BILL ANALYSIS

C.S.H.B. 4533
By: Klick
Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been noted that the state is not prepared to meet the 2020 date set to transition the delivery of certain Medicaid services for recipients with physical and intellectual disabilities to a managed care delivery model. C.S.H.B. 4533 seeks to delay the implementation of this transition until such time when a pilot program established by the bill can be completed and its results analyzed.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 24 of this bill.

ANALYSIS

C.S.H.B. 4533 amends the Government Code to make changes to the system redesign for the delivery of Medicaid acute care services and long-term services and supports to persons with an intellectual or developmental disability by, among other provisions:

- requiring the Health and Human Services Commission (HHSC) to collaborate with the Intellectual and Developmental Disability System Redesign Advisory Committee in implementing the system redesign and requiring the redesigned system to provide the type and amount of Medicaid services most appropriate to the individuals' preferences in the most integrated and least restrictive setting;
- removing language authorizing HHSC to develop and implement multiple pilot programs to test one or more service delivery models involving a managed care strategy based on capitation to deliver long-term services and supports under Medicaid to individuals with an intellectual or developmental disability;
- providing for the development of a pilot program workgroup and requiring HHSC, in consultation and collaboration with the advisory committee and the workgroup, to instead develop and implement a single pilot program to test, through the STAR+PLUS Medicaid managed care program, the delivery of long-term services and supports to individuals participating in the pilot program;
- repealing the requirement for HHSC to transition Medicaid recipients receiving benefits under the Texas home living Medicaid waiver program to the STAR+PLUS Medicaid managed care program on September 1, 2020;
- requiring HHSC, in consultation and collaboration with the advisory committee and the workgroup, to review and evaluate the progress and outcomes of the pilot program and

submit, as part of the annual system redesign implementation report, a report on the pilot program's status that includes recommendations for improving the program;

- requiring HHSC, on conclusion of the program and in consultation and collaboration with the advisory committee and workgroup, to prepare and submit a written report to the legislature that evaluates the pilot program based on a certain comprehensive analysis; and
- requiring HHSC, after completing the evaluation and in consultation and collaboration with the advisory committee, to develop a plan for the transition of all or a portion of the services provided through an ICF-IID program or a Medicaid waiver program that were not included in the pilot program to a Medicaid managed care model.

C.S.H.B. 4533 sets out provisions relating to the pilot program and provides for its development, design, implementation, and operation. The bill requires the program to be implemented on September 1, 2023, and to operate for at least 24 months in a STAR+PLUS Medicaid managed care service area selected by HHSC. The bill requires HHSC, before implementing the program, to develop and implement, in consultation and collaboration with the advisory committee and workgroup, a process to ensure that program participants remain Medicaid eligible for 12 consecutive months during the program. The bill authorizes HHSC, after the evaluation of the pilot program, to continue the program to ensure continuity of care of program participants and requires HHSC to ensure that there is a comprehensive plan for transitioning the provision of Medicaid benefits for program participants to the benefits provided before participating in the program if the program is not continued. The bill requires the transition plan to be developed in consultation and collaboration with the advisory committee and workgroup with applicable stakeholder input.

C.S.H.B. 4533 establishes that the pilot program concludes on September 1, 2025, unless continued by HHSC. The bill requires HHSC to publish notice of the program's continuance in the Texas Registrar, if applicable, not later than September 1, 2025. The bill requires HHSC, before implementing the transition of certain Medicaid services to a Medicaid managed care model, to determine whether to continue operation of the Medicaid waiver programs or ICF-IID program only for purposes of providing certain long-term services and supports or to provide all or a portion of those services and supports previously available under those programs through the managed care program delivery model selected by HHSC. The bill revises provisions providing for that transition of benefit delivery.

C.S.H.B. 4533 requires HHSC, on making a determination to transition those services, to ensure that the consumer direction service delivery model is an available option for each individual with an intellectual or developmental disability who receives Medicaid benefits subject to the transition in order to achieve self-determination, choice, and control and to ensure that the individual or the individual's legally authorized representative has access to a facilitated, person-centered plan that identifies outcomes for the individual.

C.S.H.B. 4533 reenacts Section 534.053(g), Government Code, as amended by Chapters 837 (S.B. 200), 946 (S.B. 277), and 1117 (H.B. 3523), Acts of the 84th Legislature, Regular Session, 2015, to conform to changes made by Chapter 837 (S.B. 200) and Chapter 946 (S.B. 277) and amends the Government Code to set the advisory committee to be abolished on the second anniversary of the date HHSC completes implementation of the transition. The bill also provides for the expiration of provisions governing the advisory committee and provisions providing for an annual report to the legislature regarding the implementation of the system redesign on that second anniversary.

C.S.H.B. 4533 authorizes HHSC to delay implementation of a part of the system redesign without further investigation, adjustments, or legislative action if HHSC determines that it adversely affects the system of services and supports to persons and programs to which it applies. The bill requires HHSC to do the following for purposes of implementing the pilot

program and transitioning benefit delivery to a managed care delivery model following completion of the pilot program:

- implement and maintain a certification process for and maintain regulatory oversight over providers under the Texas home living and home and community-based services waiver programs; and
- require managed care organizations (MCOs) to include in their provider networks qualified comprehensive long-term services and supports providers and providers under those waiver programs that specialize in services for individuals with intellectual disabilities.

The bill sets out certain reporting requirements for a comprehensive long-term services and supports provider for those same purposes and prohibits such a provider from being held accountable for the provision of services specified in an individual's service plan that are not authorized or subsequently denied by the MCO. The bill requires HHSC, on transitioning services to a Medicaid managed care delivery model, to ensure that individuals do not lose benefits they receive under the applicable Medicaid waiver program.

C.S.H.B. 4533 requires the executive commissioner of HHSC, not later than September 1, 2020, and only if HHSC determines it would be cost effective, to seek a Section 1115 Medicaid waiver to provide Medicaid benefits to medically fragile individuals who are 21 years of age or older and whose health care costs exceed cost limits under appropriate Medicaid waiver programs.

C.S.H.B. 4533 requires the executive commissioner to adopt rules as necessary to implement the bill's changes in law.

C.S.H.B. 4533 repeals Section 534.201, Government Code.

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 4533 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes a requirement for the redesigned system to provide the type and amount of Medicaid services most appropriate to the individuals' preferences in the most integrated and least restrictive setting.

The substitute does not include provisions setting the advisory committee to be abolished and providing for the expiration of related provisions on January 1, 2029, but includes provisions that instead set the advisory committee to be abolished on the second anniversary of the date HHSC completes implementation of the transition to the Medicaid managed care delivery model and provide for the expiration of those related provisions on that same date.

The substitute establishes a pilot program workgroup and provides for its inclusion in the system redesign process. The substitute changes the purposes for which the new pilot program is to be established from testing the delivery of home and community-based services to adults with an intellectual or developmental disability to testing the delivery of long-term services and supports to individuals participating in the program.

The substitute revises and sets out additional provisions relating to the development, design, implementation, and operation of the pilot program, including with respect to:

- the stakeholders from whom HHSC is required to receive and evaluate input;
- the selection of MCOs to participate in the program;
- the persons to whom a participating MCO is to provide services and supports;
- the required design of the program and the use of innovative technologies as part of the program's design;
- the program's deliverables and provider qualifications;
- the 12-month continuous eligibility of program participants for Medicaid benefits;
- the development of measurable program goals and the reporting, tracking, and assessing of specific strategies and performance measures for achieving the identified goals;
- the eligibility criteria for participation in the program;
- the development and distribution of informational materials on the program and its benefits and impact on services; and
- the collection of information from participating MCOs for use in the program's evaluation and the report on the program.

The substitute changes the location in which the program is to be implemented from one or more health care services regions selected by HHSC to a STAR+PLUS Medicaid managed care service area selected by HHSC. The substitute changes the program from a voluntary program to one in which eligible individuals are automatically enrolled with an opportunity to opt out of participation.

The substitute revises the requirements relating to the comprehensive analysis on which the written report evaluating the program is based.

The substitute does not include a provision requiring HHSC to determine, after concluding the pilot program, whether to establish a new pilot program or to transition to the managed care delivery model. The substitute provides instead for the continuation of the pilot program, if necessary, and, after implementing the program and completing its evaluation, for the phased transition of all or a portion of the services provided through an ICF-IID program or a Medicaid waiver program that were not included in the pilot program to a Medicaid managed care model.

The substitute clarifies that HHSC may delay implementation of a part of the system redesign for an applicable reason without further investigation, adjustments, or legislative action.

The substitute includes certain reporting requirements for comprehensive long-term services and supports providers for purposes of implementing the pilot program and transitioning the provision of services to the STAR+PLUS Medicaid managed care model and prohibits such a provider from being held accountable for the provision of certain services. The substitute includes a requirement for HHSC to ensure that, on transitioning those services, individuals do not lose benefits they receive under an applicable Medicaid waiver program.

The substitute repeals the entirety of Section 534.201, Government Code, rather than certain provisions of that section, but does not repeal the following Government Code provisions:

- Sections 534.104(d) and (e)
- Section 534.108
- Section 534.110

The substitute includes a procedural provision requiring the executive commissioner to seek a certain Section 1115 Medicaid waiver by September 1, 2020, if HHSC determines such a waiver

would be cost effective.

The substitute includes the definition of "consumer direction model" and revises definitions of "comprehensive long-term services and supports provider" and "residential services."