, to develop outcome and process measures that meet certain criteria, including outcome and process measures 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, that reflect effective coordination of acute care services and long-term services and supports, that can be tied to expenditures, and that reduce preventable health care utilization and costs. Makes nonsubstantive changes.

SECTION 4.08. Amends Section 536.004(a), Government Code, to require HHSC, after consulting with the QBP 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, to develop quality-based payment systems and require managed care organizations to develop quality-based payment systems using certain quality-based outcome and process measures, for compensating a physician or other health care provider participating in the child health plan or Medicaid program that meet certain criteria.

SECTION 4.09. Amends Section 536.005, Government Code, by adding Subsection (c), to require HHSC, notwithstanding Subsection (a) (relating to the conversion of payment methodology for hospital reimbursement systems under the child health plan and Medicaid programs) and to the extent possible, to convert outpatient hospital reimbursement systems under the child health plan and Medicaid programs to an appropriate prospective payment system that will allow HHSC to more accurately classify the full range of outpatient service episodes, more accurately account for the intensity of services provided, and motivate outpatient service providers to increase efficiency and effectiveness.

SECTION 4.10. Amends Section 536.006, Government Code, as follows:

Sec. 536.006 Transparency. (a) Requires HHSC and the QBP advisory committee to:

(1)-(3) Makes no change to these subdivisions; 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 in this state and in the provider's respective region.

(b) Requires that the web-based capability required by Subsection (a)(4) support the requirements of the electronic health information exchange system under Sections 531.907 (Electronic Health Information Exchange System Stage Two: Expansion), 531.908 (Electronic Health Information Exchange System Stage Three: Expansion), and 531.909 (Incentives).

SECTION 4.11. Amends Section 536.008, Government Code, as follows:

Sec. 536.008. ANNUAL REPORT. (a) Requires HHSC to submit to the legislature and make available to the public an annual report regarding:

(1) the quality-based outcome and process measures developed under Section 536.003 (Development of Quality-Based Outcome and Process Measures), including measures based on each potentially preventable event; and

(2) Makes no change to this subdivision.

(b) Requires HHSC, as appropriate, to report outcome and process measures under Subsection (a)(1) by geographic location, which may require reporting by county, health care service region, or other appropriately defined geographic area; recipient population or eligibility group served; type of health care provider, such as acute care or long-term care provider; number of recipients who relocated to a community-based setting from a less integrated setting; quality-based payment system; and service delivery model.

(c) Prohibits the report required under this section from identifying specific health care providers.

SECTION 4.12. Amends Section 536.051(a), Government Code, to require HHSC, subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal law, to 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 potentially preventable events, rather than outcome and process measures developed under Section 536.003, including outcome measures addressing potentially preventable events. Authorizes the percentage of the premiums paid to increase each year.

SECTION 4.13. Amends Section 536.052(a), Government Code, to authorize HHSC to 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 achieve certain goals, including to reduce the incidence of unnecessary institutionalization and potentially preventable events; and to increase the use of alternative payment systems, including shared savings models, in collaboration with physicians and other health care providers.

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

(a) Requires the executive commissioner to 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) Creates this subsection from existing text. Makes no further changes to this subsection.

(b) Requires HHSC to 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), rather than with respect to potentially preventable readmissions and potentially preventable complications. Requires that a report provided under this section (Collection and Reporting of Certain Information), to the extent possible, include all potentially preventable events, rather than include potentially preventable readmissions and potentially preventable complications information, across all child health plan and Medicaid program payment systems.

(c) Provides that, except as provided by Subsection (d), a report provided to a hospital under this section is confidential and is not subject to Chapter 552 (Public Information).

(d) Authorizes HHSC to release the information in the report described by Subsection (b) not earlier than one year after the date the report is submitted to the hospital, and 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. Amends Section 536.152(a), Government Code, to require HHSC, subject to Subsection (b) (relating to a certain report HHSC is required to provide to a hospital at least one year before HHSC adjusts child health plan and Medicaid reimbursements to the hospital under this section (Reimbursement Adjustments)), using the data collected under Section 536.151 and the diagnosis-related groups (DRG) methodology implemented under Section 536.005 (Conversion of Payment Methodology), if applicable, after consulting with the QBP advisory committee, 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, based on the hospital's performance, rather than 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. Amends Section 536.202(a), Government Code, as follows:

(a) Requires HHSC, after consulting with the QBP advisory committee, to 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)-(6) Makes no change to these subdivisions; 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. Amends Chapter 536, Government Code, by adding Subchapter F, 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) Authorizes HHSC, subject to this subchapter, after consulting with the QBP advisory committee and other appropriate stakeholders representing nursing facility providers with an interest in the provision of long-term services and supports, to 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. Requires that a quality-based payment system developed under this section 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) Authorizes HHSC to develop a quality-based payment system for Medicaid long-term care 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. Requires HHSC, to ensure that HHSC is using the best data to inform the development and implementation of quality-based payment systems under Section 536.251, to evaluate the reliability, validity, and functionality of post-acute and long-term services and supports data sets. Requires that HHSC's evaluation under this section assess:

(1) to what degree data sets relied on by HHSC meet a standard for integrating care, for developing coordinated care plans, and 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) Requires the executive commissioner to 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) Requires HHSC to 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. Requires that, to the extent possible, a report provided under this section include applicable potentially preventable events information across all Medicaid program payment systems.

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

(d) Authorizes HHSC to release the information in the report described by Subsection (b) not earlier than one year after the date the report is submitted to the provider, and 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. Requires HHSC, as soon as practicable after the effective date of this Act, to 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 Section 533.0071(4)(E), Government Code, as amended by this article.

SECTION 4.19. Requires HHSC, not later than September 1, 2013, to convert outpatient hospital reimbursement systems as required by Section 536.005(c), Government Code, as added by this article.

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

SECTION 5.01. Amends Section 533.013, Government Code, by adding Subsection (e), as follows:

(e) Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practices. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, in pursuing premium rate-setting strategies under this section, to review and consider strategies employed or under consideration by other states. Authorizes HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, if necessary, to 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. Amends the heading to Section 531.024, Government Code, to read as follows:

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

SECTION 6.02. Amends Section 531.024, Government Code, by adding Subsection (a-1), to require HHSC and other health and human services agencies, to the extent permitted under applicable federal law and notwithstanding any provision of Chapter 191 (Administration of Vital Statistics Records) or 192 (Birth Records), Health and Safety Code, to 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. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.024115, as follows:

Sec. 531.024115. SERVICE DELIVERY AREA ALIGNMENT. Requires HHSC, notwithstanding Section 533.0025(e) (relating to requiring HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to determine the most cost-effective alignment of managed care service delivery areas; authorizing the commissioner of HHSC to consider the number of lives impacted, the usual source of health care services for residents in an area, and other factors that impact the delivery of health care services in the area) or any other law, to the extent possible, to align service delivery areas under the Medicaid and child health plan programs.

SECTION 6.04. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.0981, as follows:

Sec. 531.0981. WELLNESS SCREENING PROGRAM. Authorizes HHSC, if cost-effective, to 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. Provides that Section 531.024115, Government Code, as added by this article:

(1) applies only with respect to a contract between HHSC 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 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, that is entered into or renewed on or after the effective date of this Act; and

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

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

(a-1) Authorizes a local mental health authority, in addition to the services required under Subsection (a) (relating to requiring a local mental health authority to ensure the provision of assessment services, crisis services, and intensive and comprehensive services using disease management practices for adults with bipolar disorder, schizophrenia, or clinically severe depression and for children with serious emotional illnesses; and requiring the local mental health authority to ensure that individuals are engaged with certain treatment services) 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), to 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) Requires the local mental health authority to ensure that individuals described by Subsection (a-1) are engaged with treatment services in a clinically appropriate manner.

(b-1) Requires TXMHMR to 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 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. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0284, as follows:

Sec. 32.0284. CALCULATION OF PAYMENTS UNDER CERTAIN SUPPLEMENTAL HOSPITAL PAYMENT PROGRAMS. (a) Defines "commission" and "supplemental hospital payment program" in this section.

(b) Requires HHSC, for purposes of calculating the hospital-specific limit used to determine a hospital's uncompensated care payment under a supplemental hospital payment program, to 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. Amends Section 32.053, Human Resources Code, by adding Subsection (i), as follows:

(i) Authorizes HHSC, to the extent allowed by GAA, to transfer general revenue funds appropriated to HHSC for the medical assistance program to DADS 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. Authorizes HHSC, under this Act, to 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. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 7.02. Requires HHSC, as soon as practicable after the effective date of this Act, to 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. Requires HHSC, if HHSC determines that it is cost-effective, to 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. Authorizes HHSC to use any available revenue, including legislative appropriations and available federal funds, for purposes of implementing any provision of this Act.

SECTION 7.05. (a) Effective date, except as provided by Subsection (b) of this section: September 1, 2013.

(b) Effective date, Section 533.0354, Health and Safety Code, as amended by this Act: January 1, 2014.