

By: Nelson

S.B. No. 7

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 care 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 CARE 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 CARE SERVICES AND SUPPORTS TO PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 534.001. DEFINITIONS. In this chapter:

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

(3) "ICF-IID" means the Medicaid program serving individuals with intellectual and developmental disabilities who receive care in intermediate care facilities, but does not include

1 a state supported living center, as defined by Section 531.002,  
2 Health and Safety Code.

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

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

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

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

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

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

19 (C) the deaf, blind, and multiple disabilities  
20 (DBMD) waiver program; and

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

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

25 [Sections 534.003-534.050 reserved for expansion]

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

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

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

12           (2) improve individuals' access to services by  
13 ensuring that the individuals receive information about all  
14 available programs and services and how to apply for the programs  
15 and services;

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

18           (4) promote integrated coordinated case management of  
19 acute care services and long-term care services and supports;

20           (5) improve the coordination of acute care services  
21 and long-term care services and supports;

22           (6) improve acute care and long-term care outcomes,  
23 including reducing potentially preventable events;

24           (7) promote high-quality care; and

25           (8) promote person-centered planning and  
26 self-direction.

27       Sec. 534.052. IMPLEMENTATION OF SYSTEM. The commission and

1 department shall jointly implement the acute care services and  
2 long-term care services and supports system for individuals with  
3 intellectual and developmental disabilities in the manner and in  
4 the stages described in this chapter.

5 Sec. 534.053. ANNUAL REPORT ON IMPLEMENTATION. (a) Not  
6 later than September 1 of each year, the commission shall submit a  
7 report to the legislature regarding:

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

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

16 (b) This section expires January 1, 2019.

17 [Sections 534.054-534.100 reserved for expansion]

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

20 Sec. 534.101. PILOT PROGRAMS TO TEST MANAGED CARE  
21 STRATEGIES BASED ON CAPITATION. The commission and the department  
22 may develop and implement pilot programs in accordance with this  
23 subchapter to test one or more service delivery models involving a  
24 managed care strategy based on capitation to deliver long-term care  
25 services and supports under the Medicaid program to individuals  
26 with intellectual and developmental disabilities.

27 Sec. 534.102. STAKEHOLDER INPUT. In developing and

1 implementing pilot programs under this subchapter, the department  
2 shall develop a process for statewide stakeholder input to be  
3 received and evaluated.

4 Sec. 534.103. PILOT PROGRAM PROVIDERS. (a) The department  
5 shall identify local intellectual and developmental disability  
6 authorities and private care providers that are good candidates to  
7 develop a service delivery model involving a managed care strategy  
8 based on capitation and to test the model in the provision of  
9 long-term care services and supports under the Medicaid program to  
10 individuals with intellectual and developmental disabilities  
11 through a pilot program established under this subchapter.

12 (b) The department shall solicit managed care strategy  
13 proposals from the local intellectual and developmental disability  
14 authorities and private care providers identified under Subsection  
15 (a).

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

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

21 (2) improve quality and promote integrated  
22 coordinated case management of acute care services and long-term  
23 services and supports;

24 (3) promote person-centered planning and  
25 self-direction; and

26 (4) promote efficiency and the best use of funding.

27 (d) The department shall evaluate each submitted managed

1 care strategy proposal and determine whether:

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

4 (2) the local intellectual and developmental  
5 disability authority or private care provider that submitted the  
6 proposal is likely able to provide the long-term care services and  
7 supports appropriate to the individuals who will receive care  
8 through the program.

9 (e) Based on the evaluation performed by the department  
10 under Subsection (d), the department may select as pilot program  
11 service providers one intellectual and developmental disability  
12 authority and one private care provider.

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

19 Sec. 534.104. PILOT PROGRAM GOALS. (a) The department  
20 shall identify measurable goals to be achieved by each pilot  
21 program implemented under this subchapter.

22 (b) The department shall propose specific strategies for  
23 achieving the identified goals. A proposed strategy may be  
24 evidence-based if there is an evidence-based strategy available for  
25 meeting the pilot program's goals.

26 Sec. 534.105. IMPLEMENTATION, LOCATION, AND DURATION.

27 (a) The commission and department shall implement any pilot

1 programs established under this subchapter not later than September  
2 1, 2014.

3 (b) A pilot program established under this subchapter must  
4 operate for not less than 24 months.

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

7 Sec. 534.106. COORDINATING SERVICES. In providing  
8 long-term care services and supports under the Medicaid program to  
9 an individual with intellectual or developmental disabilities, a  
10 pilot program service provider shall:

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

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

16 (B) a Medicaid waiver program; or

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

19 (2) coordinate with managed care organizations to  
20 promote integrated coordinated case management of acute care  
21 services and long-term care services and supports.

22 Sec. 534.107. PILOT PROGRAM INFORMATION. (a) The  
23 commission and the department shall collect and compute the  
24 following information with respect to each pilot program  
25 established under this subchapter to the extent it is available:

26 (1) the difference between the average monthly cost  
27 per person for all services received by individuals participating

1 in the pilot program while the program is operating, including  
2 services provided through the pilot program and other services with  
3 which pilot program services are coordinated as described by  
4 Section 534.106, and the average cost per person for all services  
5 received by the individuals before the operation of the pilot  
6 program;

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

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

18           (4) the difference between the average total Medicaid  
19 cost by level of care for individuals in various residential  
20 settings receiving services through the pilot program during the  
21 operation of the program and the average total Medicaid cost by  
22 level of care for those individuals before the operation of the  
23 program;

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



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

4 (6) the difference between the percentage of  
5 individuals receiving services through the pilot program whose  
6 behavioral outcomes have improved since the beginning of the  
7 program and the percentage of individuals receiving services  
8 through the program whose behavioral outcomes improved before the  
9 operation of the program, as measured over a comparable period.

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

15 Sec. 534.108. PERSON-CENTERED PLANNING. The commission, in  
16 cooperation with the department, shall ensure that each individual  
17 with intellectual or developmental disabilities who receives  
18 services and supports under the Medicaid program through a pilot  
19 program established under this subchapter has choice, direction,  
20 and control over Medicaid benefits should the individual choose the  
21 consumer direction model, as defined by Section 531.051.

22 Sec. 534.109. TRANSITION BETWEEN PROGRAMS. The commission  
23 shall ensure that there is a comprehensive plan for transitioning  
24 services from the Medicaid waiver program to another program to  
25 protect continuity of care.

26 Sec. 534.110. CONCLUSION OF PILOT PROGRAMS; EXPIRATION. On  
27 September 1, 2018:

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

3           (2) this subchapter expires.

4           [Sections 534.111-534.150 reserved for expansion]

5           SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND

6                           CERTAIN OTHER SERVICES

7           Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR  
8 INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. The  
9 commission shall provide Medicaid program benefits for acute care  
10 services to individuals with intellectual and developmental  
11 disabilities through:

12           (1) the STAR Medicaid managed care program, or the  
13 most appropriate capitated managed care program delivery model, if  
14 the individual receives long-term care Medicaid waiver program  
15 services or ICF-IID services not integrated into the STAR + PLUS  
16 Medicaid managed care delivery model or other managed care delivery  
17 model under Section 534.201 or 534.202; and

18           (2) the STAR + PLUS Medicaid managed care program or  
19 the most appropriate integrated capitated managed care program  
20 delivery model, if the individual is eligible to receive medical  
21 assistance for acute care services and is not receiving medical  
22 assistance under a Medicaid waiver program.

23           Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR  
24 + PLUS MEDICAID MANAGED CARE PROGRAM. The commission shall  
25 implement the most cost-effective option for the delivery of basic  
26 attendant and habilitation services for individuals with  
27 intellectual and developmental disabilities under the STAR + PLUS

1 Medicaid managed care program that maximizes federal funding for  
2 the delivery of services across that and other similar programs.

3 Sec. 534.153. STAKEHOLDER INPUT. In implementing the most  
4 cost-effective option under this subchapter, the commission shall  
5 develop a process for statewide stakeholder input to be received  
6 and evaluated.

7 [Sections 534.154-534.200 reserved for expansion]

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

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

16 (b) Not later than September 1, 2016, the commission shall  
17 transition the provision of Medicaid program benefits to  
18 individuals to whom this section applies to the STAR + PLUS Medicaid  
19 managed care program delivery model or the most appropriate  
20 integrated capitated managed care program delivery model, as  
21 determined by the commission based on the cost effectiveness and  
22 the experience of the STAR + PLUS Medicaid managed care program in  
23 providing basic attendant and habilitation services and the pilot  
24 programs established under Subchapter C, subject to Subsection  
25 (c)(1).

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

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

5           (2) cease operation of the Texas home living (TxHmL)  
6 waiver program and expand all or a portion of the long-term care  
7 services and supports previously available under the waiver program  
8 to the managed care program delivery model selected by the  
9 commission.

10          (d) In implementing the transition described by Subsection  
11 (b), the commission shall develop a process for statewide  
12 stakeholder input to be received and evaluated.

13          (e) The commission shall ensure that there is a  
14 comprehensive plan for transitioning services from the Texas home  
15 living (TxHmL) waiver program to another program to protect  
16 continuity of care.

17          Sec. 534.202. TRANSITION OF ICF-IID RECIPIENTS AND CERTAIN  
18 OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM.

19          (a) This section applies to individuals with intellectual and  
20 developmental disabilities who are receiving long-term services  
21 and supports and who, on the date the commission implements the  
22 transition described by Subsection (b):

23                 (1) meet the eligibility criteria required to receive  
24 long-term care services and supports under a Medicaid waiver  
25 program other than the Texas home living (TxHmL) waiver program; or

26                 (2) reside in a facility licensed under Chapter 252,  
27 Health and Safety Code, or in a community-based ICF-IID operated by

1 local authorities.

2 (b) After implementing the transition required by Section  
3 534.201 but not later than September 1, 2018, the commission shall  
4 transition the provision of Medicaid program benefits to  
5 individuals to whom this section applies to the STAR + PLUS Medicaid  
6 managed care program delivery model or the most appropriate  
7 integrated capitated managed care program delivery model, as  
8 determined by the commission based on cost-effectiveness and an  
9 evaluation of the experience of the transition of Texas home living  
10 (TxHmL) waiver program recipients to a managed care program  
11 delivery model under Section 534.201, subject to Subsection (c)(1).

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

14 (1) continue operation of the Medicaid waiver programs  
15 for purposes of providing supplemental long-term care services and  
16 supports not available under the managed care program delivery  
17 model selected by the commission; or

18 (2) cease operation of the Medicaid waiver programs  
19 and expand all or a portion of the long-term care services and  
20 supports previously available under the waiver programs to the  
21 managed care program delivery model selected by the commission.

22 (d) In implementing the transition described by Subsection  
23 (b), the commission shall develop a process for statewide  
24 stakeholder input to be received and evaluated.

25 (e) The commission shall ensure that there is a  
26 comprehensive plan for transitioning services from the Medicaid  
27 waiver program to another program to protect continuity of care.

1 SECTION 1.02. The Health and Human Services Commission  
2 shall submit:

3 (1) the initial report on the implementation of the  
4 acute care services and long-term care services and supports system  
5 for individuals with intellectual and developmental disabilities  
6 as required by Section 534.053, Government Code, as added by this  
7 Act, not later than September 1, 2014; and

8 (2) the final report under that section not later than  
9 September 1, 2018.

10 SECTION 1.03. The Health and Human Services Commission and  
11 the Department of Aging and Disability Services shall implement any  
12 pilot program to be established under Subchapter C, Chapter 534,  
13 Government Code, as added by this Act, as soon as practicable after  
14 the effective date of this Act.

15 ARTICLE 2. MEDICAID MANAGED CARE EXPANSION

16 SECTION 2.01. Subsection (b), Section 533.0025, Government  
17 Code, is amended to read as follows:

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

1           ~~[(1) a health maintenance organization model,~~  
2 ~~including the acute care portion of Medicaid Star + Plus pilot~~  
3 ~~programs;~~  
4           ~~[(2) a primary care case management model;~~  
5           ~~[(3) a prepaid health plan model;~~  
6           ~~[(4) an exclusive provider organization model; or~~  
7           ~~[(5) another Medicaid managed care model or~~  
8 ~~arrangement].~~

9           SECTION 2.02. Subchapter A, Chapter 533, Government Code,  
10 is amended by adding Sections 533.00251 and 533.00252 to read as  
11 follows:

12           Sec. 533.00251. DELIVERY OF SERVICES THROUGH STAR + PLUS  
13 MEDICAID MANAGED CARE PROGRAM. (a) In this section:

14           (1) "Nursing facility" has the meaning assigned by  
15 Section 531.912.

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

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

22           (c) Notwithstanding any other law, the commission shall  
23 provide benefits under the medical assistance program to recipients  
24 who reside in nursing facilities through the STAR + PLUS Medicaid  
25 managed care program. In implementing this subsection, the  
26 commission shall ensure:

27           (1) that the commission is responsible for setting the

1 reimbursement rate paid to a nursing facility under the managed  
2 care program;

3 (2) that a nursing facility is paid not later than the  
4 10th day after the date the facility submits a proper claim;

5 (3) the appropriate utilization of services;

6 (4) a reduction in the incidence of potentially  
7 preventable events; and

8 (5) that a managed care organization providing  
9 services under the managed care program provides payment incentives  
10 to nursing facility providers that reward reductions in preventable  
11 acute care costs and encourage transformative efforts in the  
12 delivery of nursing facility services.

13 Sec. 533.00252. STAR KIDS MEDICAID MANAGED CARE PROGRAM.

14 (a) In this section:

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

22 (2) "Medical assistance" has the meaning assigned by  
23 Section 32.003, Human Resources Code.

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

26 (b) The commission shall establish a mandatory STAR Kids  
27 capitated managed care program tailored to provide medical



1 assistance benefits to children with disabilities who are not  
2 otherwise enrolled in the STAR + PLUS Medicaid managed care  
3 program. The managed care program developed under this section  
4 must:

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

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

10 (3) improve the health outcomes of recipients;

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

13 (5) achieve cost containment and cost efficiency;

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

16 (7) reduce the incidence of potentially preventable  
17 events by ensuring the availability of appropriate services and  
18 care management;

19 (8) require a health home; and

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

24 (c) The commission shall provide medical assistance  
25 benefits through the STAR Kids managed care program established  
26 under this section to children who are receiving benefits under the  
27 medically dependent children (MDCP) waiver program. The commission

1 shall ensure that the STAR Kids managed care program provides all or  
2 a portion of the benefits provided under the medically dependent  
3 children (MDCP) waiver program to the extent necessary to implement  
4 this subsection.

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

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

13 SECTION 2.04. Subsections (c) and (d), Section 533.0025,  
14 Government Code, and Subchapter D, Chapter 533, Government Code,  
15 are repealed.

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

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

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

22 (1) "Department" means the Department of Aging and  
23 Disability Services.

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

26 (b) Subject to the availability of federal funding, the  
27 department shall develop and implement a comprehensive assessment

1 instrument and a resource allocation process. The assessment  
2 instrument and resource allocation process must be designed to  
3 recommend for each individual with intellectual and developmental  
4 disabilities enrolled in a Medicaid waiver program the type,  
5 intensity, and range of services that are both appropriate and  
6 available, based on the functional needs of that individual.

7 (c) The department may satisfy the requirement to implement  
8 the comprehensive assessment instrument and the resource  
9 allocation process developed under Subsection (b) by implementing  
10 the instrument and process only for purposes of pilot programs  
11 established under Subchapter C, Chapter 534, Government Code. This  
12 subsection expires on the date Subchapter C, Chapter 534,  
13 Government Code, expires.

14 (d) The department shall establish a prior authorization  
15 process for requests for placement of an individual with  
16 intellectual and developmental disabilities in a group home. The  
17 process must ensure that placement in a group home is available only  
18 to individuals for whom a more independent setting is not  
19 appropriate or available.

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

23 Sec. 533.03551. FLEXIBLE, LOW-COST RESIDENTIAL OPTIONS.

24 (a) To the extent permitted under federal law and regulations, the  
25 executive commissioner shall adopt or amend rules as necessary to  
26 allow for the development of additional housing supports for  
27 individuals with intellectual and developmental disabilities in

1 urban and rural areas, including:

2 (1) congregate living arrangements, such as houses,  
3 condominiums, or rental properties that may be in close proximity  
4 to each other;

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

6 (3) assistance with living more independently; and

7 (4) rental properties with on-site supports.

8 (b) The Department of Aging and Disability Services, in  
9 cooperation with the Texas Department of Housing and Community  
10 Affairs, shall coordinate with federal, state, and local public  
11 housing entities as necessary to expand opportunities for  
12 accessible, affordable, and integrated housing to meet the complex  
13 needs of individuals with intellectual and developmental  
14 disabilities.

15 (c) The Department of Aging and Disability Services shall  
16 develop a process for statewide stakeholder input to ensure the  
17 most comprehensive review of opportunities and options for  
18 residential services.

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

23 (b) Subject to the availability of federal funding, the  
24 department shall develop and implement specialized training for  
25 providers, family members, caregivers, and first responders  
26 providing direct services and supports to individuals with  
27 intellectual and developmental disabilities and behavioral health

1 needs.

2 (c) Subject to the availability of federal funding, the  
3 department shall establish one or more behavioral health  
4 intervention teams to provide services and supports to individuals  
5 with intellectual and developmental disabilities and behavioral  
6 health needs. An intervention team may include one or more  
7 professionals such as a:

8 (1) psychiatrist or psychologist;

9 (2) physician;

10 (3) registered nurse;

11 (4) behavior analyst;

12 (5) social worker; or

13 (6) crisis coordinator.

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

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

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

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

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

26 (5) provide clinical and other referrals.

1 ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENTS PROVISIONS

2 SECTION 4.01. Subchapter A, Chapter 533, Government Code,  
3 is amended by adding Section 533.00511 to read as follows:

4 Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM  
5 FOR MANAGED CARE ORGANIZATIONS. (a) In this section, "potentially  
6 preventable admission," "potentially preventable ancillary  
7 service," "potentially preventable complication," "potentially  
8 preventable emergency room visit," "potentially preventable  
9 readmission," and "potentially preventable event" have the  
10 meanings assigned by Section 536.001.

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

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

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

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

24 SECTION 4.02. Section 533.013, Government Code, is amended  
25 by adding Subsection (e) to read as follows:

26 (e) The commission shall pursue premium rate-setting  
27 strategies that encourage payment reform to providers and more

1 efficient service delivery and provider practices. In this effort,  
2 the commission shall review strategies employed or being considered  
3 by other states and, if necessary, shall submit a waiver to the  
4 federal Centers for Medicare and Medicaid Services.

5 SECTION 4.03. Section 533.014, Government Code, is amended  
6 by amending Subsection (b) and adding Subsection (c) to read as  
7 follows:

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

12 (c) If cost-effective, the commission may allocate shared  
13 profits earned by managed care organizations to provide incentives  
14 to specific managed care organizations in order to promote quality  
15 of care, encourage payment reform, reward local service delivery  
16 reform, increase efficiency, and reduce inappropriate or  
17 preventable service utilization.

18 SECTION 4.04. Section 536.003, Government Code, is amended  
19 by amending Subsections (a) and (b) and adding Subsection (a-1) to  
20 read as follows:

21 (a) The commission, in consultation with the advisory  
22 committee, shall develop quality-based outcome and process  
23 measures that promote the provision of efficient, quality health  
24 care and that can be used in the child health plan and Medicaid  
25 programs to implement quality-based payments for acute and  
26 long-term care services across all delivery models and payment  
27 systems, including fee-for-service and managed care payment

1 systems. Subject to Subsection (a-1), the ~~[The]~~ commission, in  
2 developing outcome and process measures under this section, must  
3 include measures based on all ~~[consider measures addressing]~~  
4 potentially preventable events.

5 (a-1) The outcome measures based on potentially preventable  
6 events must be risk-adjusted and allow for rate-based performance  
7 among health care providers.

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

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

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

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

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

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

22 (6) that can be tied to expenditures; and

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

25 SECTION 4.05. Subchapter A, Chapter 536, Government Code,  
26 is amended by adding Sections 536.0031 and 536.0032 to read as  
27 follows:



1       Sec. 536.0031. SHARING OF DATA AMONG HEALTH AND HUMAN  
2 SERVICES AGENCIES. To the extent permitted under state and federal  
3 requirements, the commission and other health and human services  
4 agencies shall share data to facilitate patient care coordination,  
5 quality improvement, and cost savings in the Medicaid program, CHIP  
6 program, and other programs supported by general revenue.

7       Sec. 536.0032. MANAGED CARE COLLABORATIVE PROGRAM  
8 IMPROVEMENT PLANS. In consultation with the Medicaid and CHIP  
9 Quality-Based Payment Advisory Committee, the commission shall  
10 establish a clinical improvement program to establish goals, and  
11 the commission shall require managed care organizations to develop  
12 and implement collaborative program improvement strategies to  
13 address these goals. Clinical goals established under the program  
14 may be targeted by region and program type.

15       SECTION 4.06. Subsection (a), Section 536.004, Government  
16 Code, is amended to read as follows:

17       (a) Using quality-based outcome and process measures  
18 developed under Section 536.003 and subject to this section, the  
19 commission, after consulting with the advisory committee, shall  
20 develop quality-based payment systems, and require managed care  
21 organizations to develop quality-based payment systems, for  
22 compensating a physician or other health care provider  
23 participating in the child health plan or Medicaid program that:

- 24               (1) align payment incentives with high-quality,  
25 cost-effective health care;
- 26               (2) reward the use of evidence-based best practices;
- 27               (3) promote the coordination of health care;

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

3 (5) promote effective health care delivery models; and

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

6 SECTION 4.07. Section 536.005, Government Code, is amended  
7 by adding Subsection (c) to read as follows:

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

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

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

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

19 SECTION 4.08. Section 536.006, Government Code, is amended  
20 to read as follows:

21 Sec. 536.006. TRANSPARENCY. The commission and the  
22 advisory committee shall:

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

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

1 Section 536.003; and

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

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

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

21 (4) develop a web-based capability to provide managed  
22 care organizations and providers with data on their clinical and  
23 utilization performance, including comparisons to other peer  
24 organizations and providers in Texas and in their region; this  
25 capability must support the requirements of the electronic health  
26 information exchange system described in Sections 531.907-531.909.

27 SECTION 4.09. Section 536.008, Government Code, is amended

1 to read as follows:

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

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

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

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

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

16                   (2) recipient population or eligibility group served;

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

19                   (4) quality-based payment system; and

20                   (5) service delivery model.

21           (c) The annual report may not identify specific health care  
22 providers.

23           SECTION 4.10. Subsection (a), Section 536.051, Government  
24 Code, is amended to read as follows:

25           (a) Subject to Section 1903(m)(2)(A), Social Security Act  
26 (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal  
27 law, the commission shall base a percentage, which may increase

1 from one year to the next, of the premiums paid to a managed care  
2 organization participating in the child health plan or Medicaid  
3 program on the organization's performance with respect to outcome  
4 and process measures developed under Section 536.003 that address  
5 all[, ~~including outcome measures addressing~~] potentially  
6 preventable events and that advance quality improvement and  
7 innovation. The measures utilized should change over time in order  
8 to promote continuous system reform, improved quality, and reduced  
9 costs. The commission may adjust measures to account for managed  
10 care organizations new to a service area.

11 SECTION 4.11. Subsection (a), Section 536.052, Government  
12 Code, is amended to read as follows:

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

- 18 (1) achieve high-quality, cost-effective health care;  
19 (2) increase the use of high-quality, cost-effective  
20 delivery models; ~~and~~  
21 (3) reduce potentially preventable events; and  
22 (4) increase the use of alternative payment systems.

23 SECTION 4.12. Section 536.151, Government Code, is amended  
24 by amending Subsections (a) and (b) and adding Subsection (a-1) to  
25 read as follows:

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

1           (1) potentially preventable admissions and  
2 readmissions of child health plan program enrollees and Medicaid  
3 recipients;

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

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

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

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

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

25         SECTION 4.13. Subsection (a), Section 536.152, Government  
26 Code, is amended to read as follows:

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

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

13 SECTION 4.14. Subsection (a), Section 536.202, Government  
14 Code, is amended to read as follows:

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

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

25 (2) reduce potentially preventable events;

26 (3) promote prevention and wellness;

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

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

3           (6) contain costs; and

4           (7) improve integration of acute care services and  
5 long-term care services and supports.

6           SECTION 4.15. Chapter 536, Government Code, is amended by  
7 adding Subchapter F to read as follows:

8           SUBCHAPTER F. QUALITY-BASED LONG-TERM CARE PAYMENT SYSTEMS

9           Sec. 536.251. QUALITY-BASED LONG-TERM CARE PAYMENTS.

10 (a) Subject to this subchapter, the commission, after consulting  
11 with the advisory committee, may develop and implement  
12 quality-based payment systems for Medicaid long-term care services  
13 and supports providers designed to improve quality of care and  
14 reduce the provision of unnecessary services. A quality-based  
15 payment system developed under this section must base payments to  
16 providers on quality and efficiency measures that may include  
17 measurable wellness and prevention criteria and use of  
18 evidence-based best practices, sharing a portion of any realized  
19 cost savings achieved by the provider, and ensuring quality of care  
20 outcomes, including a reduction in potentially preventable events.

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

25           Sec. 536.252. EVALUATION OF DATA SETS. To ensure that the  
26 commission is using the best data to inform the development and  
27 implementation of quality-based payment systems under Section



1 536.251, the commission shall evaluate the reliability, validity,  
2 and functionality of post-acute and long-term care services and  
3 supports data sets. The commission's evaluation under this section  
4 should assess:

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

7 (A) for integrating care;

8 (B) for developing coordinated care plans; and

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

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

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

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

1 (c) A report provided to a provider under this section is  
2 confidential and is not subject to Chapter 552.

3 SECTION 4.16. Not later than September 1, 2013, the Health  
4 and Human Services Commission shall convert outpatient hospital  
5 reimbursement systems as required by Subsection (c), Section  
6 536.005, Government Code, as added by this Act.

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

9 SECTION 5.01. Subchapter A, Chapter 533, Government Code,  
10 is amended by adding Section 533.0133 to read as follows:

11 Sec. 533.0133. INCLUSION OF RETROACTIVE FEE-FOR-SERVICE  
12 PAYMENTS IN PREMIUMS PAID. If the commission determines that it is  
13 cost-effective, the commission shall include all or a portion of  
14 any retroactive fee-for-service payments payable under the medical  
15 assistance program in the premium paid to a managed care  
16 organization under a managed care plan, including retroactive  
17 fee-for-service payments owed for services provided to a recipient  
18 before the recipient's enrollment in the medical assistance program  
19 or the managed care program, as applicable.

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

22 Sec. 32.0642. PREMIUM REQUIREMENT FOR RECEIPT OF CERTAIN  
23 SERVICES. To the extent permitted under and in a manner that is  
24 consistent with Title XIX, Social Security Act (42 U.S.C. Section  
25 1396 et seq.), and any other applicable law or regulation or under a  
26 federal waiver or other authorization, the executive commissioner  
27 of the Health and Human Services Commission shall adopt and

1 implement in the most cost-effective manner a premium for long-term  
2 care services provided to a child under the medical assistance  
3 program to be paid by the child's parent or other legal guardian.

4 ARTICLE 6. FEDERAL AUTHORIZATION, FUNDING, AND EFFECTIVE DATE

5 SECTION 6.01. If before implementing any provision of this  
6 Act a state agency determines that a waiver or authorization from a  
7 federal agency is necessary for implementation of that provision,  
8 the agency affected by the provision shall request the waiver or  
9 authorization and may delay implementing that provision until the  
10 waiver or authorization is granted.

11 SECTION 6.02. The Health and Human Services Commission may  
12 use any available revenue, including legislative appropriations  
13 and available federal funds, for purposes of implementing any  
14 provision of this Act.

15 SECTION 6.03. This Act takes effect September 1, 2013.