BILL ANALYSIS

C.S.S.B. 7
By: Nelson
Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties assert that the state would benefit from legislation designed to improve the coordination of Medicaid long-term care services and supports with acute care services, redesign the long-term care services and supports system to more efficiently serve individuals with intellectual and developmental disabilities, and expand on quality-based payment initiatives to promote high-quality, efficient care throughout Medicaid. C.S.S.B. 7 seeks to accomplish this by amending 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

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 1.01, 2.02, 2.18 3.02, and 4.17 of this bill.

ANALYSIS

Section 531.0055, Government Code, as amended by Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, expressly grants to the executive commissioner of the Health and Human Services Commission all rulemaking authority for the operation of and provision of services by the health and human services agencies. Similarly, Sections 1.16-1.29, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, provide for the transfer of a power, duty, function, program, or activity from a health and human services agency abolished by that act to the corresponding legacy agency. To the extent practical, this bill analysis is written to reflect any transfer of rulemaking authority and to update references as necessary to an agency's authority with respect to a particular health and human services program.

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

C.S.S.B. 7 amends the Government Code to require the Health and Human Service Commission (HHSC) and the Department of Aging and Disability Services (DADS) 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 certain specified goals relating to access to and the provision, coordination, and outcomes of those services and the needs of the individuals receiving those services. The bill requires HHSC and DADS, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established by the bill, to jointly implement the system in the manner and in the stages prescribed by the bill's provisions.

C.S.S.B. 7 sets out provisions relating to the establishment of the Intellectual and Developmental Disability System Redesign Advisory Committee to advise HHSC and DADS on the

implementation of the acute care services and long-term services and supports system redesign, committee member and presiding officer appointment, meeting requirements, and the compensation of committee members. The bill specifies that the advisory committee is subject to state open meetings laws and establishes that the advisory committee is abolished and that provisions relating to the advisory committee expire on January 1, 2024. The bill requires the executive commissioner of HHSC and the commissioner of DADS to appoint the members of the committee not later than October 1, 2013. The bill requires HHSC and any other health and human services agency implementing a provision of the bill that affects individuals with intellectual and developmental disabilities to consult with the advisory committee regarding the implementation.

C.S.S.B. 7, in a temporary provision set to expire January 1, 2024, requires HHSC, not later than September 30 of each year, to submit a report to the legislature regarding the implementation of the acute care services and long-term services and supports system and related recommendations. The bill requires HHSC to submit the initial report not later than September 30, 2014, and the final report not later than September 30, 2023.

C.S.S.B. 7 authorizes HHSC and DADS to develop and implement pilot programs 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. The bill requires DADS, as part of developing and implementing a pilot program, to develop a process to receive and evaluate certain statewide and regional stakeholder input. The bill sets out requirements for DADS relating to identification of private services providers that are good candidates to develop and test a service delivery model through a pilot program established under the bill's provisions and solicitation of managed care strategy proposals from those identified private services providers. The bill sets out the elements required to be addressed by a managed care strategy and requirements relating to the evaluation of submitted managed care strategy proposals and the selection of private services providers as pilot program service providers based on such evaluation. The bill requires DADS, for each pilot program service provider and as soon as possible after the bill's effective date, to develop and implement a pilot program through which the pilot program service provider will 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. The bill 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.

C.S.S.B. 7 sets out provisions relating to measurable goals of each pilot program implemented; the implementation, location, and duration of a pilot program; voluntary recipient participation in a pilot program; the coordination of Medicaid long-term services and supports provided to individuals with intellectual and developmental disabilities under a pilot program; and a facilitated, person-centered plan regarding the outcomes and budget of each individual receiving services and supports though a pilot program. The bill establishes requirements for collecting and computing certain information regarding costs, services, outcomes, recipient characteristics, client satisfaction, and information required to make a service provider evaluation with respect to each pilot program implemented under the bill's provisions. The bill requires HHSC and DADS, on or before December 1, 2017, and December 1, 2018, and in consultation with the advisory committee, to review and evaluate the progress and outcomes of each implemented pilot program and submit a report to the legislature during the operation of the pilot programs that includes recommendations for program improvement and continued implementation. The bill requires HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid program benefits between a Medicaid waiver program and a pilot program under the bill's provisions to protect continuity of care and requires each pilot program established under the bill's provisions that is still in operation to conclude and makes provisions relating to the pilot programs expire on September 1, 2019.

C.S.S.B. 7 requires HHSC 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 to monitor those benefits. The bill requires a managed care organization that contracts with HHSC to provide acute care services to provide an acute care services coordinator to each individual with an intellectual or developmental disability during the individual's transition to the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model. The bill sets out requirements for HHSC relating to implementing the delivery of basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program and providing voluntary training regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.

C.S.S.B. 7 sets out requirements for such a managed care organization relating to types of providers to be included in the organization's provider network, the review and consideration of any assessment conducted by a local intellectual and developmental disability authority providing intellectual and developmental disability service coordination, and a written agreement to coordinate services by the organization and a local intellectual and developmental disability authority.

C.S.S.B. 7 requires DADS to contract with and make contract payments to local intellectual and developmental disability authorities to conduct certain activities relating to service coordination and needs assessment, the development of an individual's plan of care, and providing recommendations for and description of outcomes based on an individual's plan of care. The bill prohibits authorities providing such service coordination from also providing attendant and habilitation services under the bill's provisions. The bill establishes that providers eligible to participate in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, or the community living assistance and support services (CLASS) waiver program on September 1, 2013, are considered significant traditional providers during the first three years basic attendant and habilitation services are provided in accordance with the bill's provisions to individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program. The bill authorizes an authority with which DADS contracts to subcontract with an eligible person, including a nonprofit entity, to coordinate the services of individuals with intellectual and developmental disabilities and requires the executive commissioner of HHSC by rule to establish minimum qualifications to be considered an "eligible person." The bill 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.

C.S.S.B. 7 requires HHSC, not later than September 1, 2018, to transition the provision of Medicaid program benefits to individuals with intellectual and developmental disabilities who are receiving long-term services and supports under the TxHmL waiver program 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 managed care strategy pilot programs established under the bill's provisions. The bill requires HHSC, at the time of the transition, to determine whether to 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 to provide all or a portion of the long-term services and supports previously available under that waiver program through the managed care program delivery model selected by HHSC.

C.S.S.B. 7 requires HHSC, after implementing the transition of TxHmL waiver program

recipients to the managed care program but not later than September 1, 2021, to transition the provision of Medicaid program benefits to individuals with intellectual and developmental disabilities who are receiving long-term services and supports under a Medicaid waiver program other than the TxHmL waiver program or an ICF-IID program 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. The bill requires HHSC, at the time of the transition, to determine whether to 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, or to provide all or a portion of the long-term services and supports previously available only under the Medicaid waiver programs or ICF-IID program through the managed care program delivery model selected by HHSC.

C.S.S.B. 7 requires a managed care organization providing services under the managed care program delivery model selected by HHSC, before transitioning the provision of benefits for children or adults with intellectual and developmental disabilities under the ICF-IID program or a Medicaid waiver program other than the TxHmL waiver program to the managed care program, 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 or adults with intellectual and developmental disabilities, as applicable. The bill requires HHSC, on determination that all or a portion of the long-term services and supports previously available only under the Medicaid waiver programs should be provided through a managed care program delivery model, to allow each recipient receiving long-term services and supports under a Medicaid waiver program the option, at the time of the transition, of continuing to receive the services and supports under the Medicaid waiver program, or receiving the services and supports through the managed care program delivery model selected by HHSC. The bill prohibits a recipient who chooses to receive long-term services and supports through a managed care program delivery model from choosing at a later time to receive the services and supports under a Medicaid waiver program.

C.S.S.B. 7 requires HHSC, in implementing both the TxHmL waiver program transition and the ICF-IID or other Medicaid waiver program transition, to develop a process to receive and evaluate input from interested statewide stakeholders that is in addition to the input provided by the advisory committee and requires HHSC to ensure that there is a comprehensive plan for transitioning the provision of applicable Medicaid program benefits that protects the continuity of care provided to individuals affected by a transition. The bill requires a contract between a managed care organization and HHSC for the organization to provide Medicaid program benefits to individuals formerly receiving services under the TxHmL waiver program, the ICF-IID program, or another Medicaid waiver program, to contain a requirement that the organization implement a process for individuals with intellectual and developmental disabilities that ensures that the individuals have a choice among providers and that, 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.

C.S.S.B. 7 requires HHSC and DADS, in provisions set to expire September 1, 2024, to review and evaluate, in consultation with the advisory committee, the outcomes of the transition of the provision of benefits to individuals under the TxHmL waiver program, the ICF-IID program, or another Medicaid waiver program to a managed care program delivery model. The bill requires HHSC and DADS to submit as part of the annual report to the legislature regarding the implementation of an acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities a report due on or before September 30 of 2019, 2020, and 2021, on the review and evaluation of those transitions that includes recommendations for continued implementation of and improvements to the acute care and long-term services and supports system. The bill establishes that, to the extent of a conflict between

the bill's provisions relating to the system redesign for delivery of such services and another state law, the bill's provisions control.

C.S.S.B. 7 amends the Health and Safety Code to clarify that the exemption from home and community support services licensing requirements for a person who provides home health, hospice, or personal assistance services applies to such a person providing those services only to persons receiving benefits under the HCS waiver program, the TxHmL waiver program, or the STAR + PLUS Medicaid managed care program.

Article 2. Medicaid Managed Care Expansion

C.S.S.B. 7 amends the Government Code to require HHSC, in a temporary provision set to expire September 1, 2015, to conduct a study to evaluate the feasibility of automatically enrolling applicants determined eligible for Medicaid benefits in a Medicaid managed care plan and to report the results of the study to the legislature not later than December 1, 2014. The bill authorizes HHSC to implement such an automatic enrollment process if determined to be feasible and authorizes HHSC to elect to implement the automatic enrollment process as to certain populations of Medicaid recipients.

C.S.S.B. 7 requires HHSC, in a temporary provisions set to expire September 1, 2019, to expand the STAR + PLUS Medicaid managed care program to all areas of Texas to serve individuals eligible for Medicaid acute care services and long-term services and supports and requires HHSC, in consultation with the STAR + PLUS Nursing Facility Advisory Committee established under the bill's provisions, to provide Medicaid benefits to recipients who reside in a licensed convalescent or nursing facility that provides services and supports to Medicaid recipients through the STAR + PLUS Medicaid managed care program. The bill establishes requirements for HHSC relating to reimbursement rates and payment under the managed care program, appropriate utilization of services, reducing potentially preventable events and unnecessary institutionalizations, services and incentives to be provided by a participating managed care organization, the certification and decertification of nursing facility beds, and the establishment of a claims portal for nursing facility providers participating in the STAR + PLUS Medicaid managed care program.

C.S.S.B. 7 requires HHSC, in a temporary provision set to expire September 1, 2018, to ensure that a nursing facility provider authorized to provide Medicaid services on September 1, 2013, is allowed to participate in the STAR + PLUS Medicaid managed care program through August 31, 2017. The bill requires HHSC 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 and 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 under the bill's provisions.

C.S.S.B. 7 requires HHSC, in a temporary provision set to expire September 1, 2015, to develop a two-phase plan in preparation for implementing the provision of Medicaid benefits to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. The bill requires the contract planning phase to be completed not later than October 1, 2013, and the initial testing phase, to be completed not later than July 15, 2014. The bill establishes the duties of HHSC in each phase and requires HHSC to submit reports and other specified information regarding the implementation of each phase to the STAR + PLUS Nursing Facility Advisory Committee established by the bill by the applicable completion deadline.

C.S.S.B. 7 establishes the STAR + PLUS Nursing Facility Advisory Committee to advise HHSC on the implementation of and other activities related to the provision of Medicaid benefits to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. The bill provides for the appointment of committee members by the governor, lieutenant governor, and speaker of the house of representatives, the appointment of a presiding

officer by the executive commissioner, and committee member service without compensation; makes the committee subject to state open meetings law; and establishes that the advisory committee is abolished and that provisions relating to the advisory committee expire on September 1, 2017. The bill requires the members of the committee to be appointed not later than September 15, 2013.

C.S.S.B. 7 sets out provisions prohibiting certain payment incentives by a managed care organization participating in the STAR + PLUS Medicaid managed care program to nursing facility providers, unless HHSC seeks and obtains an appropriate waiver or other authorization that ensures a significant portion 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 Medicaid will be returned to the state and distributed to those facilities. The bill prohibits HHSC from beginning to provide Medicaid benefits under the program before September 1, 2014. The bill requires HHSC to provide the claims portal prescribed by the bill's provisions as soon as practicable after the implementation date of the expansion of the STAR + PLUS Medicaid managed care program.

C.S.S.B. 7 requires HHSC, in consultation with the STAR Kids Managed Care Advisory Committee established by the bill and the Children's Policy Council, to establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. The bill sets out program requirements and requires HHSC to provide Medicaid benefits through the program to children who are receiving benefits under the medically dependent children (MDCP) waiver program. The bill sets out requirements for HHSC with respect to the provision of MDCP waiver program benefits through the STAR Kids managed care program, contracting with local intellectual and developmental disability authorities to provide service coordination, and monitoring the provision of benefits to medically dependent children. The bill requires HHSC to ensure that there is a plan for transitioning the provision of Medicaid program benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care and requires the plan to ensure that coordination between the programs begins when a recipient reaches 18 years of age. The bill authorizes a local intellectual and developmental disability authority with which HHSC contracts to subcontract with an eligible person, including a nonprofit entity, to provide service coordination and requires the executive commissioner by rule to establish minimum qualifications to be considered an "eligible person." The bill requires a managed care organization that contracts with HHSC to provide acute care services to provide an acute care services coordinator to each child with a disability during the child's transition to the STAR Kids capitated managed care program and requires HHSC to seek ongoing input from the Children's Policy Council regarding the establishment and implementation of the STAR Kids managed care program.

C.S.S.B. 7, in a temporary provision set to expire September 1, 2022, requires HHSC and DADS to review and evaluate the outcomes of the transition of the provision of benefits to recipients under the MDCP waiver program to the STAR Kids managed care program delivery model. The bill requires HHSC and DADS, not later than December 1, 2017, to submit an initial report to the legislature on the review and evaluation, including recommendations for continued implementation and improvement of the program and, not later than December 1 of each year after 2017 and until December 1, 2021, to submit additional reports with that same information.

C.S.S.B. 7 establishes the STAR Kids Managed Care Advisory Committee to advise HHSC on the establishment and implementation of the STAR Kids managed care program. The bill provides for committee member and presiding officer appointment and committee member service without compensation. The bill makes the committee subject to state open meetings law and establishes that the advisory committee is abolished and that provisions relating to the advisory committee expire on September 1, 2017.

C.S.S.B. 7 establishes the STAR + PLUS Quality Council to advise HHSC 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. The bill establishes provisions relating to council member and presiding officer appointment by the executive commissioner, the council's composition, meetings, and council member service without compensation. The bill establishes reporting requirements for the council and for DADS regarding the assessment of and recommendations for the acute care services and long-term services and supports provided under the STAR + PLUS Medicaid managed care program with an initial report to be submitted not later than November 1, 2014, and a final report not later than November 1, 2016. The bill makes the council subject to state open meetings law and establishes that the council is abolished and that provisions relating to the council expire on January 1, 2017. The bill requires the members of the council to be appointed not later than October 1, 2013.

C.S.S.B. 7 revises specific components required to be contained in a contract between a managed care organization and HHSC for the organization to provide health care services to recipients under the Medicaid managed care program regarding deadlines by which payments must be made to a physician or provider for health care services rendered to a recipient under a managed care plan; a comprehensive plan describing how an organization's provider network will provide recipients sufficient access to specific services and related reporting requirements; the number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services in an organization's provider network; and a requirement relating to prior HHSC approval before the managed care organization implements significant, nonnegotiated, across-the-board provider reimbursement rate reductions. The bill repeals a provision prohibiting certain requirements relating to the outpatient pharmacy benefit plan required to be developed, implemented, and maintained by a managed care organization under such a contract from being enforced on or after August 31, 2013. The bill requires HHSC to require a managed care organization that enters into or renews a contract with HHSC on or after the bill's effective date to comply with the revised contract requirements and requires HHSC to seek to amend contracts entered into with managed care organizations before the bill's effective date to require compliance. The bill establishes that, to the extent of a conflict between applicable bill provisions and a provision of a contract with a managed care organization entered into before the bill's effective date, the contract provision prevails.

C.S.S.B. 7 requires the executive commissioner, rather than HHSC, to appoint a state Medicaid managed care advisory committee, and revises and expands the composition of the advisory committee. The bill requires the executive commissioner to appoint the presiding officer of the advisory committee and, to the greatest extent possible, to appoint members of the advisory committee who reflect the geographic diversity of Texas and include members who represent rural Medicaid program recipients. The bill requires the executive commissioner to appoint the additional members to the state Medicaid managed care advisory committee not later than October 1, 2013. The bill requires the advisory committee to meet at the call of the presiding officer and at least semiannually, but no more frequently than quarterly, and requires the presiding officer of the advisory committee to convene the first meeting of the advisory committee following appointment of its additional members not later than December 1, 2013.

C.S.S.B. 7 clarifies and expands the duties of the advisory committee to include providing recommendations and ongoing advisory input to HHSC on the statewide implementation and operation of Medicaid managed care, including program design and benefits, systemic concerns from consumers and providers, the efficiency and quality of services delivered by Medicaid managed care organizations, contract requirements for Medicaid managed care organizations, Medicaid managed care provider network adequacy, and other issues as requested by the executive commissioner. The bill requires HHSC and DADS to ensure coordination and communication between the advisory committee, regional Medicaid managed care advisory committees appointed by HHSC, and other advisory committees or groups that perform functions related to Medicaid managed care, including the Intellectual and Developmental Disability System Redesign Advisory Committee established under the bill's provisions, in a

manner that enables the state Medicaid managed care advisory committee to act as a central source of agency information and stakeholder input relevant to the implementation and operation of Medicaid managed care. The bill authorizes the advisory committee to establish work groups that meet at other times for purposes of studying and making recommendations on issues the committee determines appropriate. The bill exempts the advisory committee from the applicability of statutory provisions relating to the duration of state agency advisory committees and sets out provisions relating to the compensation and reimbursement of advisory committee members.

C.S.S.B. 7 requires the executive commissioner, as soon as practicable after the bill's effective date but not later than January 1, 2015, 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 the bill's provisions. The bill requires HHSC 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.

C.S.S.B. 7 repeals Section 533.005(a-1), Government Code.

Article 3. Other Provisions Relating to Individuals with Intellectual and Developmental Disabilities

C.S.S.B. 7 amends the Health and Safety Code to require 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 a Medicaid waiver program, the ICF-IID program, or an intermediate care facility operated by the state and providing services for those individuals. The bill, in a temporary provision set to expire September 1, 2015, requires DADS, in developing the assessment instrument, to evaluate any assessment instrument in use by DADS, and authorizes DADS 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 the bill's provisions.

C.S.S.B. 7 requires DADS, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established by the bill's provisions, to establish a prior authorization process for requests for supervised living or residential support services available in the home and community-based services (HCS) Medicaid waiver program, and requires the process to ensure that supervised living or residential support services available in the HCS Medicaid waiver program are available only to individuals for whom a more independent setting is not appropriate or available. The bill, in a temporary provision set to expire January 1, 2024, requires DADS to cooperate with the advisory committee to establish the required prior authorization process.

C.S.S.B. 7 requires the executive commissioner, 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 intellectual and developmental disabilities in urban and rural areas. The bill 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 Intellectual and Developmental Disability System Redesign Advisory Committee, 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 intellectual and developmental disabilities. The bill requires DADS to

develop a process to receive input from statewide stakeholders to ensure the most comprehensive review of opportunities and options for those housing services.

C.S.S.B. 7 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, and to establish one or more behavioral health intervention teams to provide services and supports to such individuals. The bill specifies eligible members of a behavioral health intervention team, and sets out the duties of such a team in providing services and supports. The bill requires DADS to ensure that members of a behavioral health intervention team 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.

C.S.S.B. 7, in temporary provisions set to expire September 1, 2015, 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 Texas with Prader-Willi syndrome and, in doing so, to seek stakeholder input. The bill 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.

C.S.S.B. 7, in a temporary provision set to expire September 1, 2015, requires HHSC to conduct a study to evaluate the need for applying income disregards to persons with intellectual and developmental disabilities receiving Medicaid benefits, including through a Section 1915(c) waiver program, and, not later than January 15, 2015, to submit a report regarding the study to the governor, 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

Article 4. Quality-Based Outcomes and Payment Provisions

C.S.S.B. 7 amends the Government Code to require HHSC, in consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee 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 and to require managed care organizations to develop and implement collaborative program improvement strategies to address the goals. The bill authorizes goals established under the bill's provisions to be set by geographical region and program type.

C.S.S.B. 7 requires HHSC's outcome-based performance measures and incentives required to be included 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 to align to the extent possible with other state and regional quality care improvement initiatives. The bill authorizes HHSC, in performing its duties with respect to assessing feasibility and cost-effectiveness of including certain specified provisions in such a contract, to consult with participating Medicaid providers, rather than with physicians and hospitals.

C.S.S.B. 7 requires HHSC 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, including measures based on all potentially preventable events.

C.S.S.B. 7, in a provision requiring HHSC to decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks by decreasing the duplication of administrative reporting requirements for the managed care organizations, specifies that HHSC is required to decrease the duplication of administrative and process requirements for those organizations and providers. The bill specifies the purpose of the claims portal required to be provided by HHSC for providers in any managed care organization's provider network to be for the submission of acute care services and long-term services and support claims and requires HHSC, as soon as practicable after the bill's effective date, to provide such a portal.

C.S.S.B. 7 authorizes HHSC, if cost-effective, to use amounts received by the state from shared profits earned by a managed care organization through a managed care plan providing health care services under a contract with HHSC 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.

C.S.S.B. 7 increases from at least one to at least three the number of members required to be appointed to the Medicaid and CHIP Quality-Based Payment Advisory Committee who are or who represent a health care provider that primarily provides long-term services and supports. The bill requires HHSC, in developing 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 across all delivery models and payment systems, to include measures that are based on all potentially preventable events and that advance quality improvement and innovation. The bill specifies the purposes for which HHSC is authorized to change measures previously developed by HHSC and requires the outcome measures based on potentially preventable events to 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 serviced by the provider. The bill includes among the outcome and process measures required to be developed by HHSC, measures that will have the greatest effect on improving quality of care and the efficient use of acute care services and long-term services and supports and measures 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.

C.S.S.B. 7 requires HHSC, in developing quality-based payment systems for compensating a physician or other health care provider participating in the child health plan or Medicaid program, to consult with 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 and requires HHSC to require managed care organizations to also develop such quality-based payment systems. The bill requires HHSC, to the extent possible and not later than September 1, 2013, 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.

C.S.S.B. 7 requires HHSC and the Medicaid and CHIP Quality-Based Payment Advisory Committee to develop web-based capability that supports the requirements of the expanded electronic health information exchange system developed by HHSC to provide managed care organizations and health care providers with data on their clinical and utilization performance,

including comparisons to peer organizations and providers located in Texas and in the provider's respective region.

C.S.S.B. 7 requires HHSC's annual report submitted to the legislature regarding outcome and process measures developed by HHSC and the implementation of quality-based payment systems and other payment initiatives to be made available to the public. The bill revises and expands the manner in which HHSC is required to report those measures and prohibits the report from identifying specific health care providers. The bill requires HHSC 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 that address all potentially preventable events, rather than outcome and process measures that include outcome measures addressing potentially preventable events, and authorizes the percentage of the premiums paid to increase each year. The bill includes among the quality initiatives HHSC is authorized to allow a managed care organization participating in the child health plan or Medicaid program to implement in the organization's managed care plan, initiatives to reduce the incidence of unnecessary institutionalizations, in addition to 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.

C.S.S.B. 7 includes among the rules required to be adopted by the executive commissioner for purposes of collecting and reporting of information relating to the quality-based hospital reimbursement system rules for identifying potentially preventable admissions, in addition to readmissions, of child health plan program enrollees and Medicaid recipients, including preventable admissions to long-term care facilities; potentially preventable ancillary services provided to or ordered for child health plan program enrollees and Medicaid recipients; and potentially preventable emergency room visits by child health plan program enrollees and Medicaid recipients. The bill requires HHSC to release the confidential reports provided by HHSC to each applicable hospital regarding the hospital's performance with respect to potentially preventable events 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. The bill removes language requiring HHSC to adjust child health plan and Medicaid reimbursements to hospitals based on the hospital's performance with respect to exceeding, or failing to achieve, outcome and process measures that address the rates of potentially preventable readmissions and potentially preventable complications in a manner that may reward or penalize a hospital.

C.S.S.B. 7 requires HHSC, after consulting with the Medicaid and CHIP Quality-Based Payment 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, among other criteria, 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.

C.S.S.B. 7 authorizes HHSC, after consulting with the Medicaid and CHIP Quality-Based Payment 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. The bill requires such a system to 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. The bill authorizes HHSC to develop the system only if implementing the system would be feasible and cost-effective. The bill requires HHSC to evaluate the reliability, validity, and functionality of

post-acute and long-term services and supports data sets in order to ensure that HHSC is using the best data to inform the development and implementation of quality-based payment systems. The bill sets out specific elements required to be assessed as part of the evaluation.

C.S.S.B. 7 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. The bill requires HHSC to establish a program to provide a report to each Medicaid long-term services and supports provider in Texas regarding the provider's performance with respect to potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits, and requires such a report, to the extent possible, to include applicable potentially preventable events information across all Medicaid program payment systems. The bill establishes that the report is confidential and is not subject to state public information law. The bill requires HHSC to release the information in a report 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.

Article 5. Specific Provisions Relating to Premiums Under the Medical Assistance Program

C.S.S.B. 7 amends the Government Code to require HHSC to pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practice, and requires HHSC, in doing so, to review and consider strategies employed or under consideration by other states. The bill authorizes HHSC to request any necessary waiver or other authorization from a federal agency to implement strategies identified under these provisions.

Article 6. Additional Provisions Relating to Quality and Delivery of Health and Human Services

C.S.S.B. 7 amends the Government Code to require HHSC and other health and human services agencies, to the extent permitted under applicable law, 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. The bill requires HHSC to align service delivery areas under the Medicaid and child health plan programs to the extent possible.

C.S.S.B. 7 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.

Effective January 1, 2014, C.S.S.B. 7 amends the Health and Safety Code to specify that a local mental health authority is required to ensure 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 and adults with severe mental illness who are experiencing significant functional impairment due to a mental health disorder defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), including certain specified conditions and disorders, rather than the provision of such services using disease management practices for adults with bipolar disorder, schizophrenia, or clinically severe depression and children with serious emotional illnesses. The bill includes the following among those specified conditions and disorders: major depressive disorder, including single episode or recurrent major depressive disorder; post-traumatic stress disorder; schizoaffective disorder, including bipolar and depressive types; obsessive compulsive disorder; anxiety disorder; attention deficit disorder; delusional disorder; bulimia nervosa, anorexia nervosa, or other eating disorders not otherwise specified; or any other diagnosed mental health disorder. The bill

expands the mental health conditions for which each local mental health authority is required 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 those conditions to include the following disorders as defined by the DSM-5: post-traumatic stress disorder; schizoaffective disorder, including bipolar and depressive types; anxiety disorder; or delusional disorder.

C.S.S.B. 7 amends the Human Resources Code to require 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 Medicaid reimbursement was not paid, the payment is not considered a Medicaid payment. The bill defines "supplemental hospital payment program" to mean the federal disproportionate share hospitals supplemental payment program and the uncompensated care payment program established under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under the federal Social Security Act.

Article 7. Federal Authorizations, Funding, and Effective Date

C.S.S.B. 7 requires HHSC, as soon as practicable after the bill's effective date, 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 or Medicaid, the federal requirement that the person be hospitalized for at least three consecutive calendar days before Medicare covers posthospital skilled nursing facility care for the person. The bill requires HHSC, on determination 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 who are at least 21 years of age and whose costs to receive care exceed cost limits under existing Medicaid waiver programs. The bill authorizes HHSC to use any available revenue, including legislative appropriations and available federal funds, for purposes of implementing any of the bill's provisions.

EFFECTIVE DATE

Except as otherwise provided, September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.S.B. 7 may differ from the engrossed version in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the engrossed and committee substitute versions of the bill.

SENATE ENGROSSED	HOUSE COMMITTEE SUBSTITUTE
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	ARTICLE 1. Same as engrossed version.
SECTION 1.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 534 to read as follows:	SECTION 1.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 534 to read as follows:
CHAPTER 534. SYSTEM REDESIGN FOR	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.

Sec. 534.002. CONFLICT WITH OTHER LAW.

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

Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. In accordance with this chapter, the commission and the department shall jointly design and implement an acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities that supports the following goals:

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

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

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

(4) promote person-centered planning, self-direction, self-determination, community inclusion, and customized gainful 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

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(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.

Sec. 534.053. INTELLECTUAL AND DEVELOPMENTAL DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The Intellectual and Developmental Disability System Redesign Advisory Committee is established to advise the commission and the department on the implementation of the acute care services and long-term services and supports system redesign under this chapter. Subject to Subsection (b), the executive commissioner and the commissioner of the department shall jointly appoint members of the advisory committee who are stakeholders from the intellectual and developmental disabilities community, including:
(1) individuals with intellectual and developmental disabilities who are recipients of Medicaid waiver program services and individuals who are advocates of those recipients, including at least three representatives from intellectual and developmental disability advocacy organizations;

(2) representatives of Medicaid managed care and nonmanaged care health care providers, including:
(A) physicians who are primary care providers and physicians who are specialty care providers;
(B) nonphysician mental health professionals; and
(C) providers of long-term services and supports, including direct service workers;
(3) representatives of entities with

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;
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(1) individuals with intellectual and developmental disabilities who are recipients of services under the Medicaid waiver programs or the Medicaid ICF-IID program and individuals who are advocates of those recipients, including at least three representatives from intellectual and developmental disability advocacy organizations;
(2) representatives of Medicaid managed care and nonmanaged care health care providers, including:
(A) physicians who are primary care providers and physicians who are specialty care providers;
(B) nonphysician mental health professionals; and
(C) providers of long-term services and supports, including direct service workers;
(3) representatives of entities with

responsibilities for the delivery of Medicaid long-term services and supports or other Medicaid program service delivery, including:

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

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

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

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

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

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

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

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

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

(g) On January 1, 2024:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION.

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

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

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

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

Sec. 534.101. DEFINITIONS.

Sec. 534.102. PILOT PROGRAMS TO TEST MANAGED CARE STRATEGIES BASED ON CAPITATION.

Sec. 534.103. STAKEHOLDER INPUT.

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

(b) The department shall solicit managed care strategy proposals from the private services providers identified under Subsection (a).

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

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

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

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

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

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Sec. 534.102. PILOT PROGRAMS TO TEST MANAGED CARE STRATEGIES BASED ON CAPITATION.

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

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

(7) promote employment assistance and supported employment;

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

(9) promote sufficient flexibility to achieve

the goals listed in this section through the pilot program.

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

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

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

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

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

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

Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS.

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

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

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

the goals listed in this section through the pilot program.

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

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

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

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

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

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

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

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

Sec. 534.1065. RECIPIENT PARTICIPATION IN PROGRAM VOLUNTARY.

Sec. 534.107. COORDINATING SERVICES. In providing long-term services and supports under the Medicaid program to an individual with intellectual or developmental disabilities, a pilot program service provider shall:

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

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

(B) a Medicaid waiver program; or

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

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

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

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

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

(1) the difference between the average monthly cost per person for all acute care services and long-term services and supports received by individuals participating in the pilot program while the program is operating, including services provided through the pilot program and other services with which pilot program services are coordinated as described by Section 534.107, and the average 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

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

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

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

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(1) the difference between the average monthly cost per person for all acute care services and long-term services and supports received by individuals participating in the pilot program while the program is operating, including services provided through the pilot program and other services with which pilot program services are coordinated as described by Section 534.107, and the average monthly cost per person for all services received by the individuals before the operation of the pilot program;

(2) the percentage of individuals receiving services through the pilot program who begin receiving services in a nonresidential setting

instead of from a facility licensed under Chapter 252, Health and Safety Code, or any other residential setting;

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

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

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

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

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

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

instead of from a facility licensed under Chapter 252, Health and Safety Code, or any other residential setting;

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

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

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

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

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

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

concludes.
(c) In addition to the information described by Subsection (a), the pilot program service provider shall collect any information specified by the department for use by the department in making an evaluation under Section 534.104(g).
(d) On or before December 1, 2016, and December 1, 2017, the commission and the department, in consultation with the advisory committee, shall review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit a report to the legislature during the operation of the pilot programs. Each report must include recommendations for program improvement and continued implementation.

Sec. 534.109. PERSON-CENTERED PLANNING.

Sec. 534.110. TRANSITION BETWEEN PROGRAMS.

Sec. 534.111. CONCLUSION OF PILOT PROGRAMS; EXPIRATION. On September 1, 2018:
(1) each pilot program established under this subchapter that is still in operation must conclude; and
(2) this subchapter expires.

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

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

concludes.
(c) In addition to the information described by Subsection (a), the pilot program service provider shall collect any information specified by the department for use by the department in making an evaluation under Section 534.104(g).
(d) On or before December 1, 2017, and December 1, 2018, the commission and the department, in consultation with the advisory committee, shall review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit a report to the legislature during the operation of the pilot programs. Each report must include recommendations for program improvement and continued implementation.

Sec. 534.109. Substantially the same as engrossed version.

Sec. 534.110. TRANSITION BETWEEN PROGRAMS.

Sec. 534.111. CONCLUSION OF PILOT PROGRAMS; EXPIRATION. On September 1, 2019:
(1) each pilot program established under this subchapter that is still in operation must conclude; and
(2) this subchapter expires.

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

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. (a) Subject to Section 533.0025, the commission shall provide acute care Medicaid program benefits to individuals with intellectual and developmental disabilities through the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model and monitor the provision of those benefits.
(b) A managed care organization that contracts with the commission to provide acute care services in accordance with this section shall provide an acute care services coordinator to each individual with an intellectual or developmental disability during the individual's transition to the STAR +

	PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model.
Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS AND STAR KIDS MEDICAID MANAGED CARE PROGRAMS. (a) The commission shall:	Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) The commission shall:
(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS and STAR Kids Medicaid managed care programs that maximizes federal funding for the delivery of services across those and other similar programs; and	(1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs; and
(2) provide voluntary training to individuals receiving services under the STAR + PLUS and STAR Kids Medicaid managed care programs or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the programs.	(2) provide voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.
(b) The commission shall require that each managed care organization that contracts with the commission for the provision of basic attendant and habilitation services under the STAR + PLUS or STAR Kids Medicaid managed care program in accordance with this section include in the organization's provider network for the provision of those services only:	(b) The commission shall require that each managed care organization that contracts with the commission for the provision of basic attendant and habilitation services under the STAR + PLUS Medicaid managed care program in accordance with this section: (1) include in the organization's provider network for the provision of those services:
(1) home and community support services agencies licensed under Chapter 142, Health and Safety Code, with which the commission has a contract to provide services under the community living assistance and support services (CLASS) waiver program; and	(A) home and community support services agencies licensed under Chapter 142, Health and Safety Code, with which the department has a contract to provide services under the community living assistance and support services (CLASS) waiver program; and
(2) persons exempted from licensing under Section 142.003(a)(19), Health and Safety Code, with which the commission has a contract to provide services under: (A) the home and community-based services (HCS) waiver program; or (B) the Texas home living (TxHmL) waiver program.	(B) persons exempted from licensing under Section 142.003(a)(19), Health and Safety Code, with which the department has a contract to provide services under: (i) the home and community-based services (HCS) waiver program; or (ii) the Texas home living (TxHmL) waiver program;
	(2) review and consider any assessment conducted by a local intellectual and developmental disability authority providing intellectual and developmental disability service coordination under Subsection (c); and
	(3) enter into a written agreement with each

	local intellectual and developmental disability authority in the service area regarding the processes the organization and the authority will use to coordinate the services of individuals with intellectual and developmental disabilities.
(c) The Department of Aging and Disability Services shall contract with local intellectual and developmental disability authorities to provide service coordination to individuals with intellectual and developmental disabilities under the STAR + PLUS and STAR Kids Medicaid managed care programs in accordance with this section.	(c) The department shall contract with and make contract payments to local intellectual and developmental disability authorities to conduct the following activities under this section: (1) provide intellectual and developmental disability service coordination to individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program by assisting those individuals who are eligible to receive services in a community-based setting, including individuals transitioning to a community-based setting; (2) provide an assessment to the appropriate managed care organization regarding whether an individual with an intellectual or developmental disability needs attendant or habilitation services, based on the individual's functional need, risk factors, and desired outcomes; (3) assist individuals with intellectual and developmental disabilities with developing the individuals' plans of care under the STAR + PLUS Medicaid managed care program, including with making any changes resulting from periodic reassessments of the plans; (4) provide to the appropriate managed care organization and the department information regarding the recommended plans of care with which the authorities provide assistance as provided by Subdivision (3), including documentation necessary to demonstrate the need for care described by a plan; and (5) on an annual basis, provide to the appropriate managed care organization and the department a description of outcomes based on an individual's plan of care.
Local intellectual and developmental disability authorities providing service coordination under this section may not also provide attendant and habilitation services under this section.	(d) Local intellectual and developmental disability authorities providing service coordination under this section may not also provide attendant and habilitation services under this section.
(d) During the first three years basic attendant and habilitation services are provided to individuals with intellectual and developmental disabilities under the STAR + PLUS or STAR Kids Medicaid managed care program in accordance with this section,	(e) During the first three years basic attendant and habilitation services are provided to individuals with intellectual and developmental disabilities under the STAR + PLUS Medicaid managed care program in accordance with this section, providers

providers eligible to participate in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, or the community living assistance and support services (CLASS) waiver program on September 1, 2013, are considered significant traditional providers.

eligible to participate in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, or the community living assistance and support services (CLASS) waiver program on September 1, 2013, are considered significant traditional providers.

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

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

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

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

(b) Not later than September 1, 2017, the commission shall transition the provision of Medicaid program benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and habilitation services and of the pilot programs established under Subchapter C, subject to Subsection (c)(1).

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

(1) continue operation of the Texas home living (TxHmL) waiver program for purposes

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

(b) Not later than September 1, 2018, the commission shall transition the provision of Medicaid program benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and habilitation services and of the pilot programs established under Subchapter C, subject to Subsection (c)(1).

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

(1) continue operation of the Texas home living (TxHmL) waiver program for purposes

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

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

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

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

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

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

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

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

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

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

(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.

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

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

(2) an ICF-IID program.

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

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

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

(2) an ICF-IID program.

(b) After implementing the transition required by Section 534.201 but not later than September 1, 2021, the commission shall transition the provision of Medicaid program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

developmental disabilities. (f-1) Before transitioning the provision of Medicaid program benefits for adults with intellectual and developmental disabilities under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to adults with intellectual and developmental disabilities. (g) If the commission determines that all or a portion of the long-term services and supports previously available only under the Medicaid waiver programs should be provided through a managed care program delivery model under Subsection (c)(2), the commission shall, at the time of the transition, allow each recipient receiving long-term services and supports under a Medicaid waiver program the option of: (1) continuing to receive the services and supports under the Medicaid waiver program; or (2) receiving the services and supports through the managed care program delivery model selected by the commission. (h) A recipient who chooses to receive long-term services and supports through a managed care program delivery model under Subsection (g) may not, at a later time, choose to receive the services and supports under a Medicaid waiver program.	developmental disabilities. Before transitioning the provision of Medicaid program benefits for adults with intellectual and developmental disabilities under this section, a managed care organization providing services under the managed care program delivery model selected by the commission must demonstrate to the satisfaction of the commission that the organization's network of providers has experience and expertise in the provision of services to adults with intellectual and developmental disabilities. (g) If the commission determines that all or a portion of the long-term services and supports previously available only under the Medicaid waiver programs should be provided through a managed care program delivery model under Subsection (c)(2), the commission shall, at the time of the transition, allow each recipient receiving long-term services and supports under a Medicaid waiver program the option of: (1) continuing to receive the services and supports under the Medicaid waiver program; or (2) receiving the services and supports through the managed care program delivery model selected by the commission. (h) A recipient who chooses to receive long-term services and supports through a managed care program delivery model under Subsection (g) may not, at a later time, choose to receive the services and supports under a Medicaid waiver program. (i) In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization to provide Medicaid program benefits under this section must contain a requirement that the organization implement a process for individuals with intellectual and developmental disabilities that: (1) ensures that the individuals have a choice among providers; and (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.
SECTION 1.02. Subsection (a), Section 142.003, Health and Safety Code, is amended.	SECTION 1.02. Same as engrossed version.

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

SECTION 1.03. Same as engrossed version.

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

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

SECTION 1.04. Same as engrossed version.

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

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

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

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

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

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

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

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

SECTION 1.07. The Health and Human Services Commission and the Department of Aging and Disability Services shall implement any pilot program to be established under Subchapter C, Chapter 534, Government Code, as added by this article, as soon as practicable after the effective date of this Act.

SECTION 1.07. Same as engrossed version.

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

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

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

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

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

(b) This section expires September 1, 2024.

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

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

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

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

(2) submit as part of an annual report required by Section 534.054, Government Code, as added by this article, due on or before September 30 of 2019, 2020, and 2021, a report on the review and evaluation conducted under Paragraphs (A) and (B), Subdivision (1), of this subsection that includes recommendations for continued implementation of and improvements to the acute care and long-term services and supports system under Chapter 534, Government Code, as added by this article.

(b) This section expires September 1, 2024.

ARTICLE 2. MEDICAID MANAGED CARE EXPANSION

ARTICLE 2. Same as engrossed version.

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

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

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

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

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

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

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

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

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

[~~(5) another Medicaid managed care model or arrangement~~].

No equivalent provision.

(f) The commission shall:

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

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

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

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

(f) The commission shall:

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

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

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

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

SECTION 2.02. Subchapter A, Chapter 533,

SECTION 2.02. Subchapter A, Chapter 533,

Government Code, is amended by adding Sections 533.00251, 533.00252, 533.00253, and 533.00254 to read as follows:

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

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

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

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

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

(c) Notwithstanding any other law, the commission, in consultation with the advisory committee, shall provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program.

In implementing this subsection, the commission shall ensure:

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

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

(3) the appropriate utilization of services;

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

Government Code, is amended by adding Sections 533.00251, 533.002515, 533.00252, 533.00253, and 533.00254 to read as follows:

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

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

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

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

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

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

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

In implementing this subsection, the commission shall ensure:

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

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

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

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

(5) that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;	(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 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	(6) that a managed care organization providing services under the managed care program: (A) assists in collecting applied income from recipients; and (B) provides payment incentives to nursing facility providers that reward reductions in preventable acute care costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;
(7) the establishment of a single portal through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization.	(7) the establishment of a portal through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization; and (8) that rules and procedures relating to the certification and decertification of nursing facility beds under the medical assistance program are not affected.
(d) Subject to Subsection (e), the commission shall ensure that a nursing facility provider authorized to provide services under the medical assistance program on September 1, 2013, is allowed to participate in the STAR + PLUS Medicaid managed care program through August 31, 2016. This subsection expires September 1, 2017.	(d) Subject to Subsection (e), the commission shall ensure that a nursing facility provider authorized to provide services under the medical assistance program on September 1, 2013, is allowed to participate in the STAR + PLUS Medicaid managed care program through August 31, 2017. This subsection expires September 1, 2018.
(e) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program. A managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by the commission under this section.	(e) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by the commission under this section. (f) This section expires September 1, 2019.
No equivalent provision.	Sec. 533.002515. PLANNED PREPARATION FOR DELIVERY OF NURSING FACILITY BENEFITS THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) The commission shall develop a plan in

	preparation for implementing the requirement under Section 533.00251(c) that the commission provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. The plan required by this section must be completed in two phases as follows: (1) phase one: contract planning phase; and (2) phase two: initial testing phase. (b) In phase one, the commission shall develop a contract template to be used by the commission when the commission contracts with a managed care organization to provide nursing facility services under the STAR + PLUS Medicaid managed care program. In addition to the requirements of Section 533.005 and any other applicable law, the template must include: (1) nursing home credentialing requirements; (2) appeals processes; (3) termination provisions; (4) prompt payment requirements and a liquidated damages provision that contains financial penalties for failure to meet prompt payment requirements; (5) a description of medical necessity criteria; (6) a requirement that the managed care organization provide recipients and recipients' families freedom of choice in selecting a nursing facility; and (7) a description of the managed care organization's role in discharge planning and imposing prior authorization requirements. (c) In phase two, the commission shall: (1) design and test the portal required under Section 533.00251(c)(7); (2) establish and inform managed care organizations of the minimum technological or system requirements needed to use the portal required under Section 533.00251(c)(7); (3) establish operating policies that require that managed care organizations maintain a portal through which providers may confirm recipient eligibility on a monthly basis; and (4) establish the manner in which managed care organizations are to assist the commission in collecting from recipients applied income or cost-sharing payments, including copayments, as applicable. (d) This section expires September 1, 2015.
Sec. 533.00252. STAR + PLUS NURSING FACILITY ADVISORY COMMITTEE. (a)	Sec. 533.00252. STAR + PLUS NURSING FACILITY ADVISORY COMMITTEE. (a)

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

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

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

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

(4) the reporting of outcome and process measures;

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

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

(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of nursing facility providers, representatives of managed care organizations, and other stakeholders interested in nursing facility services provided in this state, including:

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

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

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

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

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

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

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

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

(f) On September 1, 2016:

(1) the advisory committee is abolished; and

(2) this section expires.

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

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

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

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

(4) the reporting of outcome and process measures;

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

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

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

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

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

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

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

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

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

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

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

(f) On September 1, 2017:

(1) the advisory committee is abolished; and

(2) this section expires.

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

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

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

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

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

(1) provide medical assistance benefits that are customized to meet the health care needs of recipients under the program through a defined system of care, including benefits described under Section 534.152;

(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;

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

(10) coordinate services provided to children also receiving services under Section 534.152.

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

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

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

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

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

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

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

(3) improve the health outcomes of recipients;

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

(5) achieve cost containment and cost efficiency;

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

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

(8) require a health home; and

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

(c) The commission shall provide medical assistance benefits through the STAR Kids managed care program established under this section to children who are receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this subsection.	(c) The commission shall provide medical assistance benefits through the STAR Kids managed care program established under this section to children who are receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall: (1) ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this subsection; (2) contract with local intellectual and developmental disability authorities to provide service coordination to the children described by this subsection; and (3) monitor the provision of benefits to children described by this subsection.
(d) The commission shall ensure that there is a plan for transitioning the provision of Medicaid program benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age.	(d) The commission shall ensure that there is a plan for transitioning the provision of Medicaid program benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age. (e) A local intellectual and developmental disability authority with which the commission contracts under this section may subcontract with an eligible person, including a nonprofit entity, to provide service coordination under Subsection (c)(2). The executive commissioner by rule shall establish minimum qualifications a person must meet to be considered an "eligible person" under this subsection. (f) A managed care organization that contracts with the commission to provide acute care services under this section shall provide an acute care services coordinator to each child with a disability during the child's transition to the STAR Kids capitated managed care program.
(e) The commission shall seek ongoing input from the Children's Policy Council regarding the establishment and implementation of the STAR Kids managed care program.	(g) The commission shall seek ongoing input from the Children's Policy Council regarding the establishment and implementation of the STAR Kids managed care program.
Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE. (a) The STAR Kids Managed Care Advisory Committee is established to advise the commission on the establishment and implementation of the STAR Kids managed	Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE. (a) The STAR Kids Managed Care Advisory Committee is established to advise the commission on the establishment and implementation of the STAR Kids managed

care program under Section 533.00253.	care program under Section 533.00253.
(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of:	(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of:
(1) families whose children will receive private-duty nursing under the program;	(1) families whose children will receive private duty nursing under the program;
(2) health care providers;	(2) health care providers;
(3) providers of home and community-based services; and	(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.	(4) other stakeholders as the executive commissioner determines appropriate.
(c) The executive commissioner shall appoint the presiding officer of the advisory committee.	(c) The executive commissioner shall appoint the presiding officer of the advisory committee.
(d) A member of the advisory committee serves without compensation.	(d) A member of the advisory committee serves without compensation.
(e) The advisory committee is subject to the requirements of Chapter 551.	(e) The advisory committee is subject to the requirements of Chapter 551.
(f) On September 1, 2016:	(f) On September 1, 2017:
(1) the advisory committee is abolished; and	(1) the advisory committee is abolished; and
(2) this section expires.	(2) this section expires.
No equivalent provision.	SECTION 2.03. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00285 to read as follows:
	Sec. 533.00285. STAR + PLUS QUALITY COUNCIL. (a) The STAR + PLUS Quality Council is established to advise the commission on the development of policy recommendations that will ensure eligible recipients receive quality, person-centered, consumer-directed acute care services and long-term services and supports in an integrated setting under the STAR + PLUS Medicaid managed care program.
	(b) The executive commissioner shall appoint the members of the council, who must be stakeholders from the acute care services and long-term services and supports community, including:
	(1) representatives of health and human services agencies;
	(2) recipients under the STAR + PLUS Medicaid managed care program;
	(3) representatives of advocacy groups representing individuals with disabilities and seniors who are recipients under the STAR + PLUS Medicaid managed care program;
	(4) representatives of service providers for individuals with disabilities; and
	(5) representatives of health maintenance organizations.

(c) The executive commissioner shall appoint the presiding officer of the council.
(d) The council shall meet at least quarterly or more frequently if the presiding officer determines that it is necessary to carry out the responsibilities of the council.
(e) Not later than November 1 of each year, the council shall submit a report to the executive commissioner and the Department of Aging and Disability Services that includes:
(1) an analysis and assessment of the quality of acute care services and long-term services and supports provided under the STAR + PLUS Medicaid managed care program;
(2) recommendations regarding how to improve the quality of acute care services and long-term services and supports provided under the program; and
(3) recommendations regarding how to ensure that recipients eligible to receive services and supports under the program receive person-centered, consumer-directed care in the most integrated setting achievable.
(f) Not later than December 1 of each even-numbered year, the Department of Aging and Disability Services, in consultation with the council, shall submit a report to the legislature regarding the assessments and recommendations contained in any report submitted by the council under Subsection (e) during the most recent state fiscal biennium.
(g) The council is subject to the requirements of Chapter 551.
(h) A member of the council serves without compensation.
(i) On January 1, 2017:
(1) the council is abolished; and
(2) this section expires.

No equivalent provision.

SECTION 2.04. Subsection (a), Section 533.005, Government Code, is amended to read as follows:
(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:
(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;
(2) capitation rates that ensure the cost-

effective provision of quality health care;

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

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

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

(6) procedures for recipient outreach and education;

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

(A) not later than:

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

(ii) the 21st 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;

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

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

(10) a requirement that the managed care

organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

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

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

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

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

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

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

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

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

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

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

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

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

(20) a requirement that the managed care organization:

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

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

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

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

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

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

(vi) long-term services and supports;

(vii) nursing services; and

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

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

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

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

(21) a requirement that the managed care

organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that:

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

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

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

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

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

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

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

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

(B) focuses on measuring outcomes; and

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

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

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

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

(C) that includes the prior authorization procedures and requirements prescribed by or

implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

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

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

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

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

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

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

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

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

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

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

	(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code; [~~and~~] (24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan; and (25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless the organization has the prior approval of the commission to make the reduction.
SECTION 2.03. Section 533.041, Government Code, is amended.	SECTION 2.05. Same as engrossed version.
SECTION 2.04. Section 533.042, Government Code, is amended.	SECTION 2.06. Same as engrossed version.
SECTION 2.05. Section 533.043, Government Code, is amended.	SECTION 2.07. Same as engrossed version.
SECTION 2.06. Section 533.044, Government Code, is amended.	SECTION 2.08. Same as engrossed version.
SECTION 2.07. Subchapter C, Chapter 533, Government Code, is amended.	SECTION 2.09. Same as engrossed version.
SECTION 2.08. Section 32.0212, Human Resources Code, is amended to read as follows: Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE. Notwithstanding any other law [~~and subject to Section 533.0025, Government Code~~], the department shall provide medical assistance for acute care services through the Medicaid managed care system implemented under Chapter 533, Government Code, or another Medicaid capitated managed care program.	No equivalent provision.

SECTION 2.09. Subsections (c) and (d), Section 533.0025, Government Code, and Subchapter D, Chapter 533, Government Code, are repealed.

No equivalent provision.

SECTION 2.10. (a) The Health and Human Services Commission and the Department of Aging and Disability Services shall:
(1) review and evaluate the outcomes of the transition of the provision of benefits to recipients under the medically dependent children (MDCP) waiver program to the STAR Kids managed care program delivery model established under Section 533.00253, Government Code, as added by this article;
(2) not later than December 1, 2016, submit an initial report to the legislature on the review and evaluation conducted under Subdivision (1) of this subsection, including recommendations for continued implementation and improvement of the program; and
(3) not later than December 1 of each year after 2016 and until December 1, 2020, submit additional reports that include the information described by Subdivision (1) of this subsection.
(b) This section expires September 1, 2021.

SECTION 2.11. (a) The Health and Human Services Commission and the Department of Aging and Disability Services shall:
(1) review and evaluate the outcomes of the transition of the provision of benefits to recipients under the medically dependent children (MDCP) waiver program to the STAR Kids managed care program delivery model established under Section 533.00253, Government Code, as added by this article;
(2) not later than December 1, 2017, 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 2017 and until December 1, 2021, submit additional reports that include the information described by Subdivision (1) of this subsection.
(b) This section expires September 1, 2022.

SECTION 2.11.

No equivalent priovision.

SECTION 2.16.

(a) The Health and Human Services Commission may not:
(1) implement Paragraph (B), Subdivision (6), Subsection (c), Section 533.00251, Government Code, as added by this article, unless the commission seeks and obtains a waiver or other authorization from the federal Centers for Medicare and Medicaid Services or other appropriate entity that ensures a significant portion, but not more than 80 percent, of accrued savings to the Medicare program as a result of reduced hospitalizations and institutionalizations and other care and efficiency improvements to nursing facilities participating in the medical assistance program in this state will be returned to this state and distributed to those facilities; and
(2) begin providing medical assistance benefits to recipients under Section 533.00251, Government Code, as added by this article, before September 1, 2014.

As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall provide a single portal through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims in accordance with Subdivision (7), Subsection (c), Section 533.00251, Government Code, as added by this article.	(b) As soon as practicable after the implementation date of Section 533.00251, Government Code, as added by this article, the Health and Human Services Commission shall provide a portal through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims in accordance with Subdivision (7), Subsection (c), Section 533.00251, Government Code, as added by this article.
No equivalent provision.	SECTION 2.10. Subsection (a-1), Section 533.005, Government Code, is repealed.
No equivalent provision.	SECTION 2.12. (a) Not later than October 1, 2013, the executive commissioner of the Health and Human Services Commission shall appoint the members of the STAR + PLUS Quality Council as required by Section 533.00285, Government Code, as added by this article. (b) The STAR + PLUS Quality Council shall submit: (1) the initial report required under Subsection (e), Section 533.00285, Government Code, as added by this article, not later than November 1, 2014; and (2) the final report required under that subsection not later than November 1, 2016. (c) The Department of Aging and Disability Services shall submit: (1) the initial report required under Subsection (f), Section 533.00285, Government Code, as added by this article, not later than December 1, 2014; and (2) the final report required under that subsection not later than December 1, 2016.
No equivalent provision.	SECTION 2.13. (a) The Health and Human Services Commission shall, in a contract between the commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act, require that the managed care organization comply with applicable provisions of Subsection (a), Section 533.005, Government Code, as amended by this article. (b) The Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before

	the effective date of this Act to require those managed care organizations to comply with applicable provisions of Subsection (a), Section 533.005, Government Code, as amended by this article. To the extent of a conflict between the applicable provisions of that subsection and a provision of a contract with a managed care organization entered into before the effective date of this Act, the contract provision prevails.
No equivalent provision.	SECTION 2.14. Not later than September 15, 2013, the governor, lieutenant governor, and speaker of the house of representatives shall appoint the members of the STAR + PLUS Nursing Facility Advisory Committee as required by Section 533.00252, Government Code, as added by this article.
No equivalent provision.	SECTION 2.15. (a) Not later than October 1, 2013, the Health and Human Services Commission shall: (1) complete phase one of the plan required under Section 533.002515, Government Code, as added by this article; and (2) submit a report regarding the implementation of phase one of the plan together with a copy of the contract template required by that section to the STAR + PLUS Nursing Facility Advisory Committee established under Section 533.00252, Government Code, as added by this article. (b) Not later than July 15, 2014, the Health and Human Services Commission shall: (1) complete phase two of the plan required under Section 533.002515, Government Code, as added by this article; and (2) submit a report regarding the implementation of phase two to the STAR + PLUS Nursing Facility Advisory Committee established under Section 533.00252, Government Code, as added by this article.
SECTION 2.12. (a) Not later than October 1, 2013, the executive commissioner of the Health and Human Services Commission shall appoint additional members to the state Medicaid managed care advisory committee to comply with Section 533.041, Government Code, as amended by this article. (b) Not later than December 1, 2013, the presiding officer of the state Medicaid	SECTION 2.17. Same as engrossed version.

managed care advisory committee shall convene the first meeting of the advisory committee following appointment of additional members as required by Subsection (a) of this section.	
No equivalent provision.	SECTION 2.18. As soon as practicable after the effective date of this Act, but not later than January 1, 2015, the executive commissioner of the Health and Human Services Commission shall adopt rules and managed care contracting guidelines governing the transition of appropriate duties and functions from the commission and other health and human services agencies to managed care organizations that are required as a result of the changes in law made by this article.
SECTION 2.13. The changes in law made by this article are not intended to negatively affect Medicaid recipients' access to quality health care. The Health and Human Services Commission, as the state agency designated to supervise the administration and operation of the Medicaid program and to plan and direct the Medicaid program in each state agency that operates a portion of the Medicaid program, including directing the Medicaid managed care system, shall continue to timely enforce all laws applicable to the Medicaid program and the Medicaid managed care system, including laws relating to provider network adequacy, the prompt payment of claims, and the resolution of patient and provider complaints.	SECTION 2.19. Same as engrossed version.
ARTICLE 3. OTHER PROVISIONS RELATING TO INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES	ARTICLE 3. Same as engrossed version.
SECTION 3.01. Subchapter B, Chapter 533, Health and Safety Code, is amended.	SECTION 3.01. Same as engrossed version.
SECTION 3.02. Subchapter B, Chapter 533, Health and Safety Code, is amended.	SECTION 3.02. Substantially same as engrossed version.
SECTION 3.03. (a) The Health and Human Services Commission and the Department of	SECTION 3.03. Same as engrossed version.

Aging and Disability Services shall conduct a study to identify crisis intervention programs currently available to, evaluate the need for appropriate housing for, and develop strategies for serving the needs of persons in this state with Prader-Willi syndrome. (b) In conducting the study, the Health and Human Services Commission and the Department of Aging and Disability Services shall seek stakeholder input. (c) Not later than December 1, 2014, the Health and Human Services Commission shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the presiding officers of the standing committees of the senate and house of representatives having jurisdiction over the Medicaid program regarding the study required by this section. (d) This section expires September 1, 2015.	
No equivalent provision.	SECTION 3.04. (a) In this section: (1) "Medicaid program" means the medical assistance program established under Chapter 32, Human Resources Code. (2) "Section 1915(c) waiver program" has the meaning assigned by Section 531.001, Government Code. (b) The Health and Human Services Commission shall conduct a study to evaluate the need for applying income disregards to persons with intellectual and developmental disabilities receiving benefits under the medical assistance program, including through a Section 1915(c) waiver program. (c) Not later than January 15, 2015, the Health and Human Services Commission shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the presiding officers of the standing committees of the senate and house of representatives having jurisdiction over the Medicaid program regarding the study required by this section. (d) This section expires September 1, 2015.
ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENT PROVISIONS	ARTICLE 4. Same as engrossed version.
SECTION 4.01. Subchapter A, Chapter 533, Government Code, is amended.	SECTION 4.01. Substantially the same as engrossed version.

SECTION 4.02. Subsections (a) and (g), Section 533.0051, Government Code, are amended.

SECTION 4.02. Same as engrossed version.

SECTION 4.03. Subchapter A, Chapter 533, Government Code, is amended.

SECTION 4.03. Same as engrossed version.

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

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

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

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

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

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

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

(B) allowing managed care organizations to

SECTION 4.04. Same as engrossed version.

provide updated address information directly to the commission for correction in the state system;

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

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

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

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

SECTION 4.05. Section 533.014, Government Code, is amended.

SECTION 4.06. Subsection (b), Section 536.002, Government Code, is amended.

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

(a) The commission, in consultation with the advisory committee, shall develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan and Medicaid programs to implement quality-based payments for acute [~~and long-term~~] care services and long-term services and supports across all delivery models and payment systems, including [~~fee-for-service and~~] managed care payment systems. Subject to Subsection (a-1), the

provide updated address information directly to the commission for correction in the state system;

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

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

(E) providing a [~~single~~] portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

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

SECTION 4.05. Same as engrossed version.

SECTION 4.06. Same as engrossed version.

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

(a) The commission, in consultation with the advisory committee, shall develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the child health plan and Medicaid programs to implement quality-based payments for acute [~~and long-term~~] care services and long-term services and supports across all delivery models and payment systems, including fee-for-service and managed care payment systems. Subject to Subsection (a-1), the

[~~The~~] commission, in developing outcome and process measures under this section, must include measures that are based on all [~~consider measures addressing~~] potentially preventable events and that advance quality improvement and innovation. The commission may change measures developed:

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

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

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

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

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

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

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

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

(3) that will have the greatest effect on improving quality of care and the efficient use of services, including acute care services and long-term services and supports; [~~and~~]

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

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

(6) that can be tied to expenditures; and

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

SECTION 4.08. Subsection (a), Section 536.004, Government Code, is amended.

SECTION 4.08. Same as engrossed version.

SECTION 4.09. Section 536.005, Government Code, is amended.

SECTION 4.09. Same as engrossed version.

SECTION 4.10. Section 536.006, Government Code, is amended.

SECTION 4.10. Same as engrossed version.

SECTION 4.11. Section 536.008, Government Code, is amended.

SECTION 4.11. Same as engrossed version.

SECTION 4.12. Subsection (a), Section 536.051, Government Code, is amended.

SECTION 4.12. Same as engrossed version.

SECTION 4.13. Subsection (a), Section 536.052, Government Code, is amended.

SECTION 4.13. Same as engrossed version.

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

(a) The executive commissioner shall adopt rules for identifying:

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

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

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

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

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

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

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

SECTION 4.14. Same as engrossed version.

section is confidential and is not subject to Chapter 552.

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

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

(2) only after receiving and evaluating interested stakeholder input regarding the public release of information under this section generally.

section is confidential and is not subject to Chapter 552.

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

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

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

SECTION 4.15. Subsection (a), Section 536.152, Government Code, is amended.

SECTION 4.15. Same as engrossed version.

SECTION 4.16. Subsection (a), Section 536.202, Government Code, is amended.

SECTION 4.16. Same as engrossed version.

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

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

Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENTS.

Sec. 536.252. EVALUATION OF DATA SETS.

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

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

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

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

Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENTS.

Sec. 536.252. EVALUATION OF DATA SETS.

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

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

Medicaid program payment systems. (c) Subject to Subsection (d), a report provided to a provider under this section is confidential and is not subject to Chapter 552. (d) The commission shall release the information in the report described by Subsection (c): (1) not earlier than one year after the date the report is submitted to the provider; and (2) only after receiving and evaluating interested stakeholder input regarding the public release of information under this section generally.	Medicaid program payment systems. (c) Subject to Subsection (d), a report provided to a provider under this section is confidential and is not subject to Chapter 552. (d) The commission may release the information in the report described by Subsection (b): (1) not earlier than one year after the date the report is submitted to the provider; and (2) only after deleting any data that relates to a provider's performance with respect to particular resource utilization groups or individual recipients.
SECTION 4.18. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall provide a single portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims as required by Paragraph (E), Subdivision (4), Section 533.0071, Government Code, as amended by this article.	SECTION 4.18. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall provide a portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims as required by Paragraph (E), Subdivision (4), Section 533.0071, Government Code, as amended by this article.
SECTION 4.19. Not later than September 1, 2013, the Health and Human Services Commission shall convert outpatient hospital reimbursement systems as required by Subsection (c), Section 536.005, Government Code, as added by this article.	SECTION 4.19. Same as engrossed version.
ARTICLE 5. SPECIFIC PROVISIONS RELATING TO PREMIUMS UNDER THE MEDICAL ASSISTANCE PROGRAM	ARTICLE 5. Same as engrossed version.
SECTION 5.01. Section 533.013, Government Code, is amended.	SECTION 5.01. Same as engrossed version.
ARTICLE 6. ADDITIONAL PROVISIONS RELATING TO QUALITY AND DELIVERY OF HEALTH AND HUMAN SERVICES	ARTICLE 6. Same as engrossed version.
SECTION 6.01. The heading to Section 531.024, Government Code, is amended.	SECTION 6.01. Same as engrossed version.
SECTION 6.02. Section 531.024,	SECTION 6.02. Section 531.024,

Government Code, is amended by adding Subsection (a-1) to read as follows: (a-1) To the extent permitted under applicable law, the commission and other health and human services agencies shall share data to facilitate patient care coordination, quality improvement, and cost savings in the Medicaid program, child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund.	Government Code, is amended by adding Subsection (a-1) to read as follows: (a-1) To the extent permitted under applicable federal law and notwithstanding any provision of Chapter 191 or 192, Health and Safety Code, the commission and other health and human services agencies shall share data to facilitate patient care coordination, quality improvement, and cost savings in the Medicaid program, child health plan program, and other health and human services programs funded using money appropriated from the general revenue fund.
No equivalent provision.	SECTION 6.03. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.024115 to read as follows: Sec. 531.024115. SERVICE DELIVERY AREA ALIGNMENT. Notwithstanding Section 533.0025(e) or any other law, to the extent possible, the commission shall align service delivery areas under the Medicaid and child health plan programs.
SECTION 6.03. Subchapter B, Chapter 531, Government Code, is amended.	SECTION 6.04. Same as engrossed version.
No equivalent provision.	SECTION 6.05. Section 531.024115, Government Code, as added by this article: (1) applies only with respect to a contract between the Health and Human Services Commission and a managed care organization, service provider, or other person or entity under the medical assistance program, including Chapter 533, Government Code, or the child health plan program established under Chapter 62, Health and Safety Code, that is entered into or renewed on or after the effective date of this Act; and (2) does not authorize the Health and Human Services Commission to alter the terms of a contract that was entered into or renewed before the effective date of this Act.
No equivalent provision.	SECTION 6.06. Section 533.0354, Health and Safety Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows: (a) A local mental health authority shall ensure 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 and adults with severe mental illness who are experiencing significant functional impairment due to a mental health disorder defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), including:

(1) bipolar disorder;

(2) [~~,~~] schizophrenia;

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

(4) post-traumatic stress disorder;

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

(6) obsessive compulsive disorder;

(7) anxiety disorder;

(8) attention deficit disorder;

(9) delusional disorder;

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

(11) any other diagnosed mental health disorder [~~, or clinically severe depression and for children with serious emotional illnesses~~].

(a-1) The local mental health authority shall ensure that individuals are engaged with treatment services that are:

(1) ongoing and matched to the needs of the individual in type, duration, and intensity;

(2) focused on a process of recovery designed to allow the individual to progress through levels of service;

(3) guided by evidence-based protocols and a strength-based paradigm of service; and

(4) monitored by a system that holds the local authority accountable for specific outcomes, while allowing flexibility to maximize local resources.

(b) The department shall require each local mental health authority to incorporate jail diversion strategies into the authority's disease management practices to reduce the involvement of the criminal justice system in [~~for~~] managing adults with the following mental health disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5):

(1) schizophrenia;

(2) [~~and~~] bipolar disorder;

(3) post-traumatic stress disorder;

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

(5) anxiety disorder; or

	(6) delusional disorder [~~to reduce the involvement of those client populations with the criminal justice system~~].
No equivalent provision.	SECTION 6.07. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0284 to read as follows: Sec. 32.0284. CALCULATION OF PAYMENTS UNDER CERTAIN SUPPLEMENTAL HOSPITAL PAYMENT PROGRAMS. (a) In this section: (1) "Commission" means the Health and Human Services Commission. (2) "Supplemental hospital payment program" means: (A) the disproportionate share hospitals supplemental payment program administered according to 42 U.S.C. Section 1396r-4; and (B) the uncompensated care payment program established under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315). (b) For purposes of calculating the hospital-specific limit used to determine a hospital's uncompensated care payment under a supplemental hospital payment program, the commission shall ensure that to the extent a third-party commercial payment exceeds the Medicaid allowable cost for a service provided to a recipient and for which reimbursement was not paid under the medical assistance program, the payment is not considered a medical assistance payment.
ARTICLE 7. FEDERAL AUTHORIZATIONS, FUNDING, AND EFFECTIVE DATE	ARTICLE 7. Same as engrossed version.
SECTION 7.01. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.	SECTION 7.01. Same as engrossed version.
SECTION 7.02. As soon as practicable after	SECTION 7.02. Same as engrossed version.

the effective date of this Act, the Health and Human Services Commission shall apply for and actively seek a waiver or authorization from the appropriate federal agency to waive, with respect to a person who is dually eligible for Medicare and Medicaid, the requirement under 42 C.F.R. Section 409.30 that the person be hospitalized for at least three consecutive calendar days before Medicare covers posthospital skilled nursing facility care for the person.	
SECTION 7.03. If the Health and Human Services Commission determines that it is cost-effective, the commission shall apply for and actively seek a waiver or authorization from the appropriate federal agency to allow the state to provide medical assistance under the waiver or authorization to medically fragile individuals: (1) who are at least 21 years of age; and (2) whose costs to receive care exceed cost limits under existing Medicaid waiver programs.	SECTION 7.03. Same as engrossed version.
SECTION 7.04. The Health and Human Services Commission may use any available revenue, including legislative appropriations and available federal funds, for purposes of implementing any provision of this Act.	SECTION 7.04. Same as engrossed version.
SECTION 7.05. This Act takes effect September 1, 2013.	SECTION 7.05. (a) Except as provided by Subsection (b) of this section, this Act takes effect September 1, 2013. (b) Section 533.0354, Health and Safety Code, as amended by this Act, takes effect January 1, 2014.