1-1 By: Nelson, Patrick S.B. No. 7
1-2 (In the Senate - Filed January 16, 2013; January 28, 2013,
1-3 read first time and referred to Committee on Health and Human
1-4 Services; March 5, 2013, reported adversely, with favorable
1-5 Committee Substitute by the following vote: Yeas 8, Nays 0;
1-6 March 5, 2013, sent to printer.)

1-7 COMMITTEE VOTE

1-8		Yea	Nay	Absent	PNV
1-9	Nelson	X			
1-10	Deuell	X			
1-11	Huffman	X			
1-12	Nichols	X			
1-13	Schwertner	X			
1-14	Taylor	X			
1-15	Uresti	X			
1-16	West			X	
1-17	Zaffirini	X			

1-18 COMMITTEE SUBSTITUTE FOR S.B. No. 7 By: Nelson

1-19 A BILL TO BE ENTITLED
1-20 AN ACT

1-21 relating to improving the delivery and quality of certain health
1-22 and human services, including the delivery and quality of Medicaid
1-23 acute care services and long-term services and supports.
1-24 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-25 ARTICLE 1. DELIVERY SYSTEM REDESIGN FOR THE PROVISION OF ACUTE CARE
1-26 SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH
1-27 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
1-28 SECTION 1.01. Subtitle I, Title 4, Government Code, is
1-29 amended by adding Chapter 534 to read as follows:
1-30 CHAPTER 534. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE
1-31 SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO PERSONS WITH
1-32 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
1-33 SUBCHAPTER A. GENERAL PROVISIONS
1-34 Sec. 534.001. DEFINITIONS. In this chapter:
1-35 (1) "Advisory committee" means the Intellectual and
1-36 Developmental Disability System Redesign Advisory Committee
1-37 established under Section 534.053.
1-38 (2) "Basic attendant services" means assistance with
1-39 the activities of daily living, including instrumental activities
1-40 of daily living, provided to an individual because of a physical,
1-41 cognitive, or behavioral limitation related to the individual's
1-42 disability or chronic health condition.
1-43 (3) "Department" means the Department of Aging and
1-44 Disability Services.
1-45 (4) "Habilitation services" includes assistance
1-46 provided to an individual with acquiring, retaining, or improving:
1-47 (A) skills related to the activities of daily
1-48 living; and
1-49 (B) the social and adaptive skills necessary to
1-50 enable the individual to live and fully participate in the
1-51 community.
1-52 (5) "ICF-IID" means the Medicaid program serving
1-53 individuals with intellectual and developmental disabilities who
1-54 receive care in intermediate care facilities other than a state
1-55 supported living center.
1-56 (6) "ICF-IID program" means a program under the
1-57 Medicaid program serving individuals with intellectual and
1-58 developmental disabilities who reside in and receive care from:
1-59 (A) intermediate care facilities licensed under
1-60 Chapter 252, Health and Safety Code; or

2-1 (B) community-based intermediate care facilities
2-2 operated by local intellectual and developmental disability
2-3 authorities.
2-4 (7) "Local intellectual and developmental disability
2-5 authority" means a local mental retardation authority described by
2-6 Section 533.035, Health and Safety Code.
2-7 (8) "Managed care organization," "managed care plan,"
2-8 and "potentially preventable event" have the meanings assigned
2-9 under Section 536.001.
2-10 (9) "Medicaid program" means the medical assistance
2-11 program established under Chapter 32, Human Resources Code.
2-12 (10) "Medicaid waiver program" means only the
2-13 following programs that are authorized under Section 1915(c) of the
2-14 federal Social Security Act (42 U.S.C. Section 1396n(c)) for the
2-15 provision of services to persons with intellectual and
2-16 developmental disabilities:
2-17 (A) the community living assistance and support
2-18 services (CLASS) waiver program;
2-19 (B) the home and community-based services (HCS)
2-20 waiver program;
2-21 (C) the deaf-blind with multiple disabilities
2-22 (DBMD) waiver program; and
2-23 (D) the Texas home living (TxHmL) waiver program.
2-24 (11) "State supported living center" has the meaning
2-25 assigned by Section 531.002, Health and Safety Code.
2-26 Sec. 534.002. CONFLICT WITH OTHER LAW. To the extent of a
2-27 conflict between a provision of this chapter and another state law,
2-28 the provision of this chapter controls.
2-29 SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND
2-30 SUPPORTS SYSTEM
2-31 Sec. 534.051. ACUTE CARE SERVICES AND LONG-TERM SERVICES
2-32 AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH INTELLECTUAL AND
2-33 DEVELOPMENTAL DISABILITIES. In accordance with this chapter, the
2-34 commission and the department shall jointly design and implement an
2-35 acute care services and long-term services and supports system for
2-36 individuals with intellectual and developmental disabilities that
2-37 supports the following goals:
2-38 (1) provide Medicaid services to more individuals in a
2-39 cost-efficient manner by providing the type and amount of services
2-40 most appropriate to the individuals' needs;
2-41 (2) improve individuals' access to services and
2-42 supports by ensuring that the individuals receive information about
2-43 all available programs and services, including employment and least
2-44 restrictive housing assistance, and how to apply for the programs
2-45 and services;
2-46 (3) improve the assessment of individuals' needs and
2-47 available supports;
2-48 (4) promote person-centered planning, self-direction,
2-49 self-determination, community inclusion, and customized gainful
2-50 employment;
2-51 (5) promote individualized budgeting based on an
2-52 assessment of an individual's needs and person-centered planning;
2-53 (6) promote integrated service coordination of acute
2-54 care services and long-term services and supports;
2-55 (7) improve acute care and long-term services and
2-56 supports outcomes, including reducing unnecessary
2-57 institutionalization and potentially preventable events;
2-58 (8) promote high-quality care;
2-59 (9) provide fair hearing and appeals processes in
2-60 accordance with applicable federal law; and
2-61 (10) ensure the availability of a local safety net
2-62 provider and local safety net services.
2-63 Sec. 534.052. IMPLEMENTATION OF SYSTEM REDESIGN. The
2-64 commission and department shall, in consultation with the advisory
2-65 committee, jointly implement the acute care services and long-term
2-66 services and supports system for individuals with intellectual and
2-67 developmental disabilities in the manner and in the stages
2-68 described in this chapter.
2-69 Sec. 534.053. INTELLECTUAL AND DEVELOPMENTAL DISABILITY

3-1 SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The Intellectual and
3-2 Developmental Disability System Redesign Advisory Committee is
3-3 established to advise the commission and the department on the
3-4 implementation of the acute care services and long-term services
3-5 and supports system redesign under this chapter. Subject to
3-6 Subsection (b), the executive commissioner and the commissioner of
3-7 the department shall jointly appoint members of the advisory
3-8 committee who are stakeholders from the intellectual and
3-9 developmental disabilities community, including:
3-10 (1) individuals with intellectual and developmental
3-11 disabilities who are recipients of Medicaid waiver program services
3-12 or individuals who are advocates of those recipients;
3-13 (2) representatives of health care providers
3-14 participating in a Medicaid managed care program, including:
3-15 (A) physicians who are primary care providers and
3-16 physicians who are specialty care providers;
3-17 (B) nonphysician mental health professionals;
3-18 and
3-19 (C) providers of long-term services and
3-20 supports, including direct service workers;
3-21 (3) representatives of entities with responsibilities
3-22 for the delivery of Medicaid long-term services and supports or
3-23 other Medicaid program service delivery, including:
3-24 (A) independent living centers;
3-25 (B) area agencies on aging;
3-26 (C) aging and disability resource centers
3-27 established under the Aging and Disability Resource Center
3-28 initiative funded in part by the federal Administration on Aging
3-29 and the Centers for Medicare and Medicaid Services;
3-30 (D) community mental health and intellectual
3-31 disability centers; and
3-32 (E) the NorthSTAR Behavioral Health Program
3-33 provided under Chapter 534, Health and Safety Code; and
3-34 (4) representatives of managed care organizations
3-35 contracting with the state to provide services to individuals with
3-36 intellectual and developmental disabilities.
3-37 (b) To the greatest extent possible, the executive
3-38 commissioner and the commissioner of the department shall appoint
3-39 members of the advisory committee who reflect the geographic
3-40 diversity of the state and include members who represent rural
3-41 Medicaid program recipients.
3-42 (c) The executive commissioner shall appoint the presiding
3-43 officer of the advisory committee.
3-44 (d) The advisory committee must meet at least quarterly or
3-45 more frequently if the presiding officer determines that it is
3-46 necessary to address planning and development needs related to
3-47 implementation of the acute care services and long-term services
3-48 and supports system.
3-49 (e) A member of the advisory committee serves without
3-50 compensation. A member of the advisory committee who is a Medicaid
3-51 program recipient or the relative of a Medicaid program recipient
3-52 is entitled to a per diem allowance and reimbursement at rates
3-53 established in the General Appropriations Act.
3-54 (f) The advisory committee is subject to the requirements of
3-55 Chapter 551.
3-56 (g) On January 1, 2024:
3-57 (1) the advisory committee is abolished; and
3-58 (2) this section expires.
3-59 Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not
3-60 later than December 1 of each year, the commission shall submit a
3-61 report to the legislature regarding:
3-62 (1) the implementation of the system required by this
3-63 chapter, including appropriate information regarding the provision
3-64 of acute care services and long-term services and supports to
3-65 individuals with intellectual and developmental disabilities under
3-66 the Medicaid program; and
3-67 (2) recommendations, including recommendations
3-68 regarding appropriate statutory changes to facilitate the
3-69 implementation.

4-1 (b) This section expires January 1, 2024.
4-2 SUBCHAPTER C. STAGE ONE: PROGRAMS TO IMPROVE SERVICE
4-3 DELIVERY MODELS
4-4 Sec. 534.101. DEFINITIONS. In this subchapter:
4-5 (1) "Capitation" means a method of compensating a
4-6 provider on a monthly basis for providing or coordinating the
4-7 provision of a defined set of services and supports that is based on
4-8 a predetermined payment per services recipient.
4-9 (2) "Provider" means a person with whom the commission
4-10 contracts for the provision of long-term services and supports
4-11 under the Medicaid program to a specific population based on
4-12 capitation.
4-13 Sec. 534.102. PILOT PROGRAMS TO TEST MANAGED CARE
4-14 STRATEGIES BASED ON CAPITATION. The commission and the department
4-15 may develop and implement pilot programs in accordance with this
4-16 subchapter to test one or more service delivery models involving a
4-17 managed care strategy based on capitation to deliver long-term
4-18 services and supports under the Medicaid program to individuals
4-19 with intellectual and developmental disabilities.
4-20 Sec. 534.103. STAKEHOLDER INPUT. As part of developing and
4-21 implementing a pilot program under this subchapter, the department
4-22 shall develop a process to receive and evaluate input from
4-23 statewide stakeholders and stakeholders from the region of the
4-24 state in which the pilot program will be implemented.
4-25 Sec. 534.104. MANAGED CARE STRATEGY PROPOSALS; PILOT
4-26 PROGRAM SERVICE PROVIDERS. (a) The department shall identify
4-27 private services providers that are good candidates to develop a
4-28 service delivery model involving a managed care strategy based on
4-29 capitation and to test the model in the provision of long-term
4-30 services and supports under the Medicaid program to individuals
4-31 with intellectual and developmental disabilities through a pilot
4-32 program established under this subchapter.
4-33 (b) The department shall solicit managed care strategy
4-34 proposals from the private services providers identified under
4-35 Subsection (a).
4-36 (c) A managed care strategy based on capitation developed
4-37 for implementation through a pilot program under this subchapter
4-38 must be designed to:
4-39 (1) increase access to long-term services and
4-40 supports;
4-41 (2) improve quality of acute care services and
4-42 long-term services and supports;
4-43 (3) promote meaningful outcomes by using
4-44 person-centered planning, individualized budgeting, and
4-45 self-determination, and promote community inclusion and customized
4-46 gainful employment;
4-47 (4) promote integrated service coordination of acute
4-48 care services and long-term services and supports;
4-49 (5) promote efficiency and the best use of funding;
4-50 (6) promote the placement of an individual in housing
4-51 that is the least restrictive setting appropriate to the
4-52 individual's needs;
4-53 (7) promote employment assistance and supported
4-54 employment;
4-55 (8) provide fair hearing and appeals processes in
4-56 accordance with applicable federal law; and
4-57 (9) promote sufficient flexibility to achieve the
4-58 goals listed in this section through the pilot program.
4-59 (d) The department, in consultation with the advisory
4-60 committee, shall evaluate each submitted managed care strategy
4-61 proposal and determine whether:
4-62 (1) the proposed strategy satisfies the requirements
4-63 of this section; and
4-64 (2) the private services provider that submitted the
4-65 proposal has a demonstrated ability to provide the long-term
4-66 services and supports appropriate to the individuals who will
4-67 receive services through the pilot program based on the proposed
4-68 strategy, if implemented.
4-69 (e) Based on the evaluation performed under Subsection (d),

5-1 the department may select as pilot program service providers one or
5-2 more private services providers.
5-3 (f) For each pilot program service provider, the department
5-4 shall develop and implement a pilot program. Under a pilot program,
5-5 the pilot program service provider shall provide long-term services
5-6 and supports under the Medicaid program to persons with
5-7 intellectual and developmental disabilities to test its managed
5-8 care strategy based on capitation.
5-9 (g) The department shall analyze information provided by
5-10 the pilot program service providers and any information collected
5-11 by the department during the operation of the pilot programs for
5-12 purposes of making a recommendation about a system of programs and
5-13 services for implementation through future state legislation or
5-14 rules.
5-15 Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS. (a) The
5-16 department, in consultation with the advisory committee, shall
5-17 identify measurable goals to be achieved by each pilot program
5-18 implemented under this subchapter. The identified goals must:
5-19 (1) align with information that will be collected
5-20 under Section 534.108(a); and
5-21 (2) be designed to improve the quality of outcomes for
5-22 individuals receiving services through the pilot program.
5-23 (b) The department, in consultation with the advisory
5-24 committee, shall propose specific strategies for achieving the
5-25 identified goals. A proposed strategy may be evidence-based if
5-26 there is an evidence-based strategy available for meeting the pilot
5-27 program's goals.
5-28 Sec. 534.106. IMPLEMENTATION, LOCATION, AND DURATION.
5-29 (a) The commission and the department shall implement any pilot
5-30 programs established under this subchapter not later than September
5-31 1, 2016.
5-32 (b) A pilot program established under this subchapter must
5-33 operate for not less than 24 months, except that a pilot program may
5-34 cease operation before the expiration of 24 months if the pilot
5-35 program service provider terminates the contract with the
5-36 commission before the agreed-to termination date.
5-37 (c) A pilot program established under this subchapter shall
5-38 be conducted in one or more regions selected by the department.
5-39 Sec. 534.107. COORDINATING SERVICES. In providing
5-40 long-term services and supports under the Medicaid program to an
5-41 individual with intellectual or developmental disabilities, a
5-42 pilot program service provider shall:
5-43 (1) coordinate through the pilot program
5-44 institutional and community-based services available to the
5-45 individual, including services provided through:
5-46 (A) a facility licensed under Chapter 252, Health
5-47 and Safety Code;
5-48 (B) a Medicaid waiver program; or
5-49 (C) a community-based ICF-IID operated by local
5-50 authorities;
5-51 (2) collaborate with managed care organizations to
5-52 provide integrated coordination of acute care services and
5-53 long-term services and supports, including discharge planning from
5-54 acute care services to community-based long-term services and
5-55 supports;
5-56 (3) have a process for preventing inappropriate
5-57 institutionalizations of individuals; and
5-58 (4) accept the risk of inappropriate
5-59 institutionalizations of individuals previously residing in
5-60 community settings.
5-61 Sec. 534.108. PILOT PROGRAM INFORMATION. (a) The
5-62 commission and the department shall collect and compute the
5-63 following information with respect to each pilot program
5-64 implemented under this subchapter to the extent it is available:
5-65 (1) the difference between the average monthly cost
5-66 per person for all acute care services and long-term services and
5-67 supports received by individuals participating in the pilot program
5-68 while the program is operating, including services provided through
5-69 the pilot program and other services with which pilot program

6-1 services are coordinated as described by Section 534.107, and the
6-2 average cost per person for all services received by the
6-3 individuals before the operation of the pilot program;
6-4 (2) the percentage of individuals receiving services
6-5 through the pilot program who begin receiving services in a
6-6 nonresidential setting instead of from a facility licensed under
6-7 Chapter 252, Health and Safety Code, or any other residential
6-8 setting;
6-9 (3) the difference between the percentage of
6-10 individuals receiving services through the pilot program who live
6-11 in non-provider-owned housing during the operation of the pilot
6-12 program and the percentage of individuals receiving services
6-13 through the pilot program who lived in non-provider-owned housing
6-14 before the operation of the pilot program;
6-15 (4) the difference between the average total Medicaid
6-16 cost, by level of need, for individuals in various residential
6-17 settings receiving services through the pilot program during the
6-18 operation of the program and the average total Medicaid cost, by
6-19 level of need, for those individuals before the operation of the
6-20 program;
6-21 (5) the difference between the percentage of
6-22 individuals receiving services through the pilot program who obtain
6-23 and maintain employment in meaningful, integrated settings during
6-24 the operation of the program and the percentage of individuals
6-25 receiving services through the program who obtained and maintained
6-26 employment in meaningful, integrated settings before the operation
6-27 of the program;
6-28 (6) the difference between the percentage of
6-29 individuals receiving services through the pilot program whose
6-30 behavioral, medical, life-activity, and other personal outcomes
6-31 have improved since the beginning of the program and the percentage
6-32 of individuals receiving services through the program whose
6-33 behavioral, medical, life-activity, and other personal outcomes
6-34 improved before the operation of the program, as measured over a
6-35 comparable period; and
6-36 (7) a comparison of the overall client satisfaction
6-37 with services received through the pilot program, including for
6-38 individuals who leave the program after a determination is made in
6-39 the individuals' cases at hearings or on appeal, and the overall
6-40 client satisfaction with services received before the individuals
6-41 entered the pilot program.
6-42 (b) The pilot program service provider shall collect any
6-43 information described by Subsection (a) that is available to the
6-44 provider and provide the information to the department and the
6-45 commission not later than the 30th day before the date the program's
6-46 operation concludes.
6-47 (c) In addition to the information described by Subsection
6-48 (a), the pilot program service provider shall collect any
6-49 information specified by the department for use by the department
6-50 in making an evaluation under Section 534.104(g).
6-51 (d) On or before December 1, 2016, and December 1, 2017, the
6-52 commission and the department, in consultation with the advisory
6-53 committee, shall review and evaluate the progress and outcomes of
6-54 each pilot program implemented under this subchapter and submit a
6-55 report to the legislature during the operation of the pilot
6-56 programs. Each report must include recommendations for program
6-57 improvement and continued implementation.
6-58 Sec. 534.109. PERSON-CENTERED PLANNING. The commission, in
6-59 cooperation with the department, shall ensure that each individual
6-60 with intellectual or developmental disabilities who receives
6-61 services and supports under the Medicaid program through a pilot
6-62 program established under this subchapter, or the individual's
6-63 legally authorized representative, has access to a facilitated,
6-64 person-centered plan that identifies outcomes for the individual
6-65 and drives the development of the individualized budget. The
6-66 consumer direction model, as defined by Section 531.051, may be an
6-67 outcome of the plan.
6-68 Sec. 534.110. TRANSITION BETWEEN PROGRAMS. The commission
6-69 shall ensure that there is a comprehensive plan for transitioning

7-1 the provision of Medicaid program benefits between a Medicaid
7-2 waiver program and a pilot program under this subchapter to protect
7-3 continuity of care.
7-4 Sec. 534.111. CONCLUSION OF PILOT PROGRAMS; EXPIRATION. On
7-5 September 1, 2018:
7-6 (1) each pilot program established under this
7-7 subchapter that is still in operation must conclude; and
7-8 (2) this subchapter expires.
7-9 SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND
7-10 CERTAIN OTHER SERVICES
7-11 Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR
7-12 INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. The
7-13 commission shall provide acute care Medicaid program benefits to
7-14 individuals with intellectual and developmental disabilities
7-15 through the STAR + PLUS Medicaid managed care program or the most
7-16 appropriate integrated capitated managed care program delivery
7-17 model.
7-18 Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR
7-19 + PLUS AND STAR KIDS MEDICAID MANAGED CARE PROGRAMS. The commission
7-20 shall implement the most cost-effective option for the delivery of
7-21 basic attendant and habilitation services for individuals with
7-22 intellectual and developmental disabilities under the STAR + PLUS
7-23 and STAR Kids Medicaid managed care programs that maximizes federal
7-24 funding for the delivery of services across those and other similar
7-25 programs.
7-26 SUBCHAPTER E. STAGE TWO: TRANSITION OF LONG-TERM CARE MEDICAID
7-27 WAIVER PROGRAM RECIPIENTS TO INTEGRATED MANAGED CARE SYSTEM
7-28 Sec. 534.201. TRANSITION OF RECIPIENTS UNDER TEXAS HOME
7-29 LIVING (TxHmL) WAIVER PROGRAM TO MANAGED CARE PROGRAM. (a) This
7-30 section applies to individuals with intellectual and developmental
7-31 disabilities who are receiving long-term services and supports
7-32 under the Texas home living (TxHmL) waiver program on the date the
7-33 commission implements the transition described by Subsection (b).
7-34 (b) Not later than September 1, 2017, the commission shall
7-35 transition the provision of Medicaid program benefits to
7-36 individuals to whom this section applies to the STAR + PLUS Medicaid
7-37 managed care program delivery model or the most appropriate
7-38 integrated capitated managed care program delivery model, as
7-39 determined by the commission based on cost-effectiveness and the
7-40 experience of the STAR + PLUS Medicaid managed care program in
7-41 providing basic attendant and habilitation services and of the
7-42 pilot programs established under Subchapter C, subject to
7-43 Subsection (c)(1).
7-44 (c) At the time of the transition described by Subsection
7-45 (b), the commission shall determine whether to:
7-46 (1) continue operation of the Texas home living
7-47 (TxHmL) waiver program for purposes of providing supplemental
7-48 long-term services and supports not available under the managed
7-49 care program delivery model selected by the commission; or
7-50 (2) provide all or a portion of the long-term services
7-51 and supports previously available under the Texas home living
7-52 (TxHmL) waiver program through the managed care program delivery
7-53 model selected by the commission.
7-54 (d) In implementing the transition described by Subsection
7-55 (b), the commission shall develop a process to receive and evaluate
7-56 input from interested statewide stakeholders that is in addition to
7-57 the input provided by the advisory committee.
7-58 (e) The commission shall ensure that there is a
7-59 comprehensive plan for transitioning the provision of Medicaid
7-60 program benefits under this section that protects the continuity of
7-61 care provided to individuals to whom this section applies.
7-62 Sec. 534.202. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND
7-63 CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE
7-64 PROGRAM. (a) This section applies to individuals with
7-65 intellectual and developmental disabilities who, on the date the
7-66 commission implements the transition described by Subsection (b),
7-67 are receiving long-term services and supports under:
7-68 (1) a Medicaid waiver program other than the Texas
7-69 home living (TxHmL) waiver program; or

8-1 (2) an ICF-IID program.
8-2 (b) After implementing the transition required by Section
8-3 534.201 but not later than September 1, 2020, the commission shall
8-4 transition the provision of Medicaid program benefits to
8-5 individuals to whom this section applies to the STAR + PLUS Medicaid
8-6 managed care program delivery model or the most appropriate
8-7 integrated capitated managed care program delivery model, as
8-8 determined by the commission based on cost-effectiveness and the
8-9 experience of the transition of Texas home living (TxHmL) waiver
8-10 program recipients to a managed care program delivery model under
8-11 Section 534.201, subject to Subsection (c)(1).
8-12 (c) At the time of the transition described by Subsection
8-13 (b), the commission shall determine whether to:
8-14 (1) continue operation of the Medicaid waiver programs
8-15 or Medicaid ICF-IID program for purposes of providing supplemental
8-16 long-term services and supports not available under the managed
8-17 care program delivery model selected by the commission; or
8-18 (2) provide all or a portion of the long-term services
8-19 and supports previously available under the Medicaid waiver
8-20 programs or Medicaid ICF-IID program through the managed care
8-21 program delivery model selected by the commission.
8-22 (d) In implementing the transition described by Subsection
8-23 (b), the commission shall develop a process to receive and evaluate
8-24 input from interested statewide stakeholders that is in addition to
8-25 the input provided by the advisory committee.
8-26 (e) The commission shall ensure that there is a
8-27 comprehensive plan for transitioning the provision of Medicaid
8-28 program benefits under this section that protects the continuity of
8-29 care provided to individuals to whom this section applies.
8-30 (f) Before transitioning the provision of Medicaid program
8-31 benefits for children under this section, a managed care
8-32 organization providing services under the managed care program
8-33 delivery model selected by the commission must demonstrate to the
8-34 satisfaction of the commission that the organization's network of
8-35 providers has experience and expertise in the provision of services
8-36 to children with intellectual and developmental disabilities.
8-37 SECTION 1.02. Not later than October 1, 2013, the executive
8-38 commissioner of the Health and Human Services Commission and the
8-39 commissioner of the Department of Aging and Disability Services
8-40 shall appoint the members of the Intellectual and Developmental
8-41 Disability System Redesign Advisory Committee as required by
8-42 Section 534.053, Government Code, as added by this article.
8-43 SECTION 1.03. The Health and Human Services Commission
8-44 shall submit:
8-45 (1) the initial report on the implementation of the
8-46 acute care services and long-term services and supports system for
8-47 individuals with intellectual and developmental disabilities as
8-48 required by Section 534.054, Government Code, as added by this
8-49 article, not later than December 1, 2014; and
8-50 (2) the final report under that section not later than
8-51 December 1, 2023.
8-52 SECTION 1.04. Not later than June 1, 2016, the Health and
8-53 Human Services Commission shall submit a report to the legislature
8-54 regarding the commission's experience in, including the
8-55 cost-effectiveness of, delivering basic attendant and habilitation
8-56 services for individuals with intellectual and developmental
8-57 disabilities under the STAR + PLUS and STAR Kids Medicaid managed
8-58 care programs under Section 534.152, Government Code, as added by
8-59 this article.
8-60 SECTION 1.05. The Health and Human Services Commission and
8-61 the Department of Aging and Disability Services shall implement any
8-62 pilot program to be established under Subchapter C, Chapter 534,
8-63 Government Code, as added by this article, as soon as practicable
8-64 after the effective date of this Act.
8-65 SECTION 1.06. (a) The Health and Human Services Commission
8-66 and the Department of Aging and Disability Services shall:
8-67 (1) in consultation with the Intellectual and
8-68 Developmental Disability System Redesign Advisory Committee
8-69 established under Section 534.053, Government Code, as added by

9-1 this article, review and evaluate the outcomes of:
9-2 (A) the transition of the provision of benefits
9-3 to individuals under the Texas home living (TxHmL) waiver program
9-4 to a managed care program delivery model under Section 534.201,
9-5 Government Code, as added by this article; and
9-6 (B) the transition of the provision of benefits
9-7 to individuals under the Medicaid waiver programs, other than the
9-8 Texas home living (TxHmL) waiver program, and the ICF-IID program
9-9 to a managed care program delivery model under Section 534.202,
9-10 Government Code, as added by this article; and
9-11 (2) submit as part of an annual report required by
9-12 Section 534.054, Government Code, as added by this article, due on
9-13 or before December 1 of 2018, 2019, and 2020, a report on the review
9-14 and evaluation conducted under Paragraphs (A) and (B), Subdivision
9-15 (1), of this subsection that includes recommendations for continued
9-16 implementation of and improvements to the acute care and long-term
9-17 services and supports system under Chapter 534, Government Code, as
9-18 added by this article.
9-19 (b) This section expires September 1, 2024.
9-20 ARTICLE 2. MEDICAID MANAGED CARE EXPANSION
9-21 SECTION 2.01. Section 533.0025, Government Code, is amended
9-22 by amending Subsections (a) and (b) and adding Subsections (f),
9-23 (g), and (h) to read as follows:
9-24 (a) In this section and Sections 533.00251, 533.00252, and
9-25 533.00253, "medical assistance" has the meaning assigned by Section
9-26 32.003, Human Resources Code.
9-27 (b) Notwithstanding [~~Except as otherwise provided by this~~
9-28 ~~section and notwithstanding~~] any other law, the commission shall
9-29 provide medical assistance for acute care services through the most
9-30 cost-effective model of Medicaid capitated managed care as
9-31 determined by the commission. The [~~If the~~] commission shall
9-32 require mandatory participation in a Medicaid capitated managed
9-33 care program for all persons eligible for acute care [~~determines~~
9-34 ~~that it is more cost-effective, the commission may provide~~] medical
9-35 assistance benefits [~~for acute care in a certain part of this state~~
9-36 ~~or to a certain population of recipients using:~~
9-37 [~~(1) a health maintenance organization model,~~
9-38 ~~including the acute care portion of Medicaid Star + Plus pilot~~
9-39 ~~programs;~~
9-40 [~~(2) a primary care case management model;~~
9-41 [~~(3) a prepaid health plan model;~~
9-42 [~~(4) an exclusive provider organization model; or~~
9-43 [~~(5) another Medicaid managed care model or~~
9-44 ~~arrangement~~].
9-45 (f) The commission shall:
9-46 (1) conduct a study to evaluate the feasibility of
9-47 automatically enrolling applicants determined eligible for
9-48 benefits under the medical assistance program in a Medicaid managed
9-49 care plan; and
9-50 (2) report the results of the study to the legislature
9-51 not later than December 1, 2014.
9-52 (g) Subsection (f) and this subsection expire September 1,
9-53 2015.
9-54 (h) If the commission determines that it is feasible, the
9-55 commission may, notwithstanding any other law, implement an
9-56 automatic enrollment process under which applicants determined
9-57 eligible for medical assistance benefits are automatically
9-58 enrolled in a Medicaid managed care plan. The commission may elect
9-59 to implement the automatic enrollment process as to certain
9-60 populations of recipients under the medical assistance program.
9-61 SECTION 2.02. Subchapter A, Chapter 533, Government Code,
9-62 is amended by adding Sections 533.00251, 533.00252, and 533.00253
9-63 to read as follows:
9-64 Sec. 533.00251. DELIVERY OF NURSING FACILITY BENEFITS
9-65 THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this
9-66 section and Section 533.00252:
9-67 (1) "Advisory committee" means the STAR + PLUS Nursing
9-68 Facility Advisory Committee established under Section 533.00252.
9-69 (2) "Nursing facility" means a convalescent or nursing

10-1 home or related institution licensed under Chapter 242, Health and
10-2 Safety Code, that provides long-term services and supports to
10-3 Medicaid recipients.
10-4 (3) "Potentially preventable event" has the meaning
10-5 assigned by Section 536.001.
10-6 (b) The commission shall expand the STAR + PLUS Medicaid
10-7 managed care program to all areas of this state to serve individuals
10-8 eligible for acute care services and long-term services and
10-9 supports under the medical assistance program.
10-10 (c) Notwithstanding any other law, the commission, in
10-11 consultation with the advisory committee, shall provide benefits
10-12 under the medical assistance program to recipients who reside in
10-13 nursing facilities through the STAR + PLUS Medicaid managed care
10-14 program. In implementing this subsection, the commission shall
10-15 ensure:
10-16 (1) that the commission is responsible for setting the
10-17 minimum reimbursement rate paid to a nursing facility under the
10-18 managed care program, including the staff rate enhancement paid to
10-19 a nursing facility that qualifies for the enhancement;
10-20 (2) that a nursing facility is paid not later than the
10-21 10th day after the date the facility submits a clean claim;
10-22 (3) the appropriate utilization of services;
10-23 (4) a reduction in the incidence of potentially
10-24 preventable events and unnecessary institutionalizations;
10-25 (5) that a managed care organization providing
10-26 services under the managed care program provides discharge
10-27 planning, transitional care, and other education programs to
10-28 physicians and hospitals regarding all available long-term care
10-29 settings;
10-30 (6) that a managed care organization providing
10-31 services under the managed care program provides payment incentives
10-32 to nursing facility providers that reward reductions in preventable
10-33 acute care costs and encourage transformative efforts in the
10-34 delivery of nursing facility services, including efforts to promote
10-35 a resident-centered care culture through facility design and
10-36 services provided; and
10-37 (7) the establishment of a single portal through which
10-38 nursing facility providers participating in the STAR + PLUS
10-39 Medicaid managed care program may submit claims to any
10-40 participating managed care organization.
10-41 (d) Subject to Subsection (e), the commission shall ensure
10-42 that a nursing facility provider authorized to provide services
10-43 under the medical assistance program on September 1, 2013, is
10-44 allowed to participate in the STAR + PLUS Medicaid managed care
10-45 program through August 31, 2016. This subsection expires September
10-46 1, 2017.
10-47 (e) The commission shall establish credentialing and
10-48 minimum performance standards for nursing facility providers
10-49 seeking to participate in the STAR + PLUS Medicaid managed care
10-50 program. A managed care organization may refuse to contract with a
10-51 nursing facility provider if the nursing facility does not meet the
10-52 minimum performance standards established by the commission under
10-53 this section.
10-54 Sec. 533.00252. STAR + PLUS NURSING FACILITY ADVISORY
10-55 COMMITTEE. (a) The STAR + PLUS Nursing Facility Advisory
10-56 Committee is established to advise the commission on the
10-57 implementation of and other activities related to the provision of
10-58 medical assistance benefits to recipients who reside in nursing
10-59 facilities through the STAR + PLUS Medicaid managed care program
10-60 under Section 533.00251, including advising the commission
10-61 regarding its duties with respect to:
10-62 (1) developing quality-based outcomes and process
10-63 measures for long-term services and supports provided in nursing
10-64 facilities;
10-65 (2) developing quality-based long-term care payment
10-66 systems and quality initiatives for nursing facilities;
10-67 (3) transparency of information received from managed
10-68 care organizations;
10-69 (4) the reporting of outcome and process measures;

11-1 (5) the sharing of data among health and human
11-2 services agencies; and
11-3 (6) patient care coordination, quality of care
11-4 improvement, and cost savings.
11-5 (b) The executive commissioner shall appoint the members of
11-6 the advisory committee. The committee must consist of nursing
11-7 facility providers, representatives of managed care organizations,
11-8 and other stakeholders interested in nursing facility services
11-9 provided in this state, including:
11-10 (1) at least one member who is a nursing facility
11-11 provider with experience providing the long-term continuum of care,
11-12 including home care and hospice;
11-13 (2) at least one member who is a nonprofit nursing
11-14 facility provider;
11-15 (3) at least one member who is a for-profit nursing
11-16 facility provider;
11-17 (4) at least one member who is a consumer
11-18 representative; and
11-19 (5) at least one member who is from a managed care
11-20 organization providing services as provided by Section 533.00251.
11-21 (c) The executive commissioner shall appoint the presiding
11-22 officer of the advisory committee.
11-23 (d) A member of the advisory committee serves without
11-24 compensation.
11-25 (e) The advisory committee is subject to the requirements of
11-26 Chapter 551.
11-27 (f) On September 1, 2016:
11-28 (1) the advisory committee is abolished; and
11-29 (2) this section expires.
11-30 Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM.
11-31 (a) In this section:
11-32 (1) "Health home" means a primary care provider
11-33 practice, or, if appropriate, a specialty care provider practice,
11-34 incorporating several features, including comprehensive care
11-35 coordination, family-centered care, and data management, that are
11-36 focused on improving outcome-based quality of care and increasing
11-37 patient and provider satisfaction under the medical assistance
11-38 program.
11-39 (2) "Potentially preventable event" has the meaning
11-40 assigned by Section 536.001.
11-41 (b) The commission shall establish a mandatory STAR Kids
11-42 capitated managed care program tailored to provide medical
11-43 assistance benefits to children with disabilities. The managed
11-44 care program developed under this section must:
11-45 (1) provide medical assistance benefits that are
11-46 customized to meet the health care needs of recipients under the
11-47 program through a defined system of care, including benefits
11-48 described under Section 534.152;
11-49 (2) better coordinate care of recipients under the
11-50 program;
11-51 (3) improve the health outcomes of recipients;
11-52 (4) improve recipients' access to health care
11-53 services;
11-54 (5) achieve cost containment and cost efficiency;
11-55 (6) reduce the administrative complexity of
11-56 delivering medical assistance benefits;
11-57 (7) reduce the incidence of unnecessary
11-58 institutionalizations and potentially preventable events by
11-59 ensuring the availability of appropriate services and care
11-60 management;
11-61 (8) require a health home;
11-62 (9) coordinate and collaborate with long-term care
11-63 service providers and long-term care management providers, if
11-64 recipients are receiving long-term services and supports outside of
11-65 the managed care organization; and
11-66 (10) coordinate services provided to children also
11-67 receiving services under Section 534.152.
11-68 (c) The commission shall provide medical assistance
11-69 benefits through the STAR Kids managed care program established

12-1 under this section to children who are receiving benefits under the
12-2 medically dependent children (MDCP) waiver program. The commission
12-3 shall ensure that the STAR Kids managed care program provides all or
12-4 a portion of the benefits provided under the medically dependent
12-5 children (MDCP) waiver program to the extent necessary to implement
12-6 this subsection.
12-7 (d) The commission shall ensure that there is a plan for
12-8 transitioning the provision of Medicaid program benefits to
12-9 recipients 21 years of age or older from under the STAR Kids program
12-10 to under the STAR + PLUS Medicaid managed care program that protects
12-11 continuity of care. The plan must ensure that coordination between
12-12 the programs begins when a recipient reaches 18 years of age.
12-13 SECTION 2.03. Section 32.0212, Human Resources Code, is
12-14 amended to read as follows:
12-15 Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE.
12-16 Notwithstanding any other law [~~and subject to Section 533.0025,~~
12-17 ~~Government Code~~], the department shall provide medical assistance
12-18 for acute care services through the Medicaid managed care system
12-19 implemented under Chapter 533, Government Code, or another Medicaid
12-20 capitated managed care program.
12-21 SECTION 2.04. Subsections (c) and (d), Section 533.0025,
12-22 Government Code, and Subchapter D, Chapter 533, Government Code,
12-23 are repealed.
12-24 SECTION 2.05. (a) The Health and Human Services Commission
12-25 and the Department of Aging and Disability Services shall:
12-26 (1) review and evaluate the outcomes of the transition
12-27 of the provision of benefits to recipients under the medically
12-28 dependent children (MDCP) waiver program to the STAR Kids managed
12-29 care program delivery model established under Section 533.00253,
12-30 Government Code, as added by this article;
12-31 (2) not later than December 1, 2016, submit an initial
12-32 report to the legislature on the review and evaluation conducted
12-33 under Subdivision (1) of this subsection, including
12-34 recommendations for continued implementation and improvement of
12-35 the program; and
12-36 (3) not later than December 1 of each year after 2016
12-37 and until December 1, 2020, submit additional reports that include
12-38 the information described by Subdivision (1) of this subsection.
12-39 (b) This section expires September 1, 2021.
12-40 SECTION 2.06. As soon as practicable after the effective
12-41 date of this Act, the Health and Human Services Commission shall
12-42 provide a single portal through which nursing facility providers
12-43 participating in the STAR + PLUS Medicaid managed care program may
12-44 submit claims in accordance with Subdivision (7), Subsection (c),
12-45 Section 533.00251, Government Code, as added by this article.
12-46 SECTION 2.07. The changes in law made by this article are
12-47 not intended to negatively affect Medicaid recipients' access to
12-48 quality health care. The Health and Human Services Commission, as
12-49 the state agency designated to supervise the administration and
12-50 operation of the Medicaid program and to plan and direct the
12-51 Medicaid program in each state agency that operates a portion of the
12-52 Medicaid program, including directing the Medicaid managed care
12-53 system, shall continue to timely enforce all laws applicable to the
12-54 Medicaid program and the Medicaid managed care system, including
12-55 laws relating to provider network adequacy, the prompt payment of
12-56 claims, and the resolution of patient and provider complaints.
12-57 ARTICLE 3. OTHER PROVISIONS RELATING TO INDIVIDUALS WITH
12-58 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
12-59 SECTION 3.01. Subchapter B, Chapter 533, Health and Safety
12-60 Code, is amended by adding Section 533.0335 to read as follows:
12-61 Sec. 533.0335. COMPREHENSIVE ASSESSMENT AND RESOURCE
12-62 ALLOCATION PROCESS. (a) In this section:
12-63 (1) "Advisory committee" means the Intellectual and
12-64 Developmental Disability System Redesign Advisory Committee
12-65 established under Section 534.053, Government Code.
12-66 (2) "Department" means the Department of Aging and
12-67 Disability Services.
12-68 (3) "Functional need" means the measurement of an
12-69 individual's services and support needs, including the individual's

13-1 intellectual, psychiatric, medical, and physical support needs.
13-2 (4) "Medicaid waiver program" has the meaning assigned
13-3 by Section 534.001, Government Code.
13-4 (b) Subject to the availability of federal funding, the
13-5 department shall develop and implement a comprehensive assessment
13-6 instrument and a resource allocation process. The assessment
13-7 instrument and resource allocation process must be designed to
13-8 recommend for each individual with intellectual and developmental
13-9 disabilities enrolled in a Medicaid waiver program the type,
13-10 intensity, and range of services that are both appropriate and
13-11 available, based on the functional needs of that individual.
13-12 (c) The department, in consultation with the advisory
13-13 committee, shall establish a prior authorization process for
13-14 requests for supervised living or residential support services
13-15 available in the home and community-based services (HCS) Medicaid
13-16 waiver program. The process must ensure that supervised living or
13-17 residential support services available in the home and
13-18 community-based services (HCS) Medicaid waiver program are
13-19 available only to individuals for whom a more independent setting
13-20 is not appropriate or available.
13-21 (d) The department shall cooperate with the advisory
13-22 committee to establish the prior authorization process required by
13-23 Subsection (c). This subsection expires January 1, 2024.
13-24 SECTION 3.02. Subchapter B, Chapter 533, Health and Safety
13-25 Code, is amended by adding Sections 533.03551 and 533.03552 to read
13-26 as follows:
13-27 Sec. 533.03551. FLEXIBLE, LOW-COST HOUSING OPTIONS.
13-28 (a) To the extent permitted under federal law and regulations, the
13-29 executive commissioner shall adopt or amend rules as necessary to
13-30 allow for the development of additional housing supports for
13-31 individuals with intellectual and developmental disabilities in
13-32 urban and rural areas, including:
13-33 (1) a selection of community-based housing options
13-34 that comprise a continuum of integration, varying from most to
13-35 least restrictive, that permits individuals to select the most
13-36 integrated and least restrictive setting appropriate to the
13-37 individual's needs and preferences;
13-38 (2) non-provider-owned residential settings;
13-39 (3) assistance with living more independently; and
13-40 (4) rental properties with on-site supports.
13-41 (b) The Department of Aging and Disability Services, in
13-42 cooperation with the Texas Department of Housing and Community
13-43 Affairs, the Department of Agriculture, the Texas State Affordable
13-44 Housing Corporation, and the Intellectual and Developmental
13-45 Disability System Redesign Advisory Committee, shall coordinate
13-46 with federal, state, and local public housing entities as necessary
13-47 to expand opportunities for accessible, affordable, and integrated
13-48 housing to meet the complex needs of individuals with intellectual
13-49 and developmental disabilities.
13-50 (c) The Department of Aging and Disability Services shall
13-51 develop a process to receive input from statewide stakeholders to
13-52 ensure the most comprehensive review of opportunities and options
13-53 for housing services described by this section.
13-54 Sec. 533.03552. BEHAVIORAL SUPPORTS FOR INDIVIDUALS WITH
13-55 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AT RISK OF
13-56 INSTITUTIONALIZATION; INTERVENTION TEAMS. (a) In this section,
13-57 "department" means the Department of Aging and Disability Services.
13-58 (b) Subject to the availability of federal funding, the
13-59 department shall develop and implement specialized training for
13-60 providers, family members, caregivers, and first responders
13-61 providing direct services and supports to individuals with
13-62 intellectual and developmental disabilities and behavioral health
13-63 needs who are at risk of institutionalization.
13-64 (c) Subject to the availability of federal funding, the
13-65 department shall establish one or more behavioral health
13-66 intervention teams to provide services and supports to individuals
13-67 with intellectual and developmental disabilities and behavioral
13-68 health needs who are at risk of institutionalization. An
13-69 intervention team may include a:

14-1 (1) psychiatrist or psychologist;
14-2 (2) physician;
14-3 (3) registered nurse;
14-4 (4) pharmacist or representative of a pharmacy;
14-5 (5) behavior analyst;
14-6 (6) social worker;
14-7 (7) crisis coordinator;
14-8 (8) peer specialist; and
14-9 (9) family partner.
14-10 (d) In providing services and supports, a behavioral health
14-11 intervention team established by the department shall:
14-12 (1) use the team's best efforts to ensure that an
14-13 individual remains in the community and avoids
14-14 institutionalization;
14-15 (2) focus on stabilizing the individual and assessing
14-16 the individual for intellectual, medical, psychiatric,
14-17 psychological, and other needs;
14-18 (3) provide support to the individual's family members
14-19 and other caregivers;
14-20 (4) provide intensive behavioral assessment and
14-21 training to assist the individual in establishing positive
14-22 behaviors and continuing to live in the community; and
14-23 (5) provide clinical and other referrals.
14-24 (e) The department shall ensure that members of a behavioral
14-25 health intervention team established under this section receive
14-26 training on trauma-informed care, which is an approach to providing
14-27 care to individuals with behavioral health needs based on awareness
14-28 that a history of trauma or the presence of trauma symptoms may
14-29 create the behavioral health needs of the individual.
14-30 SECTION 3.03. (a) The Health and Human Services Commission
14-31 and the Department of Aging and Disability Services shall conduct a
14-32 study to identify crisis intervention programs currently available
14-33 to, evaluate the need for appropriate housing for, and develop
14-34 strategies for serving the needs of persons in this state with
14-35 Prader-Willi syndrome.
14-36 (b) In conducting the study, the Health and Human Services
14-37 Commission and the Department of Aging and Disability Services
14-38 shall seek stakeholder input.
14-39 (c) Not later than December 1, 2014, the Health and Human
14-40 Services Commission shall submit a report to the governor, the
14-41 lieutenant governor, the speaker of the house of representatives,
14-42 and the presiding officers of the standing committees of the senate
14-43 and house of representatives having jurisdiction over the Medicaid
14-44 program regarding the study required by this section.
14-45 (d) This section expires September 1, 2015.
14-46 ARTICLE 4. QUALITY-BASED OUTCOMES AND PAYMENT PROVISIONS
14-47 SECTION 4.01. Subchapter A, Chapter 533, Government Code,
14-48 is amended by adding Section 533.00254 to read as follows:
14-49 Sec. 533.00254. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM.
14-50 (a) In consultation with the Medicaid and CHIP Quality-Based
14-51 Payment Advisory Committee established under Section 536.002 and
14-52 other appropriate stakeholders with an interest in the provision of
14-53 acute care services and long-term services and supports under the
14-54 Medicaid managed care program, the commission shall:
14-55 (1) establish a clinical improvement program to
14-56 identify goals designed to improve quality of care and care
14-57 management and to reduce potentially preventable events, as defined
14-58 by Section 536.001; and
14-59 (2) require managed care organizations to develop and
14-60 implement collaborative program improvement strategies to address
14-61 the goals.
14-62 (b) Goals established under this section may be set by
14-63 geographical region and program type.
14-64 SECTION 4.02. Subsections (a) and (g), Section 533.0051,
14-65 Government Code, are amended to read as follows:
14-66 (a) The commission shall establish outcome-based
14-67 performance measures and incentives to include in each contract
14-68 between a health maintenance organization and the commission for
14-69 the provision of health care services to recipients that is

15-1 procured and managed under a value-based purchasing model. The
15-2 performance measures and incentives must:
15-3 (1) be designed to facilitate and increase recipients'
15-4 access to appropriate health care services; and
15-5 (2) to the extent possible, align with other state and
15-6 regional quality care improvement initiatives.
15-7 (g) In performing the commission's duties under Subsection
15-8 (d) with respect to assessing feasibility and cost-effectiveness,
15-9 the commission may consult with participating Medicaid providers
15-10 [~~physicians~~], including those with expertise in quality
15-11 improvement and performance measurement[~~, and hospitals~~].
15-12 SECTION 4.03. Subchapter A, Chapter 533, Government Code,
15-13 is amended by adding Section 533.00511 to read as follows:
15-14 Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM
15-15 FOR MANAGED CARE ORGANIZATIONS. (a) In this section, "potentially
15-16 preventable event" has the meaning assigned by Section 536.001.
15-17 (b) The commission shall create an incentive program that
15-18 automatically enrolls a greater percentage of recipients who did
15-19 not actively choose their managed care plan in a managed care plan,
15-20 based on:
15-21 (1) the quality of care provided through the managed
15-22 care organization offering that managed care plan;
15-23 (2) the organization's ability to efficiently and
15-24 effectively provide services, taking into consideration the acuity
15-25 of populations primarily served by the organization; and
15-26 (3) the organization's performance with respect to
15-27 exceeding, or failing to achieve, appropriate outcome and process
15-28 measures developed by the commission, including measures based on
15-29 all potentially preventable events.
15-30 SECTION 4.04. Section 533.0071, Government Code, is amended
15-31 to read as follows:
15-32 Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission
15-33 shall make every effort to improve the administration of contracts
15-34 with managed care organizations. To improve the administration of
15-35 these contracts, the commission shall:
15-36 (1) ensure that the commission has appropriate
15-37 expertise and qualified staff to effectively manage contracts with
15-38 managed care organizations under the Medicaid managed care program;
15-39 (2) evaluate options for Medicaid payment recovery
15-40 from managed care organizations if the enrollee dies or is
15-41 incarcerated or if an enrollee is enrolled in more than one state
15-42 program or is covered by another liable third party insurer;
15-43 (3) maximize Medicaid payment recovery options by
15-44 contracting with private vendors to assist in the recovery of
15-45 capitation payments, payments from other liable third parties, and
15-46 other payments made to managed care organizations with respect to
15-47 enrollees who leave the managed care program;
15-48 (4) decrease the administrative burdens of managed
15-49 care for the state, the managed care organizations, and the
15-50 providers under managed care networks to the extent that those
15-51 changes are compatible with state law and existing Medicaid managed
15-52 care contracts, including decreasing those burdens by:
15-53 (A) where possible, decreasing the duplication
15-54 of administrative reporting and process requirements for the
15-55 managed care organizations and providers, such as requirements for
15-56 the submission of encounter data, quality reports, historically
15-57 underutilized business reports, and claims payment summary
15-58 reports;
15-59 (B) allowing managed care organizations to
15-60 provide updated address information directly to the commission for
15-61 correction in the state system;
15-62 (C) promoting consistency and uniformity among
15-63 managed care organization policies, including policies relating to
15-64 the preauthorization process, lengths of hospital stays, filing
15-65 deadlines, levels of care, and case management services;
15-66 (D) reviewing the appropriateness of primary
15-67 care case management requirements in the admission and clinical
15-68 criteria process, such as requirements relating to including a
15-69 separate cover sheet for all communications, submitting

16-1 handwritten communications instead of electronic or typed review
16-2 processes, and admitting patients listed on separate
16-3 notifications; and
16-4 (E) providing a single portal through which
16-5 providers in any managed care organization's provider network may
16-6 submit acute care services and long-term services and supports
16-7 claims; and
16-8 (5) reserve the right to amend the managed care
16-9 organization's process for resolving provider appeals of denials
16-10 based on medical necessity to include an independent review process
16-11 established by the commission for final determination of these
16-12 disputes.
16-13 SECTION 4.05. Section 533.014, Government Code, is amended
16-14 by amending Subsection (b) and adding Subsection (c) to read as
16-15 follows:
16-16 (b) Except as provided by Subsection (c), any [~~Any~~] amount
16-17 received by the state under this section shall be deposited in the
16-18 general revenue fund for the purpose of funding the state Medicaid
16-19 program.
16-20 (c) If cost-effective, the commission may use amounts
16-21 received by the state under this section to provide incentives to
16-22 specific managed care organizations to promote quality of care,
16-23 encourage payment reform, reward local service delivery reform,
16-24 increase efficiency, and reduce inappropriate or preventable
16-25 service utilization.
16-26 SECTION 4.06. Subsection (b), Section 536.002, Government
16-27 Code, is amended to read as follows:
16-28 (b) The executive commissioner shall appoint the members of
16-29 the advisory committee. The committee must consist of physicians
16-30 and other health care providers, representatives of health care
16-31 facilities, representatives of managed care organizations, and
16-32 other stakeholders interested in health care services provided in
16-33 this state, including:
16-34 (1) at least one member who is a physician with
16-35 clinical practice experience in obstetrics and gynecology;
16-36 (2) at least one member who is a physician with
16-37 clinical practice experience in pediatrics;
16-38 (3) at least one member who is a physician with
16-39 clinical practice experience in internal medicine or family
16-40 medicine;
16-41 (4) at least one member who is a physician with
16-42 clinical practice experience in geriatric medicine;
16-43 (5) at least three members [~~one member~~] who are [~~is~~] or
16-44 who represent [~~represents~~] a health care provider that primarily
16-45 provides long-term [~~care~~] services and supports;
16-46 (6) at least one member who is a consumer
16-47 representative; and
16-48 (7) at least one member who is a member of the Advisory
16-49 Panel on Health Care-Associated Infections and Preventable Adverse
16-50 Events who meets the qualifications prescribed by Section
16-51 98.052(a)(4), Health and Safety Code.
16-52 SECTION 4.07. Section 536.003, Government Code, is amended
16-53 by amending Subsections (a) and (b) and adding Subsection (a-1) to
16-54 read as follows:
16-55 (a) The commission, in consultation with the advisory
16-56 committee, shall develop quality-based outcome and process
16-57 measures that promote the provision of efficient, quality health
16-58 care and that can be used in the child health plan and Medicaid
16-59 programs to implement quality-based payments for acute [~~and~~
16-60 ~~long-term~~] care services and long-term services and supports across
16-61 all delivery models and payment systems, including
16-62 [~~fee-for-service and~~] managed care payment systems. Subject to
16-63 Subsection (a-1), the [~~The~~] commission, in developing outcome and
16-64 process measures under this section, must include measures that are
16-65 based on all [~~consider measures addressing~~] potentially
16-66 preventable events and that advance quality improvement and
16-67 innovation. The commission may change measures developed:
16-68 (1) to promote continuous system reform, improved
16-69 quality, and reduced costs; and

17-1 (2) to account for managed care organizations added to
17-2 a service area.
17-3 (a-1) The outcome measures based on potentially preventable
17-4 events must:
17-5 (1) allow for rate-based determination of health care
17-6 provider performance compared to statewide norms; and
17-7 (2) be risk-adjusted to account for the severity of
17-8 the illnesses of patients served by the provider.
17-9 (b) To the extent feasible, the commission shall develop
17-10 outcome and process measures:
17-11 (1) consistently across all child health plan and
17-12 Medicaid program delivery models and payment systems;
17-13 (2) in a manner that takes into account appropriate
17-14 patient risk factors, including the burden of chronic illness on a
17-15 patient and the severity of a patient's illness;
17-16 (3) that will have the greatest effect on improving
17-17 quality of care and the efficient use of services, including acute
17-18 care services and long-term services and supports; [and]
17-19 (4) that are similar to outcome and process measures
17-20 used in the private sector, as appropriate;
17-21 (5) that reflect effective coordination of acute care
17-22 services and long-term services and supports;
17-23 (6) that can be tied to expenditures; and
17-24 (7) that reduce preventable health care utilization
17-25 and costs.
17-26 SECTION 4.08. Subsection (a), Section 536.004, Government
17-27 Code, is amended to read as follows:
17-28 (a) Using quality-based outcome and process measures
17-29 developed under Section 536.003 and subject to this section, the
17-30 commission, after consulting with the advisory committee and other
17-31 appropriate stakeholders with an interest in the provision of acute
17-32 care and long-term services and supports under the child health
17-33 plan and Medicaid programs, shall develop quality-based payment
17-34 systems, and require managed care organizations to develop
17-35 quality-based payment systems, for compensating a physician or
17-36 other health care provider participating in the child health plan
17-37 or Medicaid program that:
17-38 (1) align payment incentives with high-quality,
17-39 cost-effective health care;
17-40 (2) reward the use of evidence-based best practices;
17-41 (3) promote the coordination of health care;
17-42 (4) encourage appropriate physician and other health
17-43 care provider collaboration;
17-44 (5) promote effective health care delivery models; and
17-45 (6) take into account the specific needs of the child
17-46 health plan program enrollee and Medicaid recipient populations.
17-47 SECTION 4.09. Section 536.005, Government Code, is amended
17-48 by adding Subsection (c) to read as follows:
17-49 (c) Notwithstanding Subsection (a) and to the extent
17-50 possible, the commission shall convert outpatient hospital
17-51 reimbursement systems under the child health plan and Medicaid
17-52 programs to an appropriate prospective payment system that will
17-53 allow the commission to:
17-54 (1) more accurately classify the full range of
17-55 outpatient service episodes;
17-56 (2) more accurately account for the intensity of
17-57 services provided; and
17-58 (3) motivate outpatient service providers to increase
17-59 efficiency and effectiveness.
17-60 SECTION 4.10. Section 536.006, Government Code, is amended
17-61 to read as follows:
17-62 Sec. 536.006. TRANSPARENCY. (a) The commission and the
17-63 advisory committee shall:
17-64 (1) ensure transparency in the development and
17-65 establishment of:
17-66 (A) quality-based payment and reimbursement
17-67 systems under Section 536.004 and Subchapters B, C, and D,
17-68 including the development of outcome and process measures under
17-69 Section 536.003; and

18-1 (B) quality-based payment initiatives under
18-2 Subchapter E, including the development of quality of care and
18-3 cost-efficiency benchmarks under Section 536.204(a) and efficiency
18-4 performance standards under Section 536.204(b);
18-5 (2) develop guidelines establishing procedures for
18-6 providing notice and information to, and receiving input from,
18-7 managed care organizations, health care providers, including
18-8 physicians and experts in the various medical specialty fields, and
18-9 other stakeholders, as appropriate, for purposes of developing and
18-10 establishing the quality-based payment and reimbursement systems
18-11 and initiatives described under Subdivision (1); [~~and~~]
18-12 (3) in developing and establishing the quality-based
18-13 payment and reimbursement systems and initiatives described under
18-14 Subdivision (1), consider that as the performance of a managed care
18-15 organization or physician or other health care provider improves
18-16 with respect to an outcome or process measure, quality of care and
18-17 cost-efficiency benchmark, or efficiency performance standard, as
18-18 applicable, there will be a diminishing rate of improved
18-19 performance over time; and
18-20 (4) develop web-based capability to provide managed
18-21 care organizations and health care providers with data on their
18-22 clinical and utilization performance, including comparisons to
18-23 peer organizations and providers located in this state and in the
18-24 provider's respective region.
18-25 (b) The web-based capability required by Subsection (a)(4)
18-26 must support the requirements of the electronic health information
18-27 exchange system under Sections 531.907 through 531.909.
18-28 SECTION 4.11. Section 536.008, Government Code, is amended
18-29 to read as follows:
18-30 Sec. 536.008. ANNUAL REPORT. (a) The commission shall
18-31 submit to the legislature and make available to the public an annual
18-32 report [~~to the legislature~~] regarding:
18-33 (1) the quality-based outcome and process measures
18-34 developed under Section 536.003, including measures based on each
18-35 potentially preventable event; and
18-36 (2) the progress of the implementation of
18-37 quality-based payment systems and other payment initiatives
18-38 implemented under this chapter.
18-39 (b) As appropriate, the [~~The~~] commission shall report
18-40 outcome and process measures under Subsection (a)(1) by:
18-41 (1) geographic location, which may require reporting
18-42 by county, health care service region, or other appropriately
18-43 defined geographic area;
18-44 (2) recipient population or eligibility group served;
18-45 (3) type of health care provider, such as acute care or
18-46 long-term care provider;
18-47 (4) number of recipients who relocated to a
18-48 community-based setting from a less integrated setting;
18-49 (5) quality-based payment system; and
18-50 (6) service delivery model.
18-51 (c) The report required under this section may not identify
18-52 specific health care providers.
18-53 SECTION 4.12. Subsection (a), Section 536.051, Government
18-54 Code, is amended to read as follows:
18-55 (a) Subject to Section 1903(m)(2)(A), Social Security Act
18-56 (42 U.S.C. Section 1396b(m)(2)(A)), and other applicable federal
18-57 law, the commission shall base a percentage of the premiums paid to
18-58 a managed care organization participating in the child health plan
18-59 or Medicaid program on the organization's performance with respect
18-60 to outcome and process measures developed under Section 536.003
18-61 that address all[~~, including outcome measures addressing~~]
18-62 potentially preventable events. The percentage of the premiums
18-63 paid may increase each year.
18-64 SECTION 4.13. Subsection (a), Section 536.052, Government
18-65 Code, is amended to read as follows:
18-66 (a) The commission may allow a managed care organization
18-67 participating in the child health plan or Medicaid program
18-68 increased flexibility to implement quality initiatives in a managed
18-69 care plan offered by the organization, including flexibility with

19-1 respect to financial arrangements, in order to:
19-2 (1) achieve high-quality, cost-effective health care;
19-3 (2) increase the use of high-quality, cost-effective
19-4 delivery models; [~~and~~]
19-5 (3) reduce the incidence of unnecessary
19-6 institutionalization and potentially preventable events; and
19-7 (4) increase the use of alternative payment systems,
19-8 including shared savings models, in collaboration with physicians
19-9 and other health care providers.
19-10 SECTION 4.14. Section 536.151, Government Code, is amended
19-11 by amending Subsections (a), (b), and (c) and adding Subsections
19-12 (a-1) and (d) to read as follows:
19-13 (a) The executive commissioner shall adopt rules for
19-14 identifying:
19-15 (1) potentially preventable admissions and
19-16 readmissions of child health plan program enrollees and Medicaid
19-17 recipients, including preventable admissions to long-term care
19-18 facilities;
19-19 (2) potentially preventable ancillary services
19-20 provided to or ordered for child health plan program enrollees and
19-21 Medicaid recipients;
19-22 (3) potentially preventable emergency room visits by
19-23 child health plan program enrollees and Medicaid recipients; and
19-24 (4) potentially preventable complications experienced
19-25 by child health plan program enrollees and Medicaid recipients.
19-26 (a-1) The commission shall collect data from hospitals on
19-27 present-on-admission indicators for purposes of this section.
19-28 (b) The commission shall establish a program to provide a
19-29 confidential report to each hospital in this state that
19-30 participates in the child health plan or Medicaid program regarding
19-31 the hospital's performance with respect to each potentially
19-32 preventable event described under Subsection (a) [~~readmissions and~~
19-33 ~~potentially preventable complications~~]. To the extent possible, a
19-34 report provided under this section should include all potentially
19-35 preventable events [~~readmissions and potentially preventable~~
19-36 ~~complications information~~] across all child health plan and
19-37 Medicaid program payment systems. A hospital shall distribute the
19-38 information contained in the report to physicians and other health
19-39 care providers providing services at the hospital.
19-40 (c) Except as provided by Subsection (d), a [~~A~~] report
19-41 provided to a hospital under this section is confidential and is not
19-42 subject to Chapter 552.
19-43 (d) The commission shall release the information in the
19-44 report described by Subsection (b):
19-45 (1) not earlier than one year after the date the report
19-46 is submitted to the hospital; and
19-47 (2) only after receiving and evaluating interested
19-48 stakeholder input regarding the public release of information under
19-49 this section generally.
19-50 SECTION 4.15. Subsection (a), Section 536.152, Government
19-51 Code, is amended to read as follows:
19-52 (a) Subject to Subsection (b), using the data collected
19-53 under Section 536.151 and the diagnosis-related groups (DRG)
19-54 methodology implemented under Section 536.005, if applicable, the
19-55 commission, after consulting with the advisory committee, shall to
19-56 the extent feasible adjust child health plan and Medicaid
19-57 reimbursements to hospitals, including payments made under the
19-58 disproportionate share hospitals and upper payment limit
19-59 supplemental payment programs, [~~in a manner that may reward or~~
19-60 ~~penalize a hospital~~] based on the hospital's performance with
19-61 respect to exceeding, or failing to achieve, outcome and process
19-62 measures developed under Section 536.003 that address the rates of
19-63 potentially preventable readmissions and potentially preventable
19-64 complications.
19-65 SECTION 4.16. Subsection (a), Section 536.202, Government
19-66 Code, is amended to read as follows:
19-67 (a) The commission shall, after consulting with the
19-68 advisory committee, establish payment initiatives to test the
19-69 effectiveness of quality-based payment systems, alternative

20-1 payment methodologies, and high-quality, cost-effective health
20-2 care delivery models that provide incentives to physicians and
20-3 other health care providers to develop health care interventions
20-4 for child health plan program enrollees or Medicaid recipients, or
20-5 both, that will:
20-6 (1) improve the quality of health care provided to the
20-7 enrollees or recipients;
20-8 (2) reduce potentially preventable events;
20-9 (3) promote prevention and wellness;
20-10 (4) increase the use of evidence-based best practices;
20-11 (5) increase appropriate physician and other health
20-12 care provider collaboration; [~~and~~]
20-13 (6) contain costs; and
20-14 (7) improve integration of acute care services and
20-15 long-term services and supports, including discharge planning from
20-16 acute care services to community-based long-term services and
20-17 supports.
20-18 SECTION 4.17. Chapter 536, Government Code, is amended by
20-19 adding Subchapter F to read as follows:
20-20 SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS
20-21 PAYMENT SYSTEMS
20-22 Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES AND
20-23 SUPPORTS PAYMENTS. (a) Subject to this subchapter, the
20-24 commission, after consulting with the advisory committee and other
20-25 appropriate stakeholders representing nursing facility providers
20-26 with an interest in the provision of long-term services and
20-27 supports, may develop and implement quality-based payment systems
20-28 for Medicaid long-term services and supports providers designed to
20-29 improve quality of care and reduce the provision of unnecessary
20-30 services. A quality-based payment system developed under this
20-31 section must base payments to providers on quality and efficiency
20-32 measures that may include measurable wellness and prevention
20-33 criteria and use of evidence-based best practices, sharing a
20-34 portion of any realized cost savings achieved by the provider, and
20-35 ensuring quality of care outcomes, including a reduction in
20-36 potentially preventable events.
20-37 (b) The commission may develop a quality-based payment
20-38 system for Medicaid long-term services and supports providers under
20-39 this subchapter only if implementing the system would be feasible
20-40 and cost-effective.
20-41 Sec. 536.252. EVALUATION OF DATA SETS. To ensure that the
20-42 commission is using the best data to inform the development and
20-43 implementation of quality-based payment systems under Section
20-44 536.251, the commission shall evaluate the reliability, validity,
20-45 and functionality of post-acute and long-term services and supports
20-46 data sets. The commission's evaluation under this section should
20-47 assess:
20-48 (1) to what degree data sets relied on by the
20-49 commission meet a standard:
20-50 (A) for integrating care;
20-51 (B) for developing coordinated care plans; and
20-52 (C) that would allow for the meaningful
20-53 development of risk adjustment techniques;
20-54 (2) whether the data sets will provide value for
20-55 outcome or performance measures and cost containment; and
20-56 (3) how classification systems and data sets used for
20-57 Medicaid long-term services and supports providers can be
20-58 standardized and, where possible, simplified.
20-59 Sec. 536.253. COLLECTION AND REPORTING OF CERTAIN
20-60 INFORMATION. (a) The executive commissioner shall adopt rules for
20-61 identifying the incidence of potentially preventable admissions,
20-62 potentially preventable readmissions, and potentially preventable
20-63 emergency room visits by Medicaid long-term services and supports
20-64 recipients.
20-65 (b) The commission shall establish a program to provide a
20-66 report to each Medicaid long-term services and supports provider in
20-67 this state regarding the provider's performance with respect to
20-68 potentially preventable admissions, potentially preventable
20-69 readmissions, and potentially preventable emergency room visits.

21-1 To the extent possible, a report provided under this section should
21-2 include applicable potentially preventable events information
21-3 across all Medicaid program payment systems.
21-4 (c) Subject to Subsection (d), a report provided to a
21-5 provider under this section is confidential and is not subject to
21-6 Chapter 552.
21-7 (d) The commission shall release the information in the
21-8 report described by Subsection (c):
21-9 (1) not earlier than one year after the date the report
21-10 is submitted to the provider; and
21-11 (2) only after receiving and evaluating interested
21-12 stakeholder input regarding the public release of information under
21-13 this section generally.
21-14 SECTION 4.18. As soon as practicable after the effective
21-15 date of this Act, the Health and Human Services Commission shall
21-16 provide a single portal through which providers in any managed care
21-17 organization's provider network may submit acute care services and
21-18 long-term services and supports claims as required by Paragraph
21-19 (E), Subdivision (4), Section 533.0071, Government Code, as amended
21-20 by this article.
21-21 SECTION 4.19. Not later than September 1, 2013, the Health
21-22 and Human Services Commission shall convert outpatient hospital
21-23 reimbursement systems as required by Subsection (c), Section
21-24 536.005, Government Code, as added by this article.
21-25 ARTICLE 5. SPECIFIC PROVISIONS RELATING TO PREMIUMS UNDER THE
21-26 MEDICAL ASSISTANCE PROGRAM
21-27 SECTION 5.01. Section 533.013, Government Code, is amended
21-28 by adding Subsection (e) to read as follows:
21-29 (e) The commission shall pursue and, if appropriate,
21-30 implement premium rate-setting strategies that encourage provider
21-31 payment reform and more efficient service delivery and provider
21-32 practices. In pursuing premium rate-setting strategies under this
21-33 section, the commission shall review and consider strategies
21-34 employed or under consideration by other states. If necessary, the
21-35 commission may request a waiver or other authorization from a
21-36 federal agency to implement strategies identified under this
21-37 subsection.
21-38 SECTION 5.02. Subchapter B, Chapter 32, Human Resources
21-39 Code, is amended by adding Section 32.0642 to read as follows:
21-40 Sec. 32.0642. PREMIUM REQUIREMENT FOR RECEIPT OF CERTAIN
21-41 SERVICES. To the extent permitted under and in a manner that is
21-42 consistent with Title XIX, Social Security Act (42 U.S.C. Section
21-43 1396 et seq.), and any other applicable law or regulation or under a
21-44 federal waiver or other authorization, the executive commissioner
21-45 of the Health and Human Services Commission shall adopt and
21-46 implement in the most cost-effective manner a premium for long-term
21-47 services and supports provided to a child under the medical
21-48 assistance program to be paid by the child's parent or other legal
21-49 guardian.
21-50 ARTICLE 6. ADDITIONAL PROVISIONS RELATING TO QUALITY AND DELIVERY
21-51 OF HEALTH AND HUMAN SERVICES
21-52 SECTION 6.01. The heading to Section 531.024, Government
21-53 Code, is amended to read as follows:
21-54 Sec. 531.024. PLANNING AND DELIVERY OF HEALTH AND HUMAN
21-55 SERVICES; DATA SHARING.
21-56 SECTION 6.02. Section 531.024, Government Code, is amended
21-57 by adding Subsection (a-1) to read as follows:
21-58 (a-1) To the extent permitted under applicable law, the
21-59 commission and other health and human services agencies shall share
21-60 data to facilitate patient care coordination, quality improvement,
21-61 and cost savings in the Medicaid program, child health plan
21-62 program, and other health and human services programs funded using
21-63 money appropriated from the general revenue fund.
21-64 SECTION 6.03. Subchapter B, Chapter 531, Government Code,
21-65 is amended by adding Section 531.0981 to read as follows:
21-66 Sec. 531.0981. WELLNESS SCREENING PROGRAM. If
21-67 cost-effective, the commission may implement a wellness screening
21-68 program for Medicaid recipients designed to evaluate a recipient's
21-69 risk for having certain diseases and medical conditions for

22-1 purposes of establishing a health baseline for each recipient that
22-2 may be used to tailor the recipient's treatment plan or for
22-3 establishing the recipient's health goals.

22-4 ARTICLE 7. FEDERAL AUTHORIZATIONS, FUNDING, AND EFFECTIVE DATE

22-5 SECTION 7.01. If before implementing any provision of this
22-6 Act a state agency determines that a waiver or authorization from a
22-7 federal agency is necessary for implementation of that provision,
22-8 the agency affected by the provision shall request the waiver or
22-9 authorization and may delay implementing that provision until the
22-10 waiver or authorization is granted.

22-11 SECTION 7.02. As soon as practicable after the effective
22-12 date of this Act, the Health and Human Services Commission shall
22-13 apply for and actively seek a waiver or authorization from the
22-14 appropriate federal agency to waive, with respect to a person who is
22-15 dually eligible for Medicare and Medicaid, the requirement under 42
22-16 C.F.R. Section 409.30 that the person be hospitalized for at least
22-17 three consecutive calendar days before Medicare covers
22-18 posthospital skilled nursing facility care for the person.

22-19 SECTION 7.03. The Health and Human Services Commission may
22-20 use any available revenue, including legislative appropriations
22-21 and available federal funds, for purposes of implementing any
22-22 provision of this Act.

22-23 SECTION 7.04. This Act takes effect September 1, 2013.

22-24 * * * * *