By: Raymond H.B. No. 2721

A BILL TO BE ENTITLED

AN ACT

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

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

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

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

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

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 534.001. DEFINITIONS. In this chapter:

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

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

(3) "Department" means the Department of Aging and

Disability Services.

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

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

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

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

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

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

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

(7) "Local intellectual and developmental disability authority" means a local mental retardation authority described by Section 533.035, Health and Safety Code.

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

(9) "Medicaid program" means the medical assistance

program established under Chapter 32, Human Resources Code.

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

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

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

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

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

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

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

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

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

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

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

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

(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 unnecessary institutionalization and potentially preventable events;

(8) promote high-quality care;

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

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

Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. The commission and department shall, in consultation with the advisory

committee, jointly implement the acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities in the manner and in the stages described in this chapter.

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

(1) individuals with intellectual and developmental disabilities who are recipients of Medicaid waiver program services or individuals who are advocates of those recipients;

(2) representatives of health care providers participating in a Medicaid managed care program, 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) independent living centers;

(B) area agencies on aging;

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

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

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

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

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

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

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

(e) A member of the advisory committee serves without

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

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

(g) On January 1, 2024:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than December 1 of each year, the commission shall submit a report to the legislature regarding:

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

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

(b) This section expires January 1, 2024.

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

Sec. 534.101. DEFINITIONS. In this subchapter:

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

a predetermined payment per services recipient.

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

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

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

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

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

Subsection (a).

(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 the goals listed in this section through the pilot program.

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

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

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

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

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

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

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

(1) align with information that will be collected

under Section 534.108(a); and

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

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

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

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

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

Sec. 534.107. 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 instead of from a facility licensed under Chapter 252, Health and Safety Code, or any other residential setting;

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

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

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

(6) the difference between the percentage of individuals receiving services through the pilot program whose behavioral, medical, life-activity, and other personal outcomes have improved since the beginning of the program and the percentage

of individuals receiving services through the program whose behavioral, medical, life-activity, and other personal outcomes improved before the operation of the program, as measured over a comparable period; and

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

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

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

(d) On or before December 1, 2016, and December 1, 2017, the commission and the department, in consultation with the advisory committee, shall review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit a report to the legislature during the operation of the pilot programs. Each report must include recommendations for program improvement and continued implementation.

Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in

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

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

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

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

(2) this subchapter expires.

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

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. 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.

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS AND STAR KIDS MEDICAID MANAGED CARE PROGRAMS. The commission shall 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.

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

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

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

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

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

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

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

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

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

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

(2) an ICF-IID program.

(b) After implementing the transition required by Section 534.201 but not later than September 1, 2020, the commission shall transition the provision of Medicaid program benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the transition of Texas home living (TxHmL) waiver program recipients to a managed care program delivery model under Section 534.201, subject to 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 Medicaid waiver programs or Medicaid ICF-IID 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 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 developmental disabilities.

SECTION 1.02. 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. 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 December 1, 2014; and

(2) the final report under that section not later than December 1, 2023.

SECTION 1.04. 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 1.05. 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 1.06. (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 December 1 of 2018, 2019, and 2020, a report on the review

and evaluation conducted under Paragraphs (A) and (B), Subdivision (1), of this subsection that includes recommendations for continued implementation of and improvements to the acute care and long-term services and supports system under Chapter 534, Government Code, as added by this article.

(b) This section expires September 1, 2024.

ARTICLE 2. MEDICAID MANAGED CARE EXPANSION

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

(a) In this section and Sections 533.00251, 533.00252, and 533.00253, "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~~].

(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, Government Code, is amended by adding Sections 533.00251, 533.00252, and 533.00253 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;

(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

(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.

(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.

(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.

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.

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

(1) "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.

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

(b) The commission shall 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.

(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 or a portion of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement 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.

SECTION 2.03. Section 32.0212, Human Resources Code, is amended to read as follows:

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

SECTION 2.04. Subsections (c) and (d), Section 533.0025, Government Code, and Subchapter D, Chapter 533, Government Code,

are repealed.

SECTION 2.05. (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 2.06. 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.

SECTION 2.07. The changes in law made by this article are not intended to negatively affect Medicaid recipients' access to quality health care. The Health and Human Services Commission, as the state agency designated to supervise the administration and

operation of the Medicaid program and to plan and direct the Medicaid program in each state agency that operates a portion of the Medicaid program, including directing the Medicaid managed care system, shall continue to timely enforce all laws applicable to the Medicaid program and the Medicaid managed care system, including laws relating to provider network adequacy, the prompt payment of claims, and the resolution of patient and provider complaints.

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

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

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

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

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

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

(4) "Medicaid waiver program" has the meaning assigned by Section 534.001, Government Code.

(b) Subject to the availability of federal funding, the department shall develop and implement a comprehensive assessment instrument and a resource allocation process. The assessment instrument and resource allocation process must be designed to

recommend for each individual with intellectual and developmental disabilities enrolled in a Medicaid waiver program the type, intensity, and range of services that are both appropriate and available, based on the functional needs of that individual.

(c) The department, in consultation with the advisory committee, shall establish a prior authorization process for requests for supervised living or residential support services available in the home and community-based services (HCS) Medicaid waiver program. The process must ensure that supervised living or residential support services available in the home and community-based services (HCS) Medicaid waiver program are available only to individuals for whom a more independent setting is not appropriate or available.

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

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

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

(1) a selection of community-based housing options that comprise a continuum of integration, varying from most to

least restrictive, that permits individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences;

(2) non-provider-owned residential settings;

(3) assistance with living more independently; and

(4) rental properties with on-site supports.

(b) The Department of Aging and Disability Services, in cooperation with the Texas Department of Housing and Community Affairs, the Department of Agriculture, the Texas State Affordable Housing Corporation, and the Intellectual and Developmental Disability System Redesign Advisory Committee, shall coordinate with federal, state, and local public housing entities as necessary to expand opportunities for accessible, affordable, and integrated housing to meet the complex needs of individuals with intellectual and developmental disabilities.

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

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

(b) Subject to the availability of federal funding, the department shall develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with

intellectual and developmental disabilities and behavioral health needs who are at risk of institutionalization.

(c) Subject to the availability of federal funding, the department shall establish one or more behavioral health intervention teams to provide services and supports to individuals with intellectual and developmental disabilities and behavioral health needs who are at risk of institutionalization. An intervention team may include a:

(1) psychiatrist or psychologist;

(2) physician;

(3) registered nurse;

(4) pharmacist or representative of a pharmacy;

(5) behavior analyst;

(6) social worker;

(7) crisis coordinator;

(8) peer specialist; and

(9) family partner.

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

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

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

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

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

(5) provide clinical and other referrals.

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

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

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

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

(d) This section expires September 1, 2015.

ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENT PROVISIONS

SECTION 4.01. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00254 to read as follows:

Sec. 533.00254. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002 and other appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Except as provided by Subsection (c), any [~~Any~~] amount

received by the state under this section shall be deposited in the general revenue fund for the purpose of funding the state Medicaid program.

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

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

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

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

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

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

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

(5) at least three members [~~one member~~] who are [~~is~~] or

who represent [~~represents~~] a health care provider that primarily provides long-term [~~care~~] services and supports;

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

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

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

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

(a) Using quality-based outcome and process measures

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

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

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

(3) promote the coordination of health care;

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

(5) promote effective health care delivery models; and

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

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

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

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

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

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

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

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

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

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

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

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

(3) in developing and establishing the quality-based payment and reimbursement systems and initiatives described under

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

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

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

SECTION 4.11. Section 536.008, Government Code, is amended to read as follows:

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

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

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

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

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

(2) recipient population or eligibility group served;

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

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

(5) quality-based payment system; and

(6) service delivery model.

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

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

(a) Subject to Section 1903(m)(2)(A), Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal law, the commission shall base a percentage of the premiums paid to a managed care organization participating in the child health plan or Medicaid program on the organization's performance with respect to outcome and process measures developed under Section 536.003 that address all[~~, including outcome measures addressing~~] potentially preventable events. The percentage of the premiums paid may increase each year.

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

(a) The commission may allow a managed care organization participating in the child health plan or Medicaid program

increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to:

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

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

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

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

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

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

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

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

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

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

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

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

(c) Except as provided by Subsection (d), a [~~A~~] report provided to a hospital under this section is confidential and is not subject to Chapter 552.

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

(a) Subject to Subsection (b), using the data collected

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

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

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

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

(2) reduce potentially preventable events;

(3) promote prevention and wellness;

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

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

(6) contain costs; and

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

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

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

Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS PAYMENTS. (a) Subject to this subchapter, the commission, after consulting with the advisory committee and other appropriate stakeholders representing nursing facility providers with an interest in the provision of long-term services and supports, may develop and implement quality-based payment systems for Medicaid long-term services and supports providers designed to improve quality of care and reduce the provision of unnecessary services. A quality-based payment system developed under this section must base payments to providers on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the provider, and ensuring quality of care outcomes, including a reduction in potentially preventable events.

(b) The commission may develop a quality-based payment

system for Medicaid long-term services and supports providers under this subchapter only if implementing the system would be feasible and cost-effective.

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

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

(A) for integrating care;

(B) for developing coordinated care plans; and

(C) that would allow for the meaningful development of risk adjustment techniques;

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

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

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

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

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

(d) The commission 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.

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 4.19. Not later than September 1, 2013, the Health and Human Services Commission shall convert outpatient hospital

reimbursement systems as required by Subsection (c), Section 536.005, Government Code, as added by this article.

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

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

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

SECTION 5.02. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0642 to read as follows:

Sec. 32.0642. PREMIUM REQUIREMENT FOR RECEIPT OF CERTAIN SERVICES. To the extent permitted under and in a manner that is consistent with Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.), and any other applicable law or regulation or under a federal waiver or other authorization, the executive commissioner of the Health and Human Services Commission shall adopt and implement in the most cost-effective manner a premium for long-term services and supports provided to a child under the medical assistance program to be paid by the child's parent or other legal guardian.

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

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

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

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

(a-1) To the extent permitted under applicable 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.

SECTION 6.03. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0981 to read as follows:

Sec. 531.0981. WELLNESS SCREENING PROGRAM. If cost-effective, the commission may implement a wellness screening program for Medicaid recipients designed to evaluate a recipient's risk for having certain diseases and medical conditions for purposes of establishing a health baseline for each recipient that may be used to tailor the recipient's treatment plan or for establishing the recipient's health goals.

ARTICLE 7. FEDERAL AUTHORIZATIONS, FUNDING, AND EFFECTIVE DATE

SECTION 7.01. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision,

the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

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

SECTION 7.03. 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. This Act takes effect September 1, 2013.