SENATE AMENDMENTS

2nd Printing

By: Raymond, Klick H.B. No. 3523

A BILL TO BE ENTITLED

AN ACT

relating to improving 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:

SECTION 1. Section 533.00251(g), Government Code, is amended to read as follows:

(g) Subsection [~~Subsections (c),~~] (d)[~~, (e), and (f)~~] and this subsection expire September 1, 2019.

SECTION 2. Section 534.053, Government Code, is amended by adding Subsection (e-1) and amending Subsection (g) to read as follows:

(e-1) The advisory committee may establish work groups that meet at other times for purposes of studying and making recommendations on issues the committee considers appropriate.

(g) On January 1, 2026 [~~2024~~]:

(1) the advisory committee is abolished; and

(2) this section expires.

SECTION 3. Section 534.054, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in consultation and collaboration with the advisory committee, shall prepare and submit a report to the legislature that must include

[~~regarding~~]:

(1) an assessment of the implementation of the system required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with an intellectual or developmental disability under Medicaid as described by this chapter; [~~and~~]

(2) recommendations regarding implementation of and improvements to the system redesign, including recommendations regarding appropriate statutory changes to facilitate the implementation; and

(3) an assessment of the effect of the system on the following:

(A) access to long-term services and supports;

(B) the quality of acute care services and long-term services and supports;

(C) meaningful outcomes for Medicaid recipients using person-centered planning, individualized budgeting, and self-determination, including a person's inclusion in the community;

(D) the integration of service coordination of acute care services and long-term services and supports;

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

(F) employment assistance and customized, integrated, competitive employment options; and

(G) the number and types of fair hearing and appeals processes in accordance with applicable federal law.

(b) This section expires January 1, 2026 [~~2024~~].

SECTION 4. Section 534.104, Government Code, is amended by amending Subsection (a), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, amending Subsections (c), (d), (e), and (g), and adding Subsection (h) to read as follows:

(a) The department, in consultation and collaboration with the advisory committee, shall identify private services providers that are good candidates to develop a service delivery model involving a managed care strategy based on capitation and to test the model in the provision of long-term services and supports under Medicaid to individuals with an intellectual or developmental disability through a pilot program established under this subchapter.

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

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

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

(3) promote meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion [~~and customized, integrated, competitive employment~~];

(4) promote integrated service coordination of acute

care services and long-term services and supports;

(5) promote [~~efficiency and the best use of funding;~~

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

(6) [~~(7)~~] promote employment assistance and customized, integrated, and competitive [~~supported~~] employment;

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

(8) [~~(9)~~] promote sufficient flexibility to achieve the goals listed in this section through the pilot program.

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

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

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

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

(g) The department, in consultation and collaboration with the advisory committee, shall analyze information provided by the

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

(h) The analysis under Subsection (g) must include an assessment of the effect of the managed care strategies implemented in the pilot programs on:

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

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

(3) meaningful outcomes using person-centered planning, individualized budgeting, and self-determination, including a person's inclusion in the community;

(4) the integration of service coordination of acute care services and long-term services and supports;

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

(6) employment assistance and customized, integrated, competitive employment options; and

(7) the number and types of fair hearing and appeals processes in accordance with applicable federal law.

SECTION 5. Sections 534.106(a) and (b), Government Code, are amended to read as follows:

(a) The commission and the department shall implement any pilot programs established under this subchapter not later than September 1, 2017 [~~2016~~].

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

SECTION 6. Section 534.108(d), Government Code, is amended to read as follows:

(d) The [~~On or before December 1, 2016, and December 1, 2017, the~~] commission and the department, in consultation and collaboration with the advisory committee, shall review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit, as part of the annual report to the legislature required by Section 534.054, a report to the legislature during the operation of the pilot programs. Each report must include recommendations for program improvement and continued implementation.

SECTION 7. Section 534.110, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

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

(b) The transition plan shall be developed in consultation and collaboration with the advisory committee and with stakeholder input as described by Section 534.103.

SECTION 8. Section 534.151, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a) Subject to Section 533.0025, the commission shall provide acute care Medicaid benefits to individuals with an intellectual or developmental disability through the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model and monitor the provision of those benefits.

(b) The commission and the department, in consultation and collaboration with the advisory committee, shall analyze the outcomes of providing acute care Medicaid benefits to individuals with an intellectual or developmental disability under a model specified in Subsection (a). The analysis must:

(1) include an assessment of the effects on:

(A) access to and quality of acute care services; and

(B) the number and types of fair hearing and appeals processes in accordance with applicable federal law;

(2) be incorporated into the annual report to the legislature required under Section 534.054; and

(3) include recommendations for delivery model improvements and implementation for consideration by the legislature, including recommendations for needed statutory changes.

SECTION 9. The heading to Section 534.152, Government Code, is amended to read as follows:

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM PROVIDERS.

SECTION 10. Section 534.152, Government Code, is amended by adding Subsection (g) to read as follows:

(g) The department may contract with providers participating in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, the community living assistance and support services (CLASS) waiver program, or the deaf-blind with multiple disabilities (DBMD) waiver program for the delivery of basic attendant and habilitation services described in Subsection (a) for individuals to which that subsection applies. The department has regulatory and oversight authority over the providers with which the department contracts for the delivery of those services.

SECTION 11. Section 534.201, Government Code, is amended by amending Subsections (b) and (e), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, amending Subsection (d), and adding Subsection (g) to read as follows:

(b) On or after [~~Not later than~~] September 1, 2018 [~~2017~~], the commission may [~~shall~~] transition the provision of Medicaid benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness

and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and habilitation services and of the pilot programs established under Subchapter C, subject to Subsection (c)(1).

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

(e) The commission, in consultation and collaboration with the advisory committee, shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

(g) The commission, in consultation and collaboration with the advisory committee, shall analyze the outcomes of the transition of the long-term services and supports under the Texas home living (TxHmL) Medicaid waiver program to a managed care program delivery model. The analysis must:

(1) include an assessment of the effect of the transition on:

(A) access to long-term services and supports;

(B) meaningful outcomes using person-centered planning, individualized budgeting, and self-determination, including a person's inclusion in the community;

(C) the integration of service coordination of acute care services and long-term services and supports;

(D) employment assistance and customized, integrated, competitive employment options; and

(E) the number and types of fair hearing and appeals processes in accordance with applicable federal law;

(2) be incorporated into the annual report to the legislature required under Section 534.054; and

(3) include recommendations for improvements to the transition implementation for consideration by the legislature, including recommendations for needed statutory changes.

SECTION 12. Section 534.202(b), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

(b) After implementing the transition required by Section 534.201, if that transition is implemented [~~but not later than September 1, 2020~~], the commission may, on or after September 1, 2021, [~~shall~~] transition the provision of Medicaid benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the transition of Texas home living (TxHmL) waiver program recipients to a managed care program delivery model under Section 534.201, subject to Subsections (c)(1) and (g).

SECTION 13. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or

authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 14. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2015.

ADOPTED

MAY 26 2015

Secretary of the Senate

By: _____ H.B. No. 3523

Substitute the following for H.B. No. 3523:

By: _____ C C.S. H.B. No. 3523

A BILL TO BE ENTITLED

AN ACT

relating to improving 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:

SECTION 1. Section 533.00251, Government Code, is amended by amending Subsection (c), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, and amending Subsection (g) to read as follows:

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

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

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

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

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

(5) that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(6) that a managed care organization providing services under the managed care program:

(A) assists in collecting applied income from recipients; and

(B) provides payment incentives to nursing facility providers that reward reductions in preventable acute care costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(7) the establishment of a portal that is in compliance with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization;

(8) that rules and procedures relating to the certification and decertification of nursing facility beds under Medicaid are not affected; [~~and~~]

(9) that a managed care organization providing services under the managed care program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(10) that the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the managed care program.

(g) Subsection [~~Subsections (c),~~] (d)[~~, (e), and (f)~~] and this subsection expire September 1, 2021 [~~2019~~].

SECTION 2. Effective September 1, 2021, Section 533.00251(c), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

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

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

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

(2) [~~(3)~~] the appropriate utilization of services consistent with criteria established by the commission;

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

(4) [~~(5)~~] that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(5) [~~(6)~~] that a managed care organization providing services under the managed care program:

(A) assists in collecting applied income from recipients; and

(B) provides payment incentives to nursing facility providers that reward reductions in preventable acute care costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(6) [~~(7)~~] the establishment of a portal that is in compliance with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization;

(7) [~~(8)~~] that rules and procedures relating to the certification and decertification of nursing facility beds under Medicaid are not affected; [~~and~~]

(8) [~~(9)~~] that a managed care organization providing services under the managed care program, to the greatest extent

possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(9) that the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the managed care program.

SECTION 3. Section 534.053, Government Code, is amended by adding Subsection (e-1) and amending Subsection (g) to read as follows:

(e-1) The advisory committee may establish work groups that meet at other times for purposes of studying and making recommendations on issues the committee considers appropriate.

(g) On January 1, 2026 [~~2024~~]:

(1) the advisory committee is abolished; and

(2) this section expires.

SECTION 4. Section 534.054, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in consultation and collaboration with the advisory committee, shall prepare and submit a report to the legislature that must include [~~regarding~~]:

(1) an assessment of the implementation of the system

required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with an intellectual or developmental disability under Medicaid as described by this chapter; [~~and~~]

(2) recommendations regarding implementation of and improvements to the system redesign, including recommendations regarding appropriate statutory changes to facilitate the implementation; and

(3) an assessment of the effect of the system on the following:

(A) access to long-term services and supports;

(B) the quality of acute care services and long-term services and supports;

(C) meaningful outcomes for Medicaid recipients using person-centered planning, individualized budgeting, and self-determination, including a person's inclusion in the community;

(D) the integration of service coordination of acute care services and long-term services and supports;

(E) the efficiency and use of funding;

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

(G) employment assistance and customized, integrated, competitive employment options; and

(H) the number and types of fair hearing and

appeals processes in accordance with applicable federal law.

(b) This section expires January 1, 2026 [~~2024~~].

SECTION 5. Section 534.104, Government Code, is amended by amending Subsection (a), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, amending Subsections (b), (c), (d), (e), and (g), and adding Subsection (h) to read as follows:

(a) The department, in consultation and collaboration with the advisory committee, shall identify private services providers or managed care organizations that are good candidates to develop a service delivery model involving a managed care strategy based on capitation and to test the model in the provision of long-term services and supports under Medicaid to individuals with an intellectual or developmental disability through a pilot program established under this subchapter.

(b) The department shall solicit managed care strategy proposals from the private services providers and managed care organizations identified under Subsection (a). In addition, the department may accept and approve a managed care strategy proposal from any qualified entity that is a private services provider or managed care organization if the proposal provides for a comprehensive array of long-term services and supports, including case management and service coordination.

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

(1) increase access to long-term services and

supports;

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

(3) promote meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion [~~and customized, integrated, competitive employment~~];

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

(5) promote efficiency and the best use of funding;

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

(7) promote employment assistance and customized, integrated, and competitive [~~supported~~] employment;

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

(9) promote sufficient flexibility to achieve the goals listed in this section through the pilot program.

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

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

(2) the private services provider or managed care organization that submitted the proposal has a demonstrated ability to provide the long-term services and supports appropriate to the

individuals who will receive services through the pilot program based on the proposed strategy, if implemented.

(e) Based on the evaluation performed under Subsection (d), the department may select as pilot program service providers one or more private services providers or managed care organizations with whom the commission will contract.

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

(h) The analysis under Subsection (g) must include an assessment of the effect of the managed care strategies implemented in the pilot programs on:

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

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

(3) meaningful outcomes using person-centered planning, individualized budgeting, and self-determination, including a person's inclusion in the community;

(4) the integration of service coordination of acute care services and long-term services and supports;

(5) the efficiency and use of funding;

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

(7) employment assistance and customized, integrated, competitive employment options; and

(8) the number and types of fair hearing and appeals processes in accordance with applicable federal law.

SECTION 6. Sections 534.106(a) and (b), Government Code, are amended to read as follows:

(a) The commission and the department shall implement any pilot programs established under this subchapter not later than September 1, 2017 [~~2016~~].

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

SECTION 7. Section 534.108(d), Government Code, is amended to read as follows:

(d) The [~~On or before December 1, 2016, and December 1, 2017, the~~] commission and the department, in consultation and collaboration with the advisory committee, shall review and evaluate the progress and outcomes of each pilot program implemented under this subchapter and submit, as part of the annual report to the legislature required by Section 534.054, a report to the legislature during the operation of the pilot programs. Each report must include recommendations for program improvement and continued implementation.

SECTION 8. Section 534.110, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015,

is amended to read as follows:

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

(b) The transition plan shall be developed in consultation and collaboration with the advisory committee and with stakeholder input as described by Section 534.103.

SECTION 9. Section 534.151, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a) Subject to Section 533.0025, the commission shall provide acute care Medicaid benefits to individuals with an intellectual or developmental disability through the STAR + PLUS Medicaid managed care program or the most appropriate integrated capitated managed care program delivery model and monitor the provision of those benefits.

(b) The commission and the department, in consultation and collaboration with the advisory committee, shall analyze the outcomes of providing acute care Medicaid benefits to individuals with an intellectual or developmental disability under a model specified in Subsection (a). The analysis must:

(1) include an assessment of the effects on:

(A) access to and quality of acute care services;

and

(B) the number and types of fair hearing and appeals processes in accordance with applicable federal law;

(2) be incorporated into the annual report to the legislature required under Section 534.054; and

(3) include recommendations for delivery model improvements and implementation for consideration by the legislature, including recommendations for needed statutory changes.

SECTION 10. The heading to Section 534.152, Government Code, is amended to read as follows:

Sec. 534.152. DELIVERY OF CERTAIN OTHER SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM PROVIDERS.

SECTION 11. Section 534.152, Government Code, is amended by adding Subsection (g) to read as follows:

(g) The department may contract with providers participating in the home and community-based services (HCS) waiver program, the Texas home living (TxHmL) waiver program, the community living assistance and support services (CLASS) waiver program, or the deaf-blind with multiple disabilities (DBMD) waiver program for the delivery of basic attendant and habilitation services described in Subsection (a) for individuals to which that subsection applies. The department has regulatory and oversight authority over the providers with which the department contracts for the delivery of those services.

SECTION 12. Section 534.201, Government Code, is amended by

amending Subsections (b) and (e), as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, amending Subsection (d), and adding Subsection (g) to read as follows:

(b) On [~~Not later than~~] September 1, 2018 [~~2017~~], the commission shall transition the provision of Medicaid benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as determined by the commission based on cost-effectiveness and the experience of the STAR + PLUS Medicaid managed care program in providing basic attendant and habilitation services and of the pilot programs established under Subchapter C, subject to Subsection (c)(1).

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

(e) The commission, in consultation and collaboration with the advisory committee, shall ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits under this section that protects the continuity of care provided to individuals to whom this section applies.

(g) The commission, in consultation and collaboration with the advisory committee, shall analyze the outcomes of the transition of the long-term services and supports under the Texas home living (TxHmL) Medicaid waiver program to a managed care

program delivery model. The analysis must:

(1) include an assessment of the effect of the transition on:

(A) access to long-term services and supports;

(B) meaningful outcomes using person-centered planning, individualized budgeting, and self-determination, including a person's inclusion in the community;

(C) the integration of service coordination of acute care services and long-term services and supports;

(D) employment assistance and customized, integrated, competitive employment options; and

(E) the number and types of fair hearing and appeals processes in accordance with applicable federal law;

(2) be incorporated into the annual report to the legislature required under Section 534.054; and

(3) include recommendations for improvements to the transition implementation for consideration by the legislature, including recommendations for needed statutory changes.

SECTION 13. Section 534.202(b), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:

(b) After implementing the transition required by Section 534.201, on [~~but not later than~~] September 1, 2021 [~~2020~~], the commission shall transition the provision of Medicaid benefits to individuals to whom this section applies to the STAR + PLUS Medicaid managed care program delivery model or the most appropriate integrated capitated managed care program delivery model, as

determined by the commission based on cost-effectiveness and the experience of the transition of Texas home living (TxHmL) waiver program recipients to a managed care program delivery model under Section 534.201, subject to Subsections (c)(1) and (g).

SECTION 14. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 15. Except as otherwise provided by this Act:

(1) this Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution; and

(2) if this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2015.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 84TH LEGISLATIVE REGULAR SESSION

May 27, 2015

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3523** by Raymond (Relating to improving the delivery and quality of Medicaid acute care services and long-term care services and supports.), **As Passed 2nd House**

The fiscal implications of the bill cannot be determined at this time, due to the lack of specific estimates of both reduced revenue and potential lost savings and related to the delay of transition of certain programs into managed care.

The bill would delay the start date for certain pilot programs from not later than September 1, 2016 to not later than September 1, 2017 and allows the pilot programs to operate for up to 24 months instead of requiring that they operate for at least 24 months. The bill would allow managed care organizations to participate in the pilot programs. It is assumed that these changes will not affect any cost associated with operating the pilot programs, but these provisions could shift the costs between fiscal years if they begin later or operate for a shorter period of time.

The bill would allow the Department of Aging and Disability Services (DADS) to contract directly with providers participating in certain long-term-care waivers to provide certain attendant and habilitation services through the STAR+PLUS program and gives the agency regulatory and oversight authority over those providers for the delivery of those services. According to the Health and Human Services Commission (HHSC), any cost associated with these provisions can be absorbed within available resources of DADS and HHSC.

The bill would delay the transition to managed care of services provided to persons enrolled in the Texas Home Living Waiver (TxHmL) from not later than September 1, 2017 to on September 1, 2018. Further, the bill would delay by at least one year (from no later than September 1, 2020 to on September 1, 2021) the transition date for the carve-into managed care of services provided to individuals with intellectual and developmental disabilities who receive care in intermediate care facilities other than a state supported living center or a Medicaid waiver program other than TxHmL. Any savings that may have been achieved by providing services through managed care will be delayed. Additionally, delaying the transitions into managed care will result in the loss of premium tax revenue. Savings and revenue associated with the provision of TxHmL services will be lost in fiscal years 2017 and 2018. Also, savings and revenue associated with the provision of services for persons receiving care in intermediate care facilities or other waivers will be lost in fiscal years 2020 and 2021. Specific estimates of lost savings and reduced revenue cannot be provided.

Additionally, the bill requires HHSC to conduct an assessment of the outcomes of the TxHmL transition and include those findings in the annual report to be submitted by September 30th of each year. Based on analysis provided by HHSC, the first required evaluation of the TxHmL

waiver transition, due by September 30th, would be delayed due to a six-month data delay. It is assumed that DADS and HHSC can accomplish this provision of the bill within existing resources.

The bill would remove the requirement for HHSC to set the minimum staff rate enhancement paid to certain nursing facilities in the STAR+PLUS program and instead require HHSC to approve the rate enhancement methodology. Effective September 1, 2021, the bill would remove the requirement that HHSC set the minimum reimbursement rate paid to a nursing facility in the STAR+PLUS program. There may be an cost or savings related to these provisions but the effect on reimbursement rates cannot be determined.

Finally, the bill would amend the requirements and responsibilities related to the Intellectual and Developmental Disability System Redesign Advisory Committee and delay abolishment of the committee until January 1, 2026. The bill would require HHSC to analyze the outcomes of providing acute care Medicaid benefits to individuals with intellectual and developmental disabilities under managed care. It is assumed that HHSC can accomplish this provision of the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission, 539 Aging and Disability Services, Department of

LBB Staff: UP, SD, CH, NB, WP, LR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 84TH LEGISLATIVE REGULAR SESSION

May 22, 2015

TO: Honorable Charles Schwertner, Chair, Senate Committee on Health & Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3523** by Raymond (Relating to improving the delivery and quality of Medicaid acute care services and long-term care services and supports.), **Committee Report 2nd House, Substituted**

The fiscal implications of the bill cannot be determined at this time, due to the lack of specific estimates of both reduced revenue and potential lost savings and related to the delay of transition of certain programs into managed care.

The bill would delay the start date for certain pilot programs from not later than September 1, 2016 to not later than September 1, 2017 and allows the pilot programs to operate for up to 24 months instead of requiring that they operate for at least 24 months. The bill would allow managed care organizations to participate in the pilot programs. It is assumed that these changes will not affect any cost associated with operating the pilot programs, but these provisions could shift the costs between fiscal years if they begin later or operate for a shorter period of time.

The bill would allow the Department of Aging and Disability Services (DADS) to contract directly with providers participating in certain long-term-care waivers to provide certain attendant and habilitation services through the STAR+PLUS program and gives the agency regulatory and oversight authority over those providers for the delivery of those services. According to the Health and Human Services Commission (HHSC), any cost associated with these provisions can be absorbed within available resources of DADS and HHSC.

The bill would delay the transition to managed care of services provided to persons enrolled in the Texas Home Living Waiver (TxHmL) from not later than September 1, 2017 to on September 1, 2018. Further, the bill would delay by at least one year (from no later than September 1, 2020 to on September 1, 2021) the transition date for the carve-into managed care of services provided to individuals with intellectual and developmental disabilities who receive care in intermediate care facilities other than a state supported living center or a Medicaid waiver program other than TxHmL. Any savings that may have been achieved by providing services through managed care will be delayed. Additionally, delaying the transitions into managed care will result in the loss of premium tax revenue. Savings and revenue associated with the provision of TxHmL services will be lost in fiscal years 2017 and 2018. Also, savings and revenue associated with the provision of services for persons receiving care in intermediate care facilities or other waivers will be lost in fiscal years 2020 and 2021. Specific estimates of lost savings and reduced revenue cannot be provided.

Additionally, the bill requires HHSC to conduct an assessment of the outcomes of the TxHmL transition and include those findings in the annual report to be submitted by September 30th of

each year. Based on analysis provided by HHSC, the first required evaluation of the TxHmL waiver transition, due by September 30th, would be delayed due to a six-month data delay. It is assumed that DADS and HHSC can accomplish this provision of the bill within existing resources.

The bill would remove the requirement for HHSC to set the minimum staff rate enhancement paid to certain nursing facilities in the STAR+PLUS program and instead require HHSC to approve the rate enhancement methodology. Effective September 1, 2021, the bill would remove the requirement that HHSC set the minimum reimbursement rate paid to a nursing facility in the STAR+PLUS program. There may be an cost or savings related to these provisions but the effect on reimbursement rates cannot be determined.

Finally, the bill would amend the requirements and responsibilities related to the Intellectual and Developmental Disability System Redesign Advisory Committee and delay abolishment of the committee until January 1, 2026. The bill would require HHSC to analyze the outcomes of providing acute care Medicaid benefits to individuals with intellectual and developmental disabilities under managed care. It is assumed that HHSC can accomplish this provision of the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission, 539 Aging and Disability Services, Department of

LBB Staff: UP, CH, NB, WP, LR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 84TH LEGISLATIVE REGULAR SESSION

May 18, 2015

TO: Honorable Charles Schwertner, Chair, Senate Committee on Health & Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3523** by Raymond (Relating to improving the delivery and quality of Medicaid acute care services and long-term care services and supports.), **As Engrossed**

The fiscal implications of the bill cannot be determined at this time, due to the lack of specific estimates of both reduced revenue and potential lost savings and related to the delay of transition of certain programs into managed care.

The bill would delay the start date for certain pilot programs from not later than September 1, 2016 to not later than September 1, 2017 and allows the pilot programs to operate for up to 24 months instead of requiring that they operate for a full 24 months. It is assumed that these changes will not affect any cost associated with operating the pilot programs, but these provisions could shift the costs between fiscal years if they begin later or operate for a shorter period of time.

The bill would allow the Department of Aging and Disability Services (DADS) to contract directly with providers participating in certain long-term-care waivers to provide certain attendant and habilitation services through the STAR+PLUS program and gives the agency regulatory and oversight authority over those providers for the delivery of those services. According to the Health and Human Services Commission (HHSC), any cost associated with these provisions can be absorbed within available resources of DADS and HHSC.

The bill would delay the transition to managed care of services provided to persons enrolled in the Texas Home Living Waiver (TxHmL) from not later than September 1, 2017 to on or after September 1, 2018, and makes the transition optional. Further, the bill would delay by at least one year (from no later than September 1, 2020 to no sooner than September 1, 2021) the transition date for the carve-into managed care of services provided to individuals with intellectual and developmental disabilities who receive care in intermediate care facilities other than a state supported living center or a Medicaid waiver program other than TxHmL, and makes this transition optional as well. Any savings that may have been achieved by providing services through managed care will be delayed or not realized (if the transitions are not implemented). Additionally, delaying or not implementing the transitions into managed care will result in the loss of premium tax revenue. Savings and revenue associated with the provision of TxHmL services will be lost in fiscal years 2017 and 2018 at a minimum, and may be lost in later fiscal years if the transition is further delayed or not implemented. Also, savings and revenue associated with the provision of services for persons receiving care in intermediate care facilities or other waivers will be lost in fiscal years 2020 and 2021, and may be lost in later fiscal years if the transition is further delayed or not implemented. Specific estimates of lost savings and reduced revenue cannot be provided.

Additionally, the bill requires HHSC to conduct an assessment of the outcomes of the TxHmL transition and include those findings in the annual report to be submitted by September 30th of each year. Based on analysis provided by HHSC, the first required evaluation of the TxHmL waiver transition, due by September 30th, would be delayed due to a six-month data delay. It is assumed that DADS and HHSC can accomplish this provision of the bill within existing resources.

Finally, the bill would amend the requirements and responsibilities related to the Intellectual and Developmental Disability System Redesign Advisory Committee. The bill would require HHSC to analyze the outcomes of providing acute care Medicaid benefits to individuals with intellectual and developmental disabilities under managed care. It is assumed that HHSC can accomplish this provision of the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission, 539 Aging and Disability Services, Department of

LBB Staff: UP, CH, NB, WP, LR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 84TH LEGISLATIVE REGULAR SESSION

April 20, 2015

TO: Honorable Richard Peña Raymond, Chair, House Committee on Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3523** by Raymond (Relating to improving the delivery and quality of Medicaid acute care services and long-term care services and supports.), **Committee Report 1st House, Substituted**

The fiscal implications of the bill cannot be determined at this time, due to the lack of specific estimates of both reduced revenue and potential lost savings and related to the delay of transition of certain programs into managed care.

The bill would delay the start date for certain pilot programs from not later than September 1, 2016 to not later than September 1, 2017 and allows the pilot programs to operate for up to 24 months instead of requiring that they operate for a full 24 months. It is assumed that these changes will not affect any cost associated with operating the pilot programs, but these provisions could shift the costs between fiscal years if they begin later or operate for a shorter period of time.

The bill would allow the Department of Aging and Disability Services (DADS) to contract directly with providers participating in certain long-term-care waivers to provide certain attendant and habilitation services through the STAR+PLUS program and gives the agency regulatory and oversight authority over those providers for the delivery of those services. According to the Health and Human Services Commission (HHSC), any cost associated with these provisions can be absorbed within available resources of DADS and HHSC.

The bill would delay the transition to managed care of services provided to persons enrolled in the Texas Home Living Waiver (TxHmL) from not later than September 1, 2017 to on or after September 1, 2018, and makes the transition optional. Further, the bill would delay by at least one year (from no later than September 1, 2020 to no sooner than September 1, 2021) the transition date for the carve-into managed care of services provided to individuals with intellectual and developmental disabilities who receive care in intermediate care facilities other than a state supported living center or a Medicaid waiver program other than TxHmL, and makes this transition optional as well. Any savings that may have been achieved by providing services through managed care will be delayed or not realized (if the transitions are not implemented). Additionally, delaying or not implementing the transitions into managed care will result in the loss of premium tax revenue. Savings and revenue associated with the provision of TxHmL services will be lost in fiscal years 2017 and 2018 at a minimum, and may be lost in later fiscal years if the transition is further delayed or not implemented. Also, savings and revenue associated with the provision of services for persons receiving care in intermediate care facilities or other waivers will be lost in fiscal years 2020 and 2021, and may be lost in later fiscal years if the transition is further delayed or not implemented. Specific estimates of lost savings and reduced revenue cannot be provided.

Additionally, the bill requires HHSC to conduct an assessment of the outcomes of the TxHmL transition and include those findings in the annual report to be submitted by September 30th of each year. Based on analysis provided by HHSC, the first required evaluation of the TxHmL waiver transition, due by September 30th, would be delayed due to a six-month data delay. It is assumed that DADS and HHSC can accomplish this provision of the bill within existing resources.

Finally, the bill would amend the requirements and responsibilities related to the Intellectual and Developmental Disability System Redesign Advisory Committee. The bill would require HHSC to analyze the outcomes of providing acute care Medicaid benefits to individuals with intellectual and developmental disabilities under managed care. It is assumed that HHSC can accomplish this provision of the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission, 539 Aging and Disability Services, Department of

LBB Staff: UP, CH, NB, WP, LR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 84TH LEGISLATIVE REGULAR SESSION

April 13, 2015

TO: Honorable Richard Peña Raymond, Chair, House Committee on Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3523** by Raymond (Relating to improving the delivery and quality of Medicaid acute care services and long-term care services and supports.), **As Introduced**

The fiscal implications of the bill cannot be determined at this time, due to the lack of specific estimates of both reduced revenue and potential lost savings and related to the delay of transition of certain programs into managed care.

The bill would delay the transition to managed care of services provided to persons enrolled in the Texas Home Living Waiver (TxHmL) from not later than September 1, 2017 to on or after September 1, 2018, and makes the transition optional. Further, the bill would delay by at least one year (from no later than September 1, 2020 to no sooner than September 1, 2021) the transition date for the carve-into managed care of services provided to individuals with intellectual and developmental disabilities who receive care in intermediate care facilities other than a state supported living center or a Medicaid waiver program other than TxHmL, and makes this transition optional as well.

Any savings that may have been achieved by providing services through managed care will be delayed or not realized (if the transitions are not implemented). Additionally, delaying or not implementing the transitions into managed care will result in the loss of premium tax revenue. Savings and revenue associated with the provision of TxHmL services will be lost in fiscal years 2017 and 2018 at a minimum, and may be lost in later fiscal years if the transition is further delayed or not implemented. Also, savings and revenue associated with the provision of services for persons receiving care in intermediate care facilities or other waivers will be lost in fiscal years 2020 and 2021, and may be lost in later fiscal years if the transition is further delayed or not implemented. Specific estimates of lost savings and reduced revenue cannot be provided.

Additionally, the bill requires the Health and Human Services Commission (HHSC) to conduct an evaluation of the outcomes of the TxHmL transition and include those findings in the annual report to be submitted by September 30th of each year. Based on analysis provided by HHSC, the first required evaluation of the TxHmL waiver transition, due by September 30th, would be delayed due to a six-month data delay. It is assumed that the Department of Aging and Disability Services (DADS) and HHSC can accomplish this provision of the bill within existing resources.

Finally, the bill would amend the requirements and responsibilities related to the Intellectual and Developmental Disability System Redesign Advisory Committee. The bill would require HHSC to analyze the outcomes of providing acute care Medicaid benefits to individuals with intellectual and developmental disabilities under managed care. It is assumed that HHSC can accomplish this provision of the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission, 539 Aging and Disability Services, Department of

LBB Staff: UP, NB, WP, CH, LR