By: Davis of Harris H.B. No. 3520

A BILL TO BE ENTITLED

AN ACT

relating to state fiscal matters related to health and human services and state agencies administering health and human services programs.

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

ARTICLE 1. REDUCTION OF EXPENDITURES AND IMPOSITION OF CHARGES AND COST-SAVING MEASURES GENERALLY

SECTION 1.01. This article applies to any state agency that receives an appropriation under Article II of the General Appropriations Act and to any program administered by any of those agencies.

SECTION 1.02. Notwithstanding any other statute of this state, each state agency to which this article applies is authorized to reduce or recover expenditures by:

(1) consolidating any reports or publications the agency is required to make and filing or delivering any of those reports or publications exclusively by electronic means;

(2) extending the effective period of any license, permit, or registration the agency grants or administers;

(3) entering into a contract with another governmental entity or with a private vendor to carry out any of the agency's duties;

(4) adopting additional eligibility requirements consistent with federal law for persons who receive benefits under

any law the agency administers to ensure that those benefits are received by the most deserving persons consistent with the purposes for which the benefits are provided, including under the following laws:

(A) Chapter 62, Health and Safety Code (child health plan program);

(B) Chapter 31, Human Resources Code (Temporary Assistance for Needy Families program);

(C) Chapter 32, Human Resources Code (Medicaid program);

(D) Chapter 33, Human Resources Code (supplemental nutrition assistance and other nutritional assistance programs); and

(E) Chapter 533, Government Code (Medicaid managed care);

(5) providing that any communication between the agency and another person and any document required to be delivered to or by the agency, including any application, notice, billing statement, receipt, or certificate, may be made or delivered by e-mail or through the Internet;

(6) adopting and collecting fees or charges to cover any costs the agency incurs in performing its lawful functions; and

(7) modifying and streamlining processes used in:

(A) the conduct of eligibility determinations for programs listed in Subdivision (4) of this subsection by or under the direction of the Health and Human Services Commission;

(B) the provision of child and adult protective

services by the Department of Family and Protective Services;

(C) the provision of community health services, consumer protection services, and mental health services by the Department of State Health Services; and

(D) the provision or administration of other services provided or programs operated by the Health and Human Services Commission or a health and human services agency, as defined by Section 531.001, Government Code.

ARTICLE 2. MEDICAID PROGRAM

SECTION 2.01. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00291, 533.00292, and 533.00293 to read as follows:

Sec. 533.00291. CARE COORDINATION BENEFITS. (a) In this section, "care coordination" means assisting recipients to develop a plan of care, including a service plan, that meets the recipient's needs and coordinating the provision of Medicaid benefits in a manner that is consistent with the plan of care. The term is synonymous with "case management," "service coordination," and "service management."

(b) The commission shall streamline and clarify the provision of care coordination benefits across Medicaid programs and services for recipients receiving benefits under a managed care delivery model. In streamlining and clarifying the provision of care coordination benefits under this section, the commission shall at a minimum:

(1) subject to Subsection (c), establish a process for determining and designating a single entity as the primary entity

responsible for a recipient's care coordination;

(2) evaluate and eliminate duplicative services intended to achieve recipient care coordination, including care coordination or related benefits provided:

(A) by a Medicaid managed care organization;

(B) by a recipient's medical or health home;

(C) through a disease management program provided by a Medicaid managed care organization;

(D) by a provider of targeted case management and psychiatric rehabilitation services; and

(E) through a program of case management for high-risk pregnant women and high-risk children established under Section 22.0031, Human Resources Code;

(3) evaluate and, if the commission determines it appropriate, modify the capitation rate paid to Medicaid managed care organizations to account for the provision of care coordination benefits by a person not affiliated with the organization; and

(4) establish and use a consistent set of terms for care coordination provided under a managed care delivery model.

(c) In establishing a process under Subsection (b)(1), the commission shall ensure that:

(1) for a recipient who receives targeted case management and psychiatric rehabilitation services, the default entity to act as the primary entity responsible for the recipient's care coordination under Subsection (b)(1) is the provider of targeted case management and psychiatric rehabilitation services;

and

(2) for recipients other than those described by Subdivision (1), the process includes an evaluation process designed to identify the provider that would best meet the care coordination needs of a recipient and that the commission incorporates into Medicaid managed care program contracts.

Sec. 533.00292. CARE COORDINATOR CASELOAD STANDARDS. (a) In this section:

(1) "Care coordination" has the meaning assigned by Section 533.00291.

(2) "Care coordinator" means a person, including a case manager, engaged by a Medicaid managed care organization to provide care coordination benefits.

(b) The executive commissioner by rule shall establish caseload standards for care coordinators providing care coordination under the STAR+PLUS home and community-based services supports (HCBS) program.

(c) The executive commissioner by rule may, if the executive commissioner determines it appropriate, establish caseload standards for care coordinators providing care coordination under Medicaid programs other than the STAR+PLUS home and community-based services supports (HCBS) program.

(d) In determining whether to establish caseload standards for a Medicaid program under Subsection (c), the executive commissioner shall consider whether implementing the standards would improve:

(1) Medicaid managed care organization contract

compliance;

(2) the quality of care coordination provided under the program;

(3) recipient health outcomes; and

(4) transparency regarding the availability of care coordination benefits to recipients and interested stakeholders.

Sec. 533.00293. INFORMATION SHARING. (a) In this section:

(1) "Care coordination" has the meaning assigned by Section 533.00291.

(2) "Care coordinator" has the meaning assigned by Section 533.00292.

(b) To the extent permitted under applicable federal and state law enacted to protect the confidentiality and privacy of patients' health information, managed care organizations under contract with the commission to provide health care services to recipients shall ensure the sharing of information, including recipient medical records, among care coordinators and health care providers as appropriate to provide care coordination benefits. For purposes of implementing this section, a managed care organization may allow a care coordinator to share a recipient's service plan with health care providers, subject to the limitations of this section.

SECTION 2.02. Section 533.0061, Government Code, as added by Chapter 1272 (S.B. 760), Acts of the 84th Legislature, Regular Session, 2015, is amended by amending Subsections (a) and (c) and adding Subsection (d) to read as follows:

(a) The commission shall establish minimum provider access

standards for the provider network of a managed care organization that contracts with the commission to provide health care services to recipients. The access standards must ensure that a managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) [~~after-hours~~] urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

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

(9) any other services identified by the commission.

(c) The commission shall biennially submit to the legislature and make available to the public a report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations and managed care organization compliance with contractual obligations related to provider access standards established under this section. The report must contain:

(1) a compilation and analysis of information submitted to the commission under Section 533.005(a)(20)(D);

(2) for both primary care providers and specialty providers, information on provider-to-recipient ratios in an organization's provider network, as well as benchmark ratios to indicate whether deficiencies exist in a given network; [~~and~~]

(3) a description of, and analysis of the results from, the commission's monitoring process established under Section 533.007(l); and

(4) a detailed analysis of recipient access to urgent care providers, including:

(A) an analysis of the implementation of any distance standard adopted under Section 32.0248(b)(1), Human Resources Code;

(B) information on urgent care provider-to-recipient ratios; and

(C) information and statistics about organization compliance with contractual obligations related to urgent care access standards, including standards established under Section 32.0248, Human Resources Code, and any other applicable standards.

(d) In this section, "urgent care provider" has the meaning assigned by Section 32.0248, Human Resources Code.

SECTION 2.03. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0248 to read as follows:

Sec. 32.0248. INCREASING ACCESS TO URGENT CARE PROVIDERS. (a) In this section, "urgent care provider" means a health care provider that:

(1) provides episodic ambulatory medical care to individuals outside of a hospital emergency room setting;

(2) does not require an individual to make an appointment;

(3) provides some services typically provided in a

primary care physician's office; and

(4) treats individuals requiring treatment of an illness or injury that requires immediate care but is not life-threatening.

(b) The executive commissioner shall adopt rules and policies to increase recipient access to urgent care providers under the medical assistance program. In adopting the rules and policies under this subsection, the executive commissioner shall consider:

(1) whether to establish a distance standard to ensure that all recipients have access to at least one urgent care provider within a specified distance of the recipient's residence;

(2) requiring that the medical assistance program provider database established under Section 32.102 accurately identify urgent care providers;

(3) requiring each managed care organization that contracts with the commission under Chapter 533, Government Code, to provide health care services to medical assistance recipients to:

(A) improve the accuracy and accessibility of information regarding urgent care providers in the managed care organization's provider network directory required under Section 533.0063, Government Code; and

(B) if the organization maintains a nurse telephone hotline for its enrolled recipients, provide information to recipients, if appropriate, on the availability of services through in-network urgent care providers; and

(4) encouraging primary care physicians participating in the medical assistance program to maintain a relationship with urgent care providers for purposes of referring recipients in need of urgent care.

(c) In addition to adopting rules and policies under Subsection (b), to increase medical assistance recipients' access to urgent care providers, the commission shall consider whether to amend the Medicaid state plan to permit urgent care providers to enroll as facility providers under the medical assistance program.

(d) The commission shall consider implementing a process to streamline provider enrollment and credentialing for urgent care providers, including applying the requirements of Sections 533.0055 and 533.0064, Government Code, to those providers.

SECTION 2.04. As soon as practicable after the effective date of this article, the executive commissioner of the Health and Human Services Commission shall adopt the rules required by Section 32.0248, Human Resources Code, as added by this article.

SECTION 2.05. This article takes effect immediately if this Act 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 this article to have immediate effect, this article takes effect September 1, 2017.

ARTICLE 3. MENTAL HEALTH SERVICES

SECTION 3.01. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0993 to read as follows:

Sec. 531.0993. GRANT PROGRAM TO REDUCE RECIDIVISM, ARREST, AND INCARCERATION AMONG INDIVIDUALS WITH MENTAL ILLNESS AND TO

REDUCE WAIT TIME FOR FORENSIC COMMITMENT. (a) For purposes of this section, "low-income household" means a household with a total income at or below 200 percent of the federal poverty guideline.

(b) Using money appropriated to the commission for that purpose, the commission shall make grants to county-based community collaboratives for the purposes of reducing:

(1) recidivism by, the frequency of arrests of, and incarceration of persons with mental illness; and

(2) the total waiting time for forensic commitment of persons with mental illness to a state hospital.

(c) A community collaborative is eligible to receive a grant under this section only if the collaborative includes a county, a local mental health authority that operates in the county, and each hospital district, if any, located in the county. A community collaborative may include other local entities designated by the collaborative's members.

(d) The commission shall condition each grant provided to a community collaborative under this section on the collaborative providing matching funds from non-state sources in a total amount at least equal to the awarded grant amount. To raise matching funds, a collaborative may seek and receive gifts, grants, or donations from any person.

(e) The commission shall estimate the number of cases of serious mental illness in low-income households located in each of the 10 most populous counties in this state. For the purposes of distributing grants under this section to community collaboratives established in those 10 counties, for each fiscal year the

commission shall determine an amount of grant money available on a per-case basis by dividing the total amount of money appropriated to the commission for the purpose of making grants under this section in that year by the estimated total number of cases of serious mental illness in low-income households located in those 10 counties.

(f) The commission shall make available to a community collaborative established in each of the 10 most populous counties in this state a grant in an amount equal to the lesser of:

(1) an amount determined by multiplying the per-case amount determined under Subsection (e) by the estimated number of cases of serious mental illness in low-income households in that county; or

(2) an amount equal to the collaborative's available matching funds.

(g) To the extent appropriated money remains available to the commission for that purpose after the commission awards grants under Subsection (f), the commission shall make available to community collaboratives established in other counties in this state grants through a competitive request for proposal process. For purposes of awarding a grant under this subsection, a collaborative may include adjacent counties if, for each member county, the collaborative's members include a local mental health authority that operates in the county and each hospital district, if any, located in the county. A grant awarded under this subsection may not exceed an amount equal to the lesser of:

(1) an amount determined by multiplying the per-case

amount determined under Subsection (e) by the estimated number of cases of serious mental illness in low-income households in the county or counties; or

(2) an amount equal to the collaborative's available matching funds.

(h) The community collaboratives established in each of the 10 most populous counties in this state shall submit to the commission a plan that:

(1) is endorsed by each of the collaborative's member entities;

(2) identifies a target population;

(3) describes how the grant money and matching funds will be used;

(4) includes outcome measures to evaluate the success of the plan, including the plan's effect on reducing state hospital admissions of the target population; and

(5) describes how the success of the plan in accordance with the outcome measures would further the state's interest in the grant program's purposes.

(i) A community collaborative that applies for a grant under Subsection (g) must submit to the commission a plan as described by Subsection (h). The commission shall consider the submitted plan together with any other relevant information in awarding a grant under Subsection (g).

(j) The commission must review and approve plans submitted under Subsection (h) or (i) before the commission distributes a grant under Subsection (f) or (g). If the commission determines

that a plan includes insufficient outcome measures, the commission may make the necessary changes to the plan to establish appropriate outcome measures. The commission may not make other changes to a plan submitted under Subsection (h) or (i).

(k) Acceptable uses for the grant money and matching funds include:

(1) the continuation of a mental health jail diversion program;

(2) the establishment or expansion of a mental health jail diversion program;

(3) the establishment of alternatives to competency restoration in a state hospital, including outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;

(4) the provision of assertive community treatment or forensic assertive community treatment with an outreach component;

(5) the provision of intensive mental health services and substance abuse treatment not readily available in the county;

(6) the provision of continuity of care services for an individual being released from a state hospital;

(7) the establishment of interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and

(8) the provision of local community hospital, crisis, respite, or residential beds.

(l) Not later than December 31 of each year for which the commission distributes a grant under this section, each community

collaborative that receives a grant shall prepare and submit a report describing the effect of the grant money and matching funds in achieving the standard defined by the outcome measures in the plan submitted under Subsection (h) or (i).

(m) The commission may make inspections of the operation and provision of mental health services provided by a community collaborative to ensure state money appropriated for the grant program is used effectively.

(n) The commission shall enter into an agreement with a qualified nonprofit or private entity to serve as the administrator of the grant program at no cost to the state. The administrator shall assist, support, and advise the commission in fulfilling the commission's responsibilities with respect to the grant program. The administrator may advise the commission on:

(1) design, development, implementation, and management of the program;

(2) eligibility requirements for grant recipients;

(3) design and management of the competitive bidding processes for applications or proposals and the evaluation and selection of grant recipients;

(4) grant requirements and mechanisms;

(5) roles and responsibilities of grant recipients;

(6) reporting requirements for grant recipients;

(7) support and technical capabilities;

(8) timelines and deadlines for the program;

(9) evaluation of the program and grant recipients;

(10) requirements for reporting on the program to

policy makers; and

(11) estimation of the number of cases of serious mental illness in low-income households in each county.

ARTICLE 4. CHILD PROTECTIVE AND PREVENTION AND EARLY INTERVENTION SERVICES

SECTION 4.01. Subchapter A, Chapter 261, Family Code, is amended by adding Section 261.004 to read as follows:

Sec. 261.004. TRACKING OF RECURRENCE OF CHILD ABUSE OR NEGLECT REPORTS. The department shall collect, compile, and monitor data regarding repeated reports of abuse or neglect involving the same child or by the same alleged perpetrator. In compiling reports under this section, the department shall group together separate reports involving different children residing in the same household.

SECTION 4.02. Subchapter A, Chapter 265, Family Code, is amended by adding Sections 265.0041 and 265.0042 to read as follows:

Sec. 265.0041. GEOGRAPHIC RISK MAPPING FOR PREVENTION AND EARLY INTERVENTION SERVICES. (a) The department shall use existing risk terrain modeling systems, predictive analytics, or geographic risk assessments to:

(1) identify geographic areas that have high risk indicators of child maltreatment and child fatalities resulting from abuse or neglect; and

(2) target the implementation and use of prevention and early intervention services to those geographic areas.

(b) The department may not use data gathered under this

section to identify a specific family or individual.

Sec. 265.0042. COLLABORATION WITH INSTITUTIONS OF HIGHER EDUCATION. (a) The Health and Human Services Commission, on behalf of the department, shall enter into agreements with institutions of higher education to conduct efficacy reviews of any prevention and early intervention programs that have not previously been evaluated for effectiveness through a scientific research evaluation process.

(b) The department shall collaborate with an institution of higher education to create and track indicators of child well-being to determine the effectiveness of prevention and early intervention services.

SECTION 4.03. Section 265.005(b), Family Code, is amended to read as follows:

(b) A strategic plan required under this section must:

(1) identify methods to leverage other sources of funding or provide support for existing community-based prevention efforts;

(2) include a needs assessment that identifies programs to best target the needs of the highest risk populations and geographic areas;

(3) identify the goals and priorities for the department's overall prevention efforts;

(4) report the results of previous prevention efforts using available information in the plan;

(5) identify additional methods of measuring program effectiveness and results or outcomes;

(6) identify methods to collaborate with other state agencies on prevention efforts; [~~and~~]

(7) identify specific strategies to implement the plan and to develop measures for reporting on the overall progress toward the plan's goals<u>; and</u>

<u>(8) identify specific strategies to increase local capacity for the delivery of prevention and early intervention services through collaboration with communities and stakeholders</u>.

ARTICLE 5. FEDERAL AUTHORIZATION; EFFECTIVE DATE

SECTION 5.01. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 5.02. Except as otherwise provided by this Act, this Act takes effect September 1, 2017.